Washington State Health Care Authority

MCO VBP Survey Questions and Answers		
#	**Respondent Questions**	**HCA Answers**
1.	Recognizing this survey is for CY16, can the HCA clarify, for incentive reporting, should amounts reported cover payments made in 2016 or payments made for 2016 contracts, regardless of when they were paid?	For incentive reporting, amounts reported should be based on month of service. So payments **for** services in CY 2016 (even if payments were made in early 2017).
2.	Please provide more clarity around categories 2C and 2D. Specifically, would non-payment of an incentive from an MCO to a provider qualify as a penalty as referenced in 2D or does penalty strictly mean a dollar amount paid back to the MCO by the provider (and not from funds already given to the provider by the MCO)?	Non-payment of an incentive payment, where the incentive payment would otherwise result in a net positive payment in addition to the base payment, would qualify as a Category 2C arrangement. A downward adjustment in payment based on a provider not meeting quality goals would qualify as a 2D arrangement.
3.	Please more clearly and specifically define "FFS architecture" as referenced in Category 3 of the HCP-LAN	"FFS architecture" refers to payment models that are built upon a fee-for-service reimbursement methodology, where payments are made for units of service while incorporating quality adjustments and cost trend targets. Please refer to the HCP-LAN APM Framework White Paper[1] for more detailed descriptions.

[1] See more on the HCP-LAN APM Framework Final White Paper here: http://hcp-lan.org/workproducts/apm-whitepaper.pdf

4.	Has the HCA closely coordinated with WSHA/WSMA/WACMHC/other provider organizations across the state on this initiative, and both this survey and the provider survey?	HCA has coordinated most closely with the MVP Action Team, which comprises broad representation from MCOs, providers, provider organizations, and other health system stakeholders, on the development of this survey.
5.	How do VBP arrangements for PT/OT/speech therapy/other ancillary services factor in to this survey?	We are looking to capture all payments to all types of providers through this survey. If PT/OT/speech therapy/other ancillary services are part of a global cap/total cost of care arrangement, then the payments would be included in the associated payment model (e.g. 3B for a two-sided risk arrangement).
6.	We are concerned about the proprietary nature of the data being requested. Can HCA please confirm that if any survey results are shared publicly, it will be in aggregate and individual MCOs will not be identified?	HCA will only share results from this survey publicly in aggregate, and will do so without identifying individual MCOs.
7.	Please elaborate on the purpose for establishing a 2016 baseline and how it will be used, outside of the VBP incentives under the Medicaid Transformation Demonstration Project.	Results from this survey will help HCA track VBP adoption over time and as a reference for performance year VBP attainment under the Apple Health contracts.
8.	Please clarify whether MCOs are required to respond to the survey and if so, explain the basis for the requirement as it does not appear to be included in current contract requirements.	There is no contractual requirement for MCOs to report calendar year 2016 baseline, however HCA aims to explore using VBP attainment and improvement under Medicaid Transformation Demonstration VBP incentives.
9.	Is the intent of this survey to establish the “official” prior performance year related to Section 2: Qualifying Provider Incentives and Section 3: Qualifying Value Based Payments as stated in Exhibit F of the Apple Health Contract? If so, will this survey be assessed by a third party contractor (Exhibit F, Section 2.9)?	The intent of this survey is to establish the “official” prior performance year, in that HCA will reference Performance Year 1 VBP attainment relative to 2016 Baseline. There are no dollars tied to the survey results or baseline levels of VBP attainment. No third party contractor will assess survey

	a. Has the third party contractor been selected yet?	results. However, HCA is considering adding 2016 Baseline reporting as a Pay for Performance requirement tied to incentives under the Medicaid Transformation Demonstration, at which point HCA would pursue validation by an independent 3rd party assessor. a. N/A
10.	Related to the above, is the intent for the 2016 Baseline Survey and Amendment 9 Exhibit F to be in sync? If so, it does not appear as if they are. As an example, in 2.8.2 of Exhibit F, "Total Payments" is defined as "the capitation payments, excluding any Safety net Assessment (SNAF), Provider Access Payment (PAP) or Trauma funding paid to the Contractor" while the survey instructions say "Total Payments means the total Medicaid payments to the providers,". The critical difference is paid to the MCO as opposed to providers.	HCA is looking for total payments paid to providers, excluding MCO payments to providers that include "SNAF, PAP, Trauma, or other pass-through payments."
11.	Given that it's already June 7th and there are many outstanding, critical questions regarding the definition of the requirements for the survey relationship of this survey to the Apple Health contract, a later deadline is more reasonable. A lot of data is being requested in a method and format that are new. More time to fully define and understand the requirements as well as build the reporting would be much appreciated.	HCA will extend the deadline for submission to 3 p.m. PDT on Wednesday July 19th
12.	Are Paid Incentives and Paid Disincentives included in Table 1? If not, is it correct to have Table 3's Total Payments column auto-populated from Table 1?	Yes, Paid Incentives and Paid Disincentives are included in Table 1.
13.	Can HCA clarify the example on tab 10 used to demonstrate how to address a regional breakdown and how this relates to how an MCO is	HCA recommends using the following equation to evaluate a regional breakdown of a payment model:

