LeadingAge New York

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Re: Comments on MLTC Value-Based Payment Clinical Advisory Group Report

Dear Messrs. Helgerson, Ulberg, and Segal, Dr. Berg, Ms. Lynam, and Mr. Noonan:

Thank you for the opportunity to comment on the Managed Long-Term Care Value-Based Payment Clinical Advisory Group Report ("the CAG Report"). We appreciate your attentiveness to our prior comments and your willingness to incorporate some of our feedback into the draft final report.

General Comments:

We begin these comments with a few high-level observations and then drill down into the substance of the report. Our members agree that the long-term care payment system should move toward one that rewards value over volume. The question is how to do so, and the CAG Report sheds little light on that question. Nationwide, value-based payment (VBP) arrangements for long-term care are in their infancy, and there are few if any operating models for us to replicate. It is easier to conceive of VBP arrangements under a duals program that covers both long-term care and other medical and post-acute care, such as FIDA, PACE or MAP. Most long-term care VBP arrangements nationally are limited to quality-related performance incentives or are operated under the auspices of a duals plan.

Absent the ability to integrate Medicare and Medicaid spending, it is difficult to structure MLTC VBP arrangements that involve shared savings or shared risk. Without access to the Medicare savings generated through the prevention efforts of long-term care providers, there is likely to be little if any savings from VBP arrangements for the partially-capitated MLTC plans which enroll the vast majority of Medicaid beneficiaries receiving long-term care services. In the mainstream program and in Medicare value-based payment programs, savings are generated to a large extent through reductions in

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utilization of duplicative or avoidable high-cost services, such as hospitalizations and unnecessary or contraindicated medications. In the partially-capitated MLTC program, savings are difficult to achieve due to the extensive care needs of members, fixed prices and wage polices, premium setting methodologies, continuity of care requirements, and fair hearing policies. Moreover, VBP incentives aimed at reducing avoidable hospitalizations are likely to reduce potential savings in MLTC, as plans and providers invest in resource-intensive interventions, and personal care hours and nursing home days are substituted for hospital days. In fact, it would not be unreasonable to expect that Medicaid expenditures would increase over baseline amounts in many such cases, leaving no funding available to share between the MLTC plan and the provider.

Not only do most long-term/post-acute care providers lack experience in MLTC VBP arrangements (some are involved in Medicare post-acute VBP initiatives), they also lag behind their primary and acute care peers in developing the infrastructure needed to support successful VBP arrangements. The State is investing $85 million annually for two years to stimulate VBP growth in the mainstream program, but has not proposed any similar investment in the MLTC program. Given the critical need for infrastructure funding in this sector, and the fact that MLTC payments represent 28 percent of all Medicaid managed care payments to providers (the largest subcategory of managed care spending), the State should invest at least a proportional sum in MLTC plans and providers.

As the CAG Report recognizes, the long-term/post-acute care sector has not achieved the same level of organizational integration and scale as its primary and acute care peers. In order to contract jointly with a managed care plan without running afoul of antitrust laws, groups of providers will have to be clinically and financially integrated. This integration and the ability to succeed will require centralized data and analytics, robust cost accounting and financial management systems, and health information exchange capacity. All of this infrastructure must be built and integrated into business processes for participating providers. The State's information systems will have to advance as well. Yet, public investment in information technology for the long-term/post-acute care sector has been minimal to date, and many providers lack the technology needed to share health information securely across the continuum and to collect, report and analyze the clinical and financial data necessary to manage risk.

Even though it is not planning to make investments in MLTC or provider infrastructure to stimulate VBP growth, the State intends to penalize MLTC plans for failing to meet VBP goals on the same schedule as mainstream plans. Given lack of public investment in health IT in the LTC system and limited integration of LTC providers, investment in VBP infrastructure is even more critical for MLTC than for the mainstream program. As noted above, the State should invest at least an amount in MLTC plans and providers proportional to that invested in the mainstream program. If the State is unwilling to provide stimulus investments for MLTC, it should eliminate VBP penalties for the MLTC sector.

