



**Department
of Health**

Managed Long Term Care Clinical Advisory Group

Value Based Payment Recommendations

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NYS Medicaid Value Based Payment

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Introduction

New York State's Delivery System Reform Incentive Payment (DSRIP) Program aims to fundamentally restructure New York State's (NYS) healthcare delivery system by reducing avoidable hospital use and improving long-term financial sustainability. To support the transformation New York State has committed to transition at least 80 percent of managed care payments to Value Based Payment (VBP) arrangements by 2020. VBP pays plans and providers for delivering high quality, high value services rather than for the volume or frequency of encounters or procedures.

The document that embodies New York State's agreement with the Centers for Medicare and Medicaid Services (CMS) is the New York State Roadmap for Medicaid Payment Reform, which is available in the VBP Resource Library.¹ The Roadmap is updated annually and details the requirements and recommendations for the implementation of VBP. It describes the types of VBP arrangements New York State has designed for the Medicaid program and provides a menu of options for managed care plans and providers.

The Roadmap describes two main types of VBP Arrangements: 1) episodic arrangements focused around a particular diagnosis or type of care; and 2) population-based arrangements focused on a group of members. Population-based arrangements include a number of "subpopulations" for whom highly specialized, intensive care is required. For these subpopulations, including members in Managed Long Term Care (MLTC), improved care coordination and integration are key goals. VBP arrangements for subpopulations are intended to encompass the total care for members and the costs associated with that care.

The Role of the Clinical Advisory Group

As part of its ongoing commitment to engage stakeholders, the New York State Department of Health (DOH) has organized Clinical Advisory Groups (CAGs) for each VBP arrangement. CAGs are groups of clinicians and subject matter experts involved in specific types of care such as maternity, behavioral health, or pediatrics brought together from around the state to provide expert feedback. In the first phase of VBP implementation in 2015 and 2016, the role of the CAGs was to discuss each VBP arrangement in detail in order to provide clinical insights and make quality measure recommendations to DOH. CAG reports containing the initial recommendations of each CAG were published and are posted on the Department of Health (DOH) website.² The MLTC CAG held four meetings in 2016, with respective recommendations published in December 2016.

In 2017, the CAGs were reconvened to prioritize and refine clinical and care delivery goals for VBP arrangements and provide recommendations to guide the long-term development of the State's quality measure set for VBP. The goal is for the CAGs to meet annually to continue to help DOH prioritize care goals and to review significant changes in clinical guidelines and evidence-based care. They will also help identify opportunities for care improvement for which future quality measurement may be appropriate.

In 2017 the MLTC CAG met twice, once in June to review the final MLTC VBP quality measure set for 2017 and Level 1 VBP guidance for MLTC, and again in August to discuss recommendations for 2018. This report serves as the 2017 annual update to the MLTC CAG's original recommendations.

Organization of the 2017 MLTC CAG VBP Recommendation Report

The MLTC CAG Recommendation Report is organized in two sections. The first section includes

¹ See New York State Department of Health, Medicaid Redesign Team, A Path Toward Value Based Payment: Annual Update, June 2016: Year 2, June 2016. ([Link](#))

² NYS DOH VBP Resource Library ([Link](#))

recommendations for final measure guidance for measurement year (MY) 2017 reporting and the MY 2018 VBP quality measure set for the MLTC VBP Arrangement. The second includes key considerations to guide the ongoing development of the MLTC VBP Arrangement.

MLTC VBP Quality Measure Recommendations

The MLTC VBP Quality Measure discussion was conducted in three segments. First, the CAG members reviewed key measure themes in the MY 2017 MLTC VBP measure set to ascertain whether there were gaps in measurement that needed to be addressed over the longer term. Measure themes were based on key clinical and functional care delivery goals the CAG had identified during its deliberations in 2016. Second, the group reviewed the 2017 measure set for changes in individual measure categorization or use classification. Measures are set as Category 1, 2, or 3 according to their relevance to the member population in question and the VBP arrangement, the reliability and validity of the measure, and the feasibility of collection and use. Measure classification recommendations pertain to how the measure will be used for payment in VBP arrangements for MLTC plans and VBP Contractors.³ Third, the CAG discussed whether changes to recommendations were needed for MY 2018.