	supposed to report a hybrid payment? It seems as if the model has multiple payments reports; if the definition of hybrid payments would be utilized, would multiple payments be reported, would the highest amount represent the plurality of payment?	$\$ for\ APM\ Subcategory \times \frac{number\ of\ billing\ providers\ (i.e.\ clinicians)\ in\ region}{number\ of\ total\ providers} = amount$ In the example provided on Sheet 10, the MCO has multiple contracts with provider group A, who has clinics in three counties but a centralized billing office. The hypothetical example is NOT an example of a hybrid payment model. As noted in "Principle 6" of the LAN APM Framework White Paper, when reporting hybrid payment models that comprise multiple payment models, MCOs should report the payment dollars for the hybrid model according to the subcategory within which the most dominant payment model falls.
14.	On the third tab (titled "3. Total Medicaid Payments"), the Instructions request reporting based on provider location. Given the LAN's and Healthier Washington's focus on the whole person, please consider changing the instruction to reporting based on the member location. Reporting dollar amounts based on the member's residence is more appropriate and more meaningful for the intent of the LAN. a. For example, if a member living in Okanogan County is sent to Seattle Children's Hospital for care, the current instructions would call for this to be reported in the King ACH Region. However, the care is associated with a member in the North Central region and would, thus, be more appropriately reported in the North Central region. b. Potentially, the survey could reference where that individual/member has a primary care assignment, which would provide some identification of the provider.	The purpose of reporting payments based on provider location is to identify where and how dollars are being spent and in which regions providers are engaged with what types of VBP arrangements. If the payments are reported by member location, reported payments could be skewed away from the regions in which providers are actually participating in the respective payment models. HCA welcomes additional information, such as numbers of members with primary care assignments in each region and subcategory.
15.	On the first tab (titled "1. Definitions"), please clarify if the request is for premium revenue from HCA to the MCO or for payments from the MCO to the providers. As written, the definitions and language around "Total Payments" (and its note) and "% Total Payments" are	Consider the following amended definition for "Total Payments": **Total Payments*** means the total Medicaid payments made by the MCO to providers, excluding any case payments,

	unclear as they contain elements of both premium revenue AND payments to providers. For example, "…case payments, administrative dollars, Washington State Health Insurance Pool (WSHIP), premium tax…" are components of premium revenue. Additionally, the term "medical premiums" is used. Meanwhile, other language references "payments made to providers" and "total dollars paid to providers." It is unclear if the survey is requesting Table 1 to be completed using premium revenue or provider payments because the language seemingly uses terminology associated with both, but the two are unrelated and mutually exclusive.	administrative dollars, Safety Net Assessment Fund (SNAF), Provider Access Payment (PAP) or Trauma funding from January 1, 2016 through December 31, 2016. Note: Total Payments should represent the total MCO payment to providers to include pharmacy, inpatient, outpatient, physician/professional, and other health services, excluding any pass-through payments. HCA welcomes the opportunity to discuss additional questions via email or conference call.
16.	How should pharmaceutical payments be included in the reported payment models?	Payments made for pharmacy services should be categorized based on any relevant incentives, disincentives, total cost of care arrangements, or cost targets linking pharmacy payments to other provider payments. For examples of how pharmacy payments can be included in subcategories in concert with broader payment models, please see the Addendum to the Alternative Payment Model Framework White Paper[2].
HCA has received requests for examples of payment models and their associated categorization under the HCP-LAN Framework. HCA will coordinate with the MVP Action Team to gather input and further explore detailed explanations of payment model designs.		

[2] See the HCP-LAN Addendum to the APM Framework White Paper here: http://hcp-lan.org/workproducts/apm-whitepaper-addendum.pdf