The inability to generate significant savings in the MLTC program is particularly troubling, since the State appears to be relying exclusively on savings generated through VBP as the source of future investment in the delivery system and the social determinants of health. We have applauded the VBP Roadmap's commitment to offering a "stable, safe, and accessible housing environment" for Medicaid beneficiaries. With current waiting lists for affordable senior housing of 7 to 11 years in many communities, a substantial expansion of capacity is needed to address growing demand. However, if

VBP shared savings is to be the primary source of investment in senior housing and long-term/post-acute care in New York State, the State will be singularly ill-prepared to care for individuals age 65 and over who will comprise 16 percent of the State's population by 2020.

Given the lack of experience with VBP under partially-capitated MLTC plans nationally, it is not surprising that the CAG report lacks detail. We appreciate and support the Department's interest in striking an appropriate balance between flexibility for plans and providers and uniformity to promote efficiencies and comparisons. However, the CAG Report, even when read in conjunction with the Roadmap and the VBP Boot Camp presentations, does not provide sufficient information for providers and plans to understand the parameters within which their VBP arrangements must operate. Although it strives to be a "playbook," the CAG Report does not yet provide sufficient information about the rules of the game, the players on the field, or the scoring methodology. Presentations at the VBP Boot Camps provided a great deal of information about the structure of VBP arrangements in the mainstream managed care program. However, similar information is not yet available for MLTC VBP arrangements, including answers to key questions, such as:

- What would an acceptable MLTC Level 1 or Level 2 arrangement look like?
- What services or provider types must be included?
- Exactly how would a member be attributed to the arrangement?
- Would certain categories of members be excluded (e.g., members on immunosuppressant therapy as a result of an organ transplant or members with late stage cancer)?
- What is the minimum number of quality measures that must be incorporated in a VBP arrangement?
- How does performance on the quality measures affect incentive payments?

MLTC plans and providers would benefit from specific examples of permissible VBP arrangements that include answers to these questions.

Report Lacks Clarity and Specificity

A) Realizing and Measuring Savings

As noted above, the CAG Report lacks specificity and clarity regarding the nature of on-menu VBP arrangements between MLTC plans and providers. It divides MLTC members into two cohorts – those receiving community-based care and those receiving nursing home care. As indicated in the following paragraph, the Report appears to contemplate two different types of VBP arrangements for the two populations, with savings to be achieved either by preventing/delaying institutionalization or by transitioning nursing home residents into the community:

> For members in need of home care, savings could be realized *by extending the period the member is able to stay at home* (i.e., admission to the nursing home is delayed or avoided all together). For those members living in a nursing home, Medicaid savings could be realized primarily *by transitioning residents who are able to do so back into the community*, supported by home care if needed. The

> savings here would be realized by *'beating the premium'* for these members: lowering admission rates and care costs below what is projected in the premium. In these ways total costs of care for the LTC member would decrease, and the savings realized can be shared between MLTC plan and the provider.

(CAG Report, p.6, emphasis added). Thus, the Report suggests that savings could be achieved in two ways (i) delaying or avoiding nursing home admissions; and (ii) transitioning nursing home residents to the community at a lower cost than the associated premium revenue.

However, the Report does not provide a realistic strategy for capturing and measuring those savings. We agree that there are savings to be gained from delaying or avoiding nursing home use in certain circumstances. However, it is difficult to measure and realize such savings over a one-year period. Like the savings achieved from immunizations or prenatal care, the savings derived from activities that delay or avoid admission to a nursing home are generally realized over periods of greater than one year; yet the measurement period for the VBP arrangements under discussion seems to be one year.
We also agree that in individual cases savings can be generated by transitioning nursing home residents to the community, and we support the goal of serving individuals in the most integrated setting appropriate to their preferences and needs. However, the Report overlooks some key factors:

i. There are relatively few long-term nursing home residents who can safely transition to the community;
ii. A successful transition requires an affordable and accessible place to live (which may not be available);
iii. Nursing home residents who could safely transition to the community may not want to do so; and
iv. Relocating from a nursing home does not always result in savings.

Our analysis of 2014 New York State MDS resident assessment data revealed that there are approximately 4,600 nursing home residents statewide categorized in the lowest acuity (PA, PB and PC) RUG III groups. Approximately 40 percent of these low-acuity residents have dementia. Only 500 of the 4,600 indicated in their MDS assessment that they would like to return home.