Review of Measure Themes

For the measure theme review the CAG focused on the longer term clinical and functional care goals for MLTC members in an MLTC VBP Arrangement in order to identify any gaps or oversights. The group was asked whether there were essential themes missing from the measure set that should be represented with added measures in future measurement years. The five themes identified and discussed include:

- 1.) Critical Prevention – Captures aspects of care related to preventing adverse events or occurrences likely to hasten decline for MLTC members (e.g., influenza, falls, chronic infections, weight loss, and emergency room visits and hospitalization);
- 2.) Functional Improvement – Captures aspects of care related to supporting and improving self-care skills and maintaining independence (e.g., continence, pulmonary sufficiency, and life skills and performance of activities of daily living);
- 3.) Personal Choice/Satisfaction – Captures aspects of care related to following individual preferences and experience of care (e.g., involvement in the development of the care plan, ensuring that appropriate care decisions can be made for individuals who are incapacitated, and reported degree of satisfaction with services);
- 4.) Quality of Life – Captures aspects of care related to happiness, enjoyment, consciousness, and social and emotional well-being (e.g., pain control, identification and treatment of behavioral health disorders such as depression, and appropriate use of sedative medications); and,
- 5.) Medication Review – Captures aspects of care related to monitoring prescription medications and preventing adverse drug interactions in members with multiple prescriptions (e.g., comprehensive medication review and monitoring of use of high risk drugs in the elderly).

After reviewing the five themes the CAG moved to a review of the MY 2017 measure set to reexamine recommended measure categorization and use classification for MY 2017 and MY 2018.

³ A VBP Contractor is a lead provider or group of providers such as an Accountable Care Organization (ACO) or Independent Practice Association (IPA) that can take responsibility for the cost and care of a group of members in a VBP contract with a managed care plan.

Review of Measure Categorization and Classification

The CAG reviewed the measure categorizations and classification framework for VBP including the category definitions and the criteria for recommended use. Measures are set as Category 1, 2, or 3. Use classifications are pay-for-performance (P4P) or pay-for-reporting (P4R). The CAG also reviewed the issues and concerns with measure use flagged during the State's feasibility review of MY 2017 CAG-recommended measures. Proposed changes to final VBP guidance for MY 2017 and recommendations for MY 2018 were discussed.

Measure categorization sorts measures according to their clinical validity, reliability, and feasibility. The three categories are:

- 1.) **CATEGORY 1** – Approved quality measures that are clinically relevant, reliable and valid, and feasible;
- 2.) **CATEGORY 2** – Measures that are clinically relevant, valid, and probably reliable, but where the feasibility issues require further investigation before full implementation is possible; and,
- 3.) **CATEGORY 3** – Measures that are insufficiently relevant, valid, reliable and/or feasible and are not recommended for VBP.

MLTC Category 1 measures for MY 2017 and MY 2018 will be calculated by the Office of Quality and Patient Safety (OQPS), to reduce the burden on MLTC plans and VBP Contractors.

Measure classification sorts measures under discussion according to their recommended uses for payment for MLTC plans and VBP contractors. Each Category 1 and 2 measure is designated as P4P or P4R.

- **P4P** – Measures designated as P4P are intended to be used for performance payments in MLTC Level 1 and in the determination of shared savings for which VBP Contractors are eligible. Performance on the measures can be used to set targets for bonus payments for MLTC Level 1 and in the determination of the target budget and calculation of shared savings.
- **P4R** – Measures designated as P4R are intended to be used by MLTC plans to incentivize VBP Contractors to report data to monitor quality of care delivered to members under the VBP contract. MLTC plans and VBP Contractors will be incentivized based on timeliness, accuracy and completeness of data reporting.

Measures can move from P4R to P4P through the annual CAG and State review process or as determined by the MLTC plan and VBP Contractor.

Proposed Final Guidance for MY 2017

The CAG reviewed the MY 2017 MLTC VBP measure set to discuss possible changes to final measure guidance. Category 1 and 2 measures from the MY 2017 measure set were considered.

