NEW YORK STATE | Department of Health

Value Based Payment Quality Improvement Program (VBP QIP)

Frequently Asked Questions

As of 1/25/2018

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VBP QIP FAQs

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Item #	Category	Question	Response
1	Structure and Timeline	How long will VBP QIP run for?	VBP QIP is a 5-year program that runs in line with DSRIP.
2	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.
3	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.

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4	Structure and Timeline	What is the role of the MCOs throughout VBP QIP?	As described in the VBP QIP Guidance Webinar held on January 24, 2018, the role of the MCO is as follows: • Validate reporting • Communicate with the facility and PPS • Collaborate • Oversee program • Distribute and report on funds *Note: The MCO is not responsible for ensuring that the Facilities achieve the goals of VBP QIP.*
5	Structure and Timeline	What is the role of the PPSs throughout VBP QIP?	The role of the PPS in VBP QIP is as follows: • Provide support (non-financial) and guidance to participating facilities • Flow funds from the MCO to the facility

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6	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 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
7	Program Payments and Funding	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.
8	Program Payments and Funding	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.

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9	Facility Plan	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.
10	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.
11	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.

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12	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.
13	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.
14	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.
15	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 VBP contracts that account for 80% of the Facility's Medicaid Managed Care revenue based on calendar year 2016 by June 29, 2018.

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16	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, 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.
17	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.
18	VBP QIP Disbursement	What type of audit authority will ensure that the money gets to the Facilities?	Both MCOs and PPSs will be held accountable for the flow of funds through MMCOR reporting. The MCO is responsible for sending money to the PPS and making sure the money is then transferred to the Facility. Facility The MCO is not responsible for auditing the Facility's expenditure of VBP QIP payments. The MCO's responsibility is to be a resource to the Facility, as it monitors and evaluates the Facility's progress throughout the 5 years of the program.

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19	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.
20	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.
21	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).
22	VBP QIP Disbursement	Will a gross up of premium be added on to cover any required statutory reserves?	Yes. A gross up of premium will be added to cover any required statutory reserves.

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23	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.
24	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. 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.
25	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.

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26	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.
27	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.
28	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.
29	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

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30	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 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.
31	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 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.
32	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.

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33	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.
34	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.

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35	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.
36	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.
37	P4P Measures	What is the definition of "population" for the P4P measures?	The population refers to all payers for the Facility.
38	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.

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39	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.
40	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.
41	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.
42	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.

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43	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.
44	P4R VBP Contracting	Will DOH release a contracting template?	No. DOH is not releasing a VBP contract template.
45	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 provided will help promote the purpose and validity of the program.
46	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.

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47	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.
48	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.
49	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.

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50	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.
51	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 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 June 29, 2018.

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52	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 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.
53	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.
54	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.

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55	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.
56	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 Managed Care amounts through a TCGP arrangement?	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 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.
57	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.

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58	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.
59	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.
60	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.

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61	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.

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62	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.
63	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 deviations are not needed for measurement in the program.
64	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.

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65	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.
66	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.
67	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.
68	Service Exclusion Waiver	Will facilities that meet the original deadline of April 1, 2018 receive a credit?	No, the new P4R deadline for facilities to submit contracts where 80% of their Medicaid Managed Care dollars are in VBP arrangements will be **June 29, 2018** for all facilities.

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69	Service Exclusion Waiver	Do submitted contracts need an effective date retroactive to January 1, 2018	All submitted new or amended contracts should have an effective date of October 1, 2018. DOH will review on a case by case basis any contracts that are submitted with an effective date before October 1.
70	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.
71	Other	Will the rates be sent to CMS for approval?	Yes. The rates will be sent to CMS for approval.
72	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.
73	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.

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74	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.
75	Other	Does this program affect the upper payment limit?	No. VBP QIP payments do not affect the upper payment limit.
76	Other	How will the State handle the coordination of communication between DOH and VBP QIP participants as well as between program participants?	To ensure an environment that promotes open dialogue and transparency, DOH expects to continue having one-on-one conversations with all VBP QIP participants. DOH also plans to develop an all-parties contact list, which will have main points of contact from each participant, and will distribute this list to all of the program's participants. DOH will be sure to inform participants of all Program developments in a timely manner as well as create a channel to ensure that DOH is immediately made aware of any party that is not fulfilling its programmatic obligations. DOH holds monthly webinars via WebEx every third Wednesday of each month for all participants to attend.
77	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.

As of 1/25/2018
VBP QIP FAQs

Item #	Category	Question	Response
78	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.