For the relatively small number of low-acuity nursing home residents who could potentially transition to the community, with affordable and accessible housing and informal supports, the cost of MLTC community services may exceed the cost of nursing home care. When a member has complex medical needs and significant functional limitations requiring 12 or more daily hours of care and/or frequent skilled services, the cost of care in the community can exceed that in a nursing home. For example, in Westchester County, based on the published 2016 fee-for-service Medicaid rates, the rate for a live-in aide alone would be approximately $261.25 daily (assuming the aide is able to take meal and sleep breaks), and the rate for an aide for a 12-hour shift would be $264.55, whereas the average Medicaid daily nursing home rate (which includes housing, meals, activities, supervision and medical care) would be $247.00. And, the community-based member would require additional services, such as transportation to appointments, CHHA visits for skilled services, home-delivered meals, and potentially Community First Choice Option services.

Another potential avenue for generating savings through nursing home transitions would be increased use of the Medicaid-funded assisted living program (ALP). ALP rates are significantly lower than nursing home rates and include an array of clinical and custodial services. However, the ALP has not yet been included in the MLTC benefit package, and ALP beds are in short supply in most regions. Providing for an ongoing and application-based process for the addition of ALP beds, based on regional needs, will be critical once the ALP becomes an MLTC benefit.

Even if plans and providers are able to generate savings over twelve-month periods, the CAG Report does not provide a sound approach for quantifying savings by comparing spending to a benchmark. It seems to suggest that VBP arrangements would rely on savings generated on a per member basis (i.e., "beating the premium"). That approach would allow providers to share in savings based on the experience of a few members, even if their overall patient/resident population exceeded the spending benchmark on a global basis. If, instead, the State intends to calculate savings based on the experience of the provider's entire census of members in each VBP arrangement, the small census of members served by most providers will limit the credibility of any valuation of the average annual savings they generate. Finally, if the premiums continue to be developed as they are now, the plans' rates will be adjusted downward for every nursing home resident they transition – they will have no unspent premium revenue to share with providers.

Thus, capturing and measuring savings over a 12-month period attributable to nursing home avoidance and achieving significant savings from nursing home transitions will present a formidable challenge for MLTC plans and their network providers.

B) Services to be Included in VBP Arrangements

The CAG Report is equivocal regarding the services that must be included in on-menu VBP arrangements. The CAG Report provides that the State "would allow arrangements to cover *only one component of long term care*:

- Home Health[1] providers contracting *total (Medicaid) costs of care* for those members assigned by the MLTC to home care
- Nursing Home providers contracting *total (Medicaid) costs of care* for those members assigned by the MLTC to a Nursing Home (emphasis added)."

(CAG Report, p.7, emphasis added). Clearly, if a home health or nursing home provider is contracting "total (Medicaid) costs of care," it is covering more than one component of the MLTC benefit package. Does the on-menu arrangement require the provider that receives attribution to contract for the total Medicaid benefit package or does it permit the provider to contract for just one benefit (e.g. a VBP arrangement for personal care only)?

We believe the Department intended something in between. We believe the report intends to permit arrangements that cover a subset of the MLTC benefit package. In its discussion of "one component,"

[1] It is unclear whether the Report is referring to CHHAs, LHCSAs, CDPAS, or all of the above.

we believe the report intends to refer to the attribution of beneficiaries either to a nursing home or to a community-based service, such as home care or adult day health care (ADHC). Although the report references only home care, we recommended throughout the CAG discussions that on-menu options also include arrangements in which attribution is based on medical model ADHC programs, as they often serve as the hub of a member's care and have the capacity to manage both clinical and custodial needs and services.

Greater clarity, with specific examples of on-menu long-term care VBP arrangements would help both providers and plans to craft on-menu arrangements. In particular, we look forward to working with the Department to develop examples of pay-for-performance models that would qualify as Level 1 arrangements. Notably, the incorporation of the Nursing Home Quality Initiative into the benchmark rates paid by MLTC plans arguably qualifies as an existing Level 1 arrangement.