Category 1

Category 1 MLTC VBP measures are aligned with the existing MLTC Quality Incentive (MLTC QI), a program that uses a 2 percent quality withhold from the MLTC premium to pay plans according to a quality and efficiency methodology established by OQPS. Measures from the MLTC QI are advantageous for use in VBP for MLTC because they are well established as P4P measures at the plan level. The main source of data for the MLTC QI measures is the Uniform Assessment System for New York, or UAS-NY, a comprehensive health and functioning assessment completed by MLTC plans for each member every 6 months or upon a change in an individual's circumstances. As a result of the CAG's alignment with the existing MLTC QI measures, all MY 2017 MLTC Category 1 measures are classified as P4P.

MLTC QI measures also include a measure of potentially avoidable hospitalizations, or PAH. A

PAH is an inpatient hospitalization that might have been avoided if proper outpatient care was received in a timely manner. Six conditions are covered by the measure: 1) anemia; 2) congestive heart failure; 3) electrolyte imbalance; 4) respiratory infection; 5) sepsis; and, 6) urinary tract infection. The measure is calculated by OQPS using Statewide Planning and Research Cooperative System (SPARCS) data. SPARCS is an all-payer hospital file that includes the primary discharge diagnosis, allowing OQPS to identify hospitalizations that were potentially avoidable for the six conditions.

The existing Nursing Home Quality Incentive (NHQI) program also has a PAH measure. The NHQI PAH measure has been adopted into the MLTC VBP initiative as a Category 1 P4P measure to facilitate the participation of nursing homes in MLTC VBP arrangements. The PAH measure for the NHQI covers the same six conditions as the MLTC QI PAH measure but is computed at the facility level for nursing homes using the CMS Minimum Data Set (MDS) and the SPARCS data set.

For the purposes of VBP OQPS will calculate the MLTC VBP PAH measure for all MLTC plan-provider combinations based on attribution files submitted by plans to OQPS. For the MLTC VBP PAH, the attribution from MLTC plan to provider level will allow MLTC plans and potential VBP Contractors to identify provider-specific PAH rates and opportunities for performance improvement incentives. OQPS will also calculate the PAH measure at the nursing home facility level and supply it to MLTC plans for use with potential VBP Contractors. MLTC plans and VBP Contractors will need to use the measure as calculated at a facility even if they cover a limited number of total occupants.

The PAH measure is required for Level 1 MLTC VBP Arrangements for partially capitated plans because a P4P agreement using the PAH measure meets the definition for Level 1 VBP for MLTC in the New York State VBP Roadmap.⁴ Other Category 1 MLTC VBP measures may also be used for Level 1 MLTC P4P VBP contracts. Category 2 measures may also be used as they contain additional measures from the NHQI that are appropriate for use for VBP contracts with nursing homes.

It should be noted that some MLTC product lines – Medicaid Advantage Plus (MAP), Program of All-Inclusive Care for the Elderly (PACE), and Fully Integrated Dual Advantage (FIDA) – include Medicare benefits. These product lines have a better line of sight into Medicare costs and enhanced capacity to integrate and coordinate the full continuum of care for MLTC members. The CAG considered possible alternatives for more advanced approaches to VBP implementation and quality measurement for MAP, PACE, and FIDA plans as part of a separate discussion.

Accordingly the CAG makes the following recommendation:

- 1.) Add the PAH measure for nursing homes to the Category 1 measure set as a P4P measure to facilitate Level 1 VBP arrangements with nursing homes**

Category 2

MLTC Category 2 measures include additional measures selected from the NHQI and the New York State MLTC Survey as well as several medication review measures used in Medicare. The CAG discussed current feasibility issues with the Category 2 measures.

The use of measures from the NHQI for VBP presents several challenges. The NHQI is a performance payment initiative developed to incentivize quality performance and improvement for nursing homes. Although the NHQI measures have been in use for a number of years, until recently nursing homes had been funded on a fee-for-service (FFS) basis and not through MLTC plans. As a result, the NHQI was not designed for use in MLTC and its measures are calculated at a facility level only. In 2015 the State began to phase nursing home benefits into MLTC as part of the premium. However, the phase-in is gradual and as of 2017 only a portion of the nursing

⁴ New York State Department of Health, A Path toward Value Based Payment: New York State Roadmap for Medicaid Payment Reform, Annual Update June 2016: Year 2, p. 18.

home costs and long-stay nursing home residents are covered by MLTCs.

Apart from the PAH measure, all other measures from the NHQI were designated Category 2 and changed from P4R to P4P. These Category 2 NHQI measures can be used as P4P measures at this time because OQPS makes the facility-level rates publicly available. Over the longer term as more nursing members are covered by MLTC plans and there is sufficient volume for member-level measurement, these measures can be reconsidered for Category 1.

The Category 2 measures for MY 2017 that capture satisfaction and personal choice require the use of surveys. For these measures there were concerns related to survey administration at the MLTC plan-VBP Contractor level. The MLTC member survey is now performed every other year by a contractual partner to the State. Sample size and random sampling methodology are important to maintaining survey validity. Concerns were also raised about the State's already-low response rates and survey fatigue for MLTC members if multiple surveys were deployed. For these reasons most of the measures that rely on surveys remain Category 2.

One survey measure was moved to Category 3 from Category 2, however, because CAG members felt it better measures plan quality and was not appropriate at the VBP Contractor level. It is the measure that captures *'Percentage of members who responded that a health plan representative talked to them about appointing someone to make decisions about their health if they are unable to do so.'*

The CAG also indicated a preference for broader measures of avoidable hospitalization and medication review where linkage with Medicare data is required. The limitation with the current PAH measure is that it includes only six conditions, and while these are important, the CAG determined that a broader range of VBP opportunities for hospital prevention is important for the MLTC subpopulation. Medication review was also identified as a significant aspect of high quality care; many elderly members have multiple prescriptions and may experience adverse interactions and overmedication. Until Medicare data becomes available these measures will remain in Category 2.

After reviewing the MY 2017 Category 2 MLTC VBP measures the CAG makes the following recommendations:

- 1.) Classify all Category 2 NHQI measures as P4P; and,**
- 2.) Remove the *'Percentage of members who responded that a health plan representative talked to them about appointing someone to make decisions about their health if they are unable to do so'* survey measure.**

Summary of CAG Recommended Changes to Final MY 2017 Guidance

A summary of CAG recommended changes to the final MY 2017 guidance is shown in the table below. Two key changes were recommended: 1) to facilitate Level 1 VBP for nursing homes; and 2) to focus the measure set on measures applicable to VBP Contractors.

Proposed Changes to the MY 2017 MLTC VBP Measure Set

Measures	Measure Source/ Steward	Classification	Change	Reason for Change
Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection*	MDS 3.0+/New York State with linkage to SPARCS* data	P4P	Added to Category 1	Level 1 VBP for Nursing Homes
Percentage of members who responded that a health plan representative talked to them about appointing someone to make decisions about their health if they are unable to do so*	MLTC Survey/New York State	P4R	Moved to Category 3	Measure of MLTC plan quality; not for VBP Contractors

*Included in the NYS DOH NHQI measure set

+ MDS 3.0 denotes the Centers for Medicare and Medicaid Services Minimum Data Set for nursing home members

* SPARCS denotes Statewide Planning and Research Cooperative System

Proposed MY 2018 VBP Measure Set Recommendations

The CAG was also asked to make recommendations for the MY 2018 VBP MLTC measure set. A number of special considerations were discussed to limit the implementation burden on MLTC plans and VBP Contractors during the first full year of VBP implementation for MLTC. These included:

- 1.) Minimizing additional collection requirements and duties;
- 2.) Limiting measure specification changes to ones needed to comport with national stewards or OQPS; and,
- 3.) Feasibility issues with the current list of Category 2 measures for MY 2017.

Accordingly, the CAG recommends the following for MY 2018:

- 1.) **The final MY 2017 measure set will remain in place for MY 2018.**

A summary of the recommended Category 1 and 2 measures for MY 2018 is shown in the tables below.