C) Quality Measures are too Numerous

We commend the hard work of the CAG staff in identifying and classifying quality measures. We remain concerned that there are far too many quality measures to allow providers and plans to target resources and personnel on critical areas for improvement. Further, we are not clear on whether every quality measure must be incorporated into every value-based payment (VBP) arrangement. Even if plans and providers are permitted to select a subset of these measures for each VBP arrangement, providers may still be faced with dozens of measures due to contracts with multiple plans emphasizing different quality priorities, which would result in significant diffusion of quality improvement efforts and greater concern about scalability of these arrangements. It will be difficult for plans and providers to implement VBP arrangements with such a broad menu of measures.

D) Category 2 Measures Do Not Satisfy CAG Criteria

We were pleased to see that most of the measures enumerated in the Report are already in use through the MLTC Quality Improvement Program, the Nursing Home Quality Initiative, or the CMS Nursing Home Compare. This will make it easier for plans and providers to implement the measures.

However, we would like to reiterate our concern that some of the Category 2 measures are not necessarily "clinically relevant, valid and probably reliable" for long-term care providers. It is not clear, for example, that the NCQA medication measures (Measures 25, 28) are appropriate for the long-term care sector. They appear to have been designed for use by Medicare Advantage plans and physician practices, not for long-term care providers and plans.[2] Similarly, we do not believe the Dartmouth Atlas is an appropriate source for quality measures (Measures 34-35). The Dartmouth Atlas is an excellent reference for data on regional variation in health care utilization. Notably, the Dartmouth Atlas website does not indicate that its analyses should be used by health care providers or plans to measure quality,

[2] NCQA provides accreditation, certification, and other products for health plans and ACOs. It only recently (in February 2016) launched LTSS updates to its health plan accreditation products to take effect in mid-2017 and a new "Case Management LTSS" product effective in late 2016.

nor does it provide specifications for converting its regional variation analyses into risk-adjusted quality measures.

We further question whether Measure 32 – Emergency Department Use with Hospitalization – is appropriate. First, it overlaps with the Measure 1 (percent of members who did not have an ER visit in the last 90 days). Second, to the extent that an ED visit is followed by an admission, the visit was likely justified, and the measure would overlap with Measures 30, 31, and 37. We do not believe that Measure 32 adds value, given the inclusion of Measure 1 and may discourage medically-necessary admissions.

Measures 33 through 35 do not appear to be actionable by long-term care providers. Neither a partially-capitated MLTC nor a long-term care provider has much influence over whether a beneficiary is admitted to the ICU, his/her hospital length of stay, or total Medicare spending in the last 6 months of life. These metrics are influenced primarily by hospitals and physicians, as well as the beneficiary and his/her family members.

E) New Funding is Needed for Quality Incentive Payments

We were pleased to see the State's plan to create an additional Quality Pool to be reward reduced rates of avoidable hospital use. We would like to urge the State again to dedicate new money to the MLTC, nursing home, and avoidable hospital use pools, rather than merely redistributing existing funds. Continuing to reduce premium revenue and facility rates to fund redistributive pools is destabilizing and prevents plans and facilities from developing sound financial plans and making needed investments in capital and staffing.

F) Application of Quality Measures to VBP Arrangements is Unclear

Finally, the CAG Report does not provide sufficient detail concerning the implementation of the quality measures in the MLTC context. VBP Boot Camp presenters indicated that quality measures in the mainstream program would be applied in two phases to VBP arrangements: (i) in setting the target budget, a potentially avoidable complication or hospitalization adjustment would be applied; and (ii) other quality measures would be applied to determine the allocation of shared savings or losses. Further, the presentations indicated that performance on all quality measures would be calculated based on a percentile distribution, rather than based on a benchmark or improvement standard. As noted by the presenter, this may not provide a sufficient incentive for providers that begin as poor performers and exhibit significant improvement, but cannot catch up to the high performers. Another question raised by the CAG report is whether and how the MLTC Quality Pool will interact with the Nursing Home Quality Incentive Program and the new Avoidable Hospitalization Pool for purposes of funding VBP incentive payments.

These types of issues were not covered in the MLTC CAG. The CAG Report would be a stronger document and would permit more stakeholder input and understanding, if it contained additional detail concerning the application of the quality measures to VBP arrangements.

Thank you again for the opportunity to comment. We look forward to continuing discussions with the Department as you work to refine the MLTC VBP initiative.

Sincerely yours,

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EVP for Innovation Strategies

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