**Recommended MLTC VBP MY 2018 Measure Set
Category 1 Measures**

Measures	Measure Source/ Steward	Classification	Measure Theme
Percentage of members who did not have an emergency room visit in the last 90 days*	UAS – NY/New York State ⁺	P4P	Critical Prevention
Percentage of members who did not have falls resulting in medical intervention in the last 90 days*	UAS – NY/New York State	P4P	Critical Prevention
Percentage of members who received an influenza vaccination in the last year*	UAS – NY/New York State	P4P	Critical Prevention
Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection*	UAS – NY/New York State with linkage to SPARCS [^] data	P4P	Critical Prevention
Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection [‡]	MDS 3.0 ⁺ /New York State with linkage to SPARCS data	P4P	Critical Prevention
Percentage of members who remained stable or demonstrated improvement in pain intensity*	UAS – NY/New York State	P4P	Functional Improvement
Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care (NFLOC) score*	UAS – NY/New York State	P4P	Functional Improvement
Percentage of members who remained stable or demonstrated improvement in urinary continence*	UAS – NY/New York State	P4P	Functional Improvement
Percentage of members who remained stable or demonstrated improvement in shortness of breath*	UAS – NY/New York State	P4P	Functional Improvement
Percentage of members who did not experience uncontrolled pain*	UAS – NY/New York State	P4P	Quality of Life
Percentage of members who were not lonely and not distressed*	UAS – NY/New York State	P4P	Quality of Life

* Included in the NYS DOH MLTC Quality Incentive measure set

⁺ UAS – NY denotes the Uniform Assessment System for New York for MLTC members; MDS 3.0 denotes the Centers for Medicare and Medicaid Services Minimum Data Set for nursing home members

[‡] Included in the NYS DOH Nursing Home Quality Initiative measure set

[^] SPARCS denotes the Statewide Planning and Research Cooperative System

**Recommended MLTC VBP MY 2018 Measure Set
Category 2 Measures**

Measures	Measure Source/Steward	Classification	Measure Theme
Percent of long stay high risk residents with pressure ulcers [‡]	MDS 3.0 ⁺ /CMS	P4P	Critical Prevention
Percent of long stay residents who received the pneumococcal vaccine [‡]	MDS 3.0/CMS	P4P	Critical Prevention
Percent of long stay residents who received the seasonal influenza vaccine [‡]	MDS 3.0/CMS	P4P	Critical Prevention
Percent of long stay residents experiencing one or more falls with major injury [‡]	MDS 3.0/CMS	P4P	Critical Prevention
Percent of long stay residents who lose too much weight [‡]	MDS 3.0/CMS	P4P	Critical Prevention
Percent of long stay residents with a urinary tract infection [‡]	MDS 3.0/CMS	P4P	Critical Prevention
Care for Older Adults – Medication Review	NCQA [§]	P4R	Critical Prevention
Use of High–Risk Medications in the Elderly	NCQA	P4R	Critical Prevention
Percent of long stay low risk residents who lose control of their bowel or bladder [‡]	MDS 3.0/CMS	P4P	Functional Improvement
Percent of long stay residents whose need for help with daily activities has increased [‡]	MDS 3.0/CMS	P4P	Functional Improvement
Percentage of members who rated the quality of home health aide or personal care aide services within the last 6 months as good or excellent [*]	MLTC Survey/New York State	P4R	Personal Choice/Satisfaction
Percentage of members who responded that they were usually or always involved in making decisions about their plan of care [*]	MLTC Survey/New York State	P4R	Personal Choice/Satisfaction
Percentage of members who reported that within the last 6 months the home health aide or personal care aide services were always or usually on time [*]	MLTC Survey/New York State	P4R	Personal Choice/Satisfaction
Percent of long stay residents who have depressive symptoms [‡]	MDS 3.0/CMS	P4P	Quality of Life
Percent of long stay residents with dementia who received an antipsychotic medication [‡]	MDS 3.0/Pharmacy Quality Alliance	P4P	Quality of Life
Percent of long stay residents who self–report moderate to severe pain [‡]	MDS 3.0/CMS	P4P	Quality of Life

* Included in the NYS DOH MLTC Quality Incentive measure set

+ MDS 3.0 denotes the Centers for Medicare and Medicaid Services Minimum Data Set for nursing home members

‡ Included in the NYS DOH Nursing Home Quality Initiative measure set

^ SPARCS denotes the Statewide Planning and Research Cooperative System

§NCQA denotes the National Committee for Quality Assurance

Considerations to Guide the Development of VBP in MLTC

The CAG reviewed key principles of VBP for MLTC and discussed a number of key considerations for the ongoing development of VBP in MLTC. Topics included a discussion of Level 2 and more advanced forms of VBP for MLTC and VBP approaches for the fully capitated MLTC product lines, which are inclusive of Medicare.

VBP Design for MLTC

New York State's VBP Roadmap identifies two principal types of VBP arrangements: 1) episode-based VBP arrangements; and 2) population-based VBP arrangements. Subpopulation arrangements are population-based arrangements for groups of members for whom severe co-morbidity or disability leads to highly specific and costly care needs, so that the majority (or even all) of the care delivered and costs are determined by the specific characteristics of these members. For these subpopulations, a VBP model which includes the total care (and thus total costs) for these often vulnerable members is best suited. As part of the movement towards managed care, the State has already identified four member groups for whom dedicated subpopulation arrangements make sense:

- Members with HIV/AIDS;
- Members eligible for Health and Recovery Plans (HARP);
- Members with Intellectual/Developmental Disabilities (I/DD); and,
- Members in Managed Long Term Care (MLTC)

All other members are part of the general population and are eligible for episode-based VBP arrangements such as Maternity and Integrated Primary Care (IPC) or for Total Care for the General Population (TCGP) VBP arrangements.

Alignment with Medicare

Two MLTC product lines cover MLTC members: 1) plans that are partially capitated, or exclusive of Medicare services; and 2) plans that are fully capitated, or inclusive of Medicare. Because Medicare covers primary and acute care, partially capitated MLTC plans must overcome challenges to coordinate care across the entire spectrum of care delivery. In addition, setting total cost of care budgets that are inclusive of the cost of acute and primary care necessitates access to Medicare cost data. Consequently, alignment with Medicare on VBP approaches and data linkage remains a high priority for the DOH.

In the meantime, however, there may be opportunities for 'proof of concept' for fully capitated MLTC product lines that are already inclusive of Medicare. This section of the report reviews the considerations for VBP for MAP, PACE, and FIDA recommended by the CAG.

Review of Level 1 VBP for Partially Capitated MLTC Plans

In recognition of the difficulty of realizing total cost of care VBP arrangements for MLTC until Medicare claims data can be accessed by partially capitated MLTC plans, the New York State VBP Roadmap allows

Level 1 MLTC VBP to be pay-for-performance (P4P). Whereas Level 1 mainstream VBP arrangements are defined as shared savings arrangements with target budgets, Level 1 for partially capitated MLTC plans is allowed to be a P4P program where MLTC plans and providers can set performance targets on recommended quality measures and pay bonuses or incentive payments according to whatever methodology is desired by the contractual parties.

New York State has issued guidance indicating MLTC partial capitation plans must implement MLTC Level 1 VBP arrangements by December 31, 2017 using the Potentially Avoidable Hospitalization (PAH) measure. Provider contracts covered by the requirement are for covered services provided by Licensed Home Care Services Agencies (LHCSAs), Certified Home Health Agencies (CHHAs), and Skilled Nursing Facilities (SNFs). The MLTC VBP Category 1 and 2 quality measure set for measurement years 2017 and 2018 are largely drawn from the MLTC QI and NHQI measure sets, including PAH measures. MLTC Level 1 VBP contracts for LHCSAs and CHHAs must include the MLTC VBP PAH as a P4P measure from Category 1. For SNF's Level 1 VBP contracts must also include the nursing home VBP PAH measure as a P4P measure also from Category 1. Other measures from Categories 1 and 2 may be included as deemed appropriate by the contracting parties. Measures for use with LHCSAs and CHHAs are selected from Category 1, and for the SNFs from Category 2

A full list of MLTC VBP Measures for MY 2017 and MY 2018 is available on the DOH website in the VBP Resource Library's MLTC folder.⁵

Key Features of More Advanced VBP in MLTC

As VBP implementation continues for MLTC, a number of key features are important for its development. Member attribution, target budget setting, and the definitions of Level 2 and 3 are likely to evolve, as is the nature of the VBP Contractor.

Members in VBP are attributed to a VBP Contractor for the purposes of calculating VBP budgets and for quality measurement. In mainstream managed care the VBP Contractor is defined as a lead provider or group of providers (e.g., Independent Practice Association or Accountable Care Organization). The VBP Contractor takes the lead in the VBP arrangement and may contract with smaller, ancillary, or less central providers for "downstream" care. As long as the VBP Contractor is in the lead and engaged in VBP, downstream providers need not enter VBP arrangements or bear risk themselves. For partially capitated MLTC plans two main provider points for member attribution are identified: 1) home care agencies, and 2) nursing homes. These providers are the locus for a majority of costs for MLTC members receiving services. In addition, because primary care services are covered by Medicare, partially capitated MLTC plans do not have direct control over primary care activities. It is envisioned that these providers – home care agencies and nursing homes – take the lead role in VBP in the near term. Direct care coordination would be performed for Medicaid long-term care services while indirect methods (e.g., check-in calls, routine communication protocols, and shared electronic records) should be employed to coordinate primary and acute care services.

As networks of providers are organized in MLTC with VBP Contractors in the lead, attribution may warrant reexamination. Over the longer term and for fully capitated plans, for example, the preferred attribution may be to the Primary Care Physician (PCP). The CAG recommends periodic reexamination of attribution as total cost of care arrangements become more possible.

It should also be noted that attribution is a guideline in the NYS VBP Roadmap, not a requirement. MLTC plans and VBP Contractors may determine alternative attribution methodologies and lead providers pursuant to their own VBP agreements.

Target budget setting and other parameters for MLTC may also require modification in the longer term. Level 2 VBP for MLTC requires target budget setting for a total package of services. For mainstream VBP arrangements, Level 2 also involves risk sharing where VBP Contractors have downside consequences for overshooting VBP budgets. In the near term for partially capitated MLTC plans the CAG discussed two

⁵ NYS DOH VBP Resource Library ([Link](#))

approaches: 1) a hybrid approach continuing to use the PAH measure as a proxy for acute care costs, plus the establishment of a target budget baseline to include the total cost of long-term care Medicaid services only; and/or, 2) a target budget approach to include long-term Medicaid services only, which are fully under the auspices of partially capitated MLTCs.

Whichever approach is taken in MLTC contracts the CAG recommends that Level 2 for partially capitated MLTC plans should be equivalent to Level 1 in mainstream with regard to target budgets and shared savings (upside only). This would also mean that Level 3 VBP for MLTC would introduce the sharing of risk rather than move to full capitation. The capability and financial capacity to bear risk varies among MLTC plans.

CAG members also expressed concerns about duplication of care coordination services. MLTC plans currently perform care coordination functions. This may be duplicated at the VBP Contractor level as lead providers capable of taking responsibility for total cost of care emerge.

Discussion of VBP Approaches for Fully Capitated MLTC Product Lines

Three types of fully capitated MLTC product lines were discussed by the CAG. Each is briefly described below.

- 1.) **Medicaid Advantage Plus (MAP)** – Covers managed long-term care services as well as Medicare co-payments and deductibles. Enrollees must be at least 18 years of age and eligible for nursing home placement.
- 2.) **Program of All-inclusive Care for the Elderly (PACE)** – PACE plans are responsible for coordinating and providing all primary, inpatient hospital, and long-term care services for members. Organizations provide health services for members age 55 and older who are eligible for nursing home admission.
- 3.) **Fully Integrated Duals Advantage (FIDA)** – Comprehensive benefit package includes all Medicare physical health, behavioral health, and prescription drug services and Medicaid physical health, behavioral health, and long-term support services. Enrollees must be at least 21 years of age.

With regard to VBP implementation for MAP, PACE, and FIDA the CAG considered a range of key questions:

What is a sufficient member volume threshold to afford VBP Contractors the potential for shared savings in an MLTC VBP Arrangement?

Many MAP, PACE, and FIDA plans have a smaller volume of members. Data from 2016 show that only five MAP, PACE, or FIDA plans have member volume exceeding 1,000 (two MAP, one PACE, and two FIDA plans).⁶ Having 1,000 members or more in a VBP arrangement helps to ensure that irregular catastrophic events for a small number of members do not routinely overtake the target budget and render the possibility of shared savings a mathematical impossibility. However, it is important to note that in shared savings arrangements there is no downside risk and smaller volume arrangements may be pursued.

Does integration of Medicare allow for additional/different quality measures?

In quality measure discussions for MLTC VBP the CAG has expressed a desire for broader measures of avoidable hospitalizations and measures to capture use of medications in particular. Because fully capitated MLTC product lines include Medicare, it may be possible to deploy additional and/or different types of quality measures for these product lines.

The CAG reviewed additional measures for hospitalization and the feasibility challenges associated with them. The review included the following measures.

⁶ New York State Department of Health, 2016 Managed Long-Term Care Report, pp. 12-14. ([Link](#))

- **Healthcare Effectiveness Data Information System (HEDIS) All-Cause Readmission Measure** – This is a validated, tested measure. However, the measure’s risk adjustment is fixed, with weights based on the Medicare-only population. Measures developed in Medicare FFS may not be appropriate for elderly members who require long-term care. The measure also requires the purchase of HEDIS and data from Medicare for members.
- **Use of High-Risk Medications Measure** – It is also a validated and tested measure, but requires the purchase of HEDIS and data from the medical and pharmacy benefits for members.
- **Potentially Preventable Readmissions (PPR)** – This is a validated and tested measure, which OQPS has tested on MLTC data. The issue is that the PPR measure overlaps with the PAH measure. Many PAHs are included in the PPR measure. In addition, because of the small size of many MLTC plans, starting from admission and looking at readmission reduces the denominator for the measure to below 30 in many cases; nearly 25 percent of MLTC plans would be removed from the measure because of small sample size (fewer than 30 members).
- **Other HEDIS and Quality Assurance Reporting Requirements (QARR) measures in use for mainstream VBP arrangements** – These measures are validated and tested but not within the dually eligible, primarily elderly population. The maximum age for many HEDIS measures is 65, for example.

Measures specifically focused on dually eligible members are under development at the national level. Their development will aid VBP implementation in MLTC.

Are current measures deployed in MLTC QI and in MAP, PACE, and FIDA applicable and useable for VBP in fully capitated MLTC product lines?

Current MLTC QI measures are calculated for MAP, PACE, and FIDA plans. These measures can be used for VBP. However, some plans are too small for appropriate calculation of the measures. Data for 2016 show that five MAP, PACE or FIDA plans were too small (fewer than 30 members) for appropriate use of MLTC QI measures (one MAP and four FIDA plans). The PAH measure for Level 1 MLTC VBP can also be used for MAP, PACE, and FIDA plans as calculated by OQPS. In addition, measures specific to MAP, PACE, and FIDA can be assessed for potential use in VBP.

What are the key opportunities to demonstrate “proof of concept” to CMS?

One advantage of fully capitated MLTC product lines is that target budgets for VBP can potentially encompass the total cost of care for members. This presents an opportunity to test the application of the construct in MLTC to provide “proof of concept.” However, FIDA is a demonstration project for CMS and, as such, is intended to provide proof of concept that fully integrated care for dually eligible members can yield savings.

Because fully capitated MLTC products are designed to integrate care, their models of care are focused on care coordination and prevention of adverse events such as hospitalization and institutionalization. PACE in particular offers tightly integrated services in a structure that is essentially a plan-provider hybrid. In addition, PACE models of care are approved by CMS and FIDA is co-governed with CMS.

CAG Recommendations

The CAG recommends the following considerations for the development of VBP in MLTC:

- 1.) Levels 2 and 3 for partially capitated MLTC plans should be equivalent to Levels 1 and 2 in mainstream VBP with VBP Contractors experiencing downside risk only as they move to Level 3.**
- 2.) Attribution for MLTC VBP should be reexamined as primary, acute, and long-term care services for MLTC members become more integrated.**
- 3.) Care should be taken with modifying models of care for MAP, PACE, and FIDA.**
 - a. Plans with existing demonstration status may necessitate CMS approval.**
 - b. Current models maximize incentives for avoidance of adverse events because they are fully capitated.**
 - c. The State should convene a MAP, PACE, and FIDA stakeholder meeting to help align its VBP approaches.**
- 4.) The strategic focus for initial development of total cost of care concepts for VBP in MLTC should be larger MAP, PACE, and FIDA plans (e.g., greater than 1,000 members).**
- 5.) MLTC VBP quality measures for partially capitated plans, including the PAH measure, should be explored for use by fully capitated MLTC product lines until additional measures appropriate for the dually eligible population become available for use. In addition, quality measures from MAP, FIDA, and PACE that may be appropriate for VBP should be explored.**