NEW YORK STATE | Department of Health | Medicaid Redesign Team

Managed Long Term Care (MLTC) Clinical Advisory Group Meeting

Eric Henderson
Deputy Director
Division of Long Term Care
Office of Health Insurance Programs

Erin Kate Calicchia
Director
Bureau of Managed Long Term Care
Office of Health Insurance Programs

Khalil Alshaer, MD
Medical Director
Division of Long Term Care
Office of Health Insurance Programs

Raina Josberger
Deputy Division Director
Office of Quality and Patient Safety

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Meeting Agenda

- Welcome and Introductions
- Review and Updates for 2017
  - Level 1 MLTC VBP Guidance
  - Update on Medicare Alignment
  - Use of Quality Measures for Measurement Year (MY) 2017
- Looking Ahead to 2018
  - MLTC VBP Measure Review for MY 2018
  - Development of Level 2 Approaches for MLTC
  - Development of Level 2 VBP Approaches for Fully Medicare Integrated MLTC Product Lines
  - Next Steps and Closing Remarks

Welcome and Introductions

- Welcome to the 5th Meeting of the MLTC Clinical Advisory Group (CAG)!
  - Our last meeting was June 9, 2017 when we reviewed the recommended quality measures for use in VBP and introduced the Level 1 guidance for MLTC plans and providers.
  - The presentation from that meeting as well as the final measure list for MY 2017 MLTC are available at the Department of Health's VBP Resource Library at the following link: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/.
- Your response to the Doodle poll to select the date was also much appreciated. We know dates in late August can be very difficult. We will post these materials as well and encourage those who could not attend the meeting to send questions along after reviewing them.
- As always, we greatly appreciate your participation in the MLTC CAG and welcome any newcomers to the group!

Review and Updates for 2017

Review and Updates for 2017

- Review of Guidance for Level 1 VBP MLTC Arrangements
- Review of the VBP Roadmap definition of Level 1 as approved by the Centers for Medicare and Medicaid Services (CMS) in April 2017
- Update on Medicare alignment
- Update on MLTC measure use for MY 2017

Review of Guidance on MLTC Level 1 VBP

- Initially, Level 1 for MLTC will be a Pay For Performance (P4P) program.
  - o MLTC plans and providers can establish quality targets and earn financial incentives for reaching or exceeding targets.
  - o Every MLTC plan is to convert provider contracts to Level 1 P4P contracts by December 31, 2017, using the State-recommended MLTC VBP Category 1 quality measures. (See Appendix for a full list of Category 1 measures.)
- A key feature of MLTC Level 1 VBP is potentially avoidable hospital use.
  - o Level 1 VBP contracts should include the potentially avoidable hospitalizations (PAH) measure in use currently as a performance measure.
  - o Other Category 1 VBP measures are drawn from the MLTC Quality Incentive (QI).
- MLTC Plans and VBP Contractors can engage in Level 2 or 3 VBP.

Use of PAH Measure Meets NYS VBP Roadmap Requirement

- Until such time as alignment with Medicare is possible NYS can establish a performance incentive payment program to reward MLTC providers for reducing avoidable hospital use.
- **This meets the alternative definition for Level 1 VBP for MLTC.**

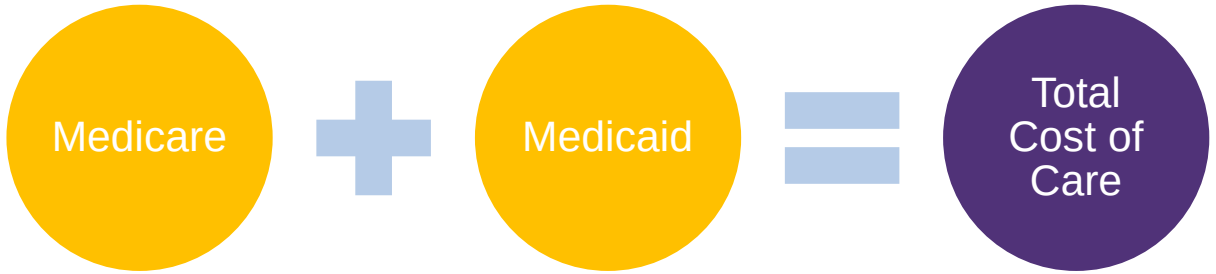
"If the Medicare dollars cannot be (virtually) pooled with the State's Medicaid dollars, and savings in Medicare cannot be shared with Medicaid providers (or vice versa), the impact of payment reform for this population threatens to be limited, and long term care providers will have difficulty achieving scale in VBP transformation. To remedy this, the State is working with CMS to create aligned shared savings possibilities within Medicaid and Medicare.

In anticipation, the State aims to treat potentially avoidable hospital use as 'quality outcomes' for this subpopulation, improving the quality of life for these members, and rewarding MLTC providers when certain levels of reduced avoidable hospital use are reached. Such arrangements could be treated as Level 1 VBP arrangements, and would be eligible for financial incentives. Improved quality and reduced overall costs can also be realized by delaying or avoiding nursing home admissions through targeted interventions amongst the MLTC population residing at home."

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 (CMS-Approved April 2017),* p. 18.

Update on Medicare Alignment and Longer Term Goals

- **Longer Term Goal for MLTC VBP**



- **Alignment of NYS VBP Approaches with Medicare Continues to be a Priority**
  - o Update on approach/status of discussions with CMS
    - ▪ NYS submitted a proposal to CMS in 2016
  - o Opportunities for “proof of concept” to CMS with fully Medicare integrated MLTC products and other innovative approaches

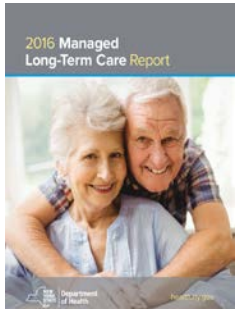
MLTC VBP Measures

Measurement Year 2017

MLTC Quality Measures

Current Uses

- 2016 MLTC Report - http://www.health.ny.gov/health_care/managed_care/mltc/reports.htm
  - o Comprehensive evaluation of plan performance and consumer satisfaction



- 2016 Regional Consumer Guides – http://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/
  - o Synthesized analysis of select measures represented with stars and bars

MLTC Quality Measures Calculation

Issue	DOH MLTC Report	Plans' VBP
Data Source	State performs an attribution algorithm that evaluates capitation payments and UAS-NY assessments to correctly attribute assessment to the correct plan-product combination.	UAS-NY data exchange – critical for measure calculation
Measure Specifications	Dictionary of Selected Managed Long-Term Care Measures.	Dictionary of Selected Managed Long-Term Care Measures.
Risk-adjustment and comparison group	Many of the measures in the Report are risk-adjusted. Plan performance is compared to statewide and other plans (when risk-adjusted).	Risk adjustment – not necessary. Comparison should be provider to itself over time
Assessment period	Assessment period is January – June 2016, keeping the latest assessment per person-plan	Discussion point

Potentially Avoidable Hospitalization (PAH)

- A PAH is an inpatient hospitalization that might have been avoided if proper outpatient care was received in a timely manner.
  - o Anemia
  - o Congestive Heart Failure
  - o Electrolyte imbalance
  - o Respiratory infection
  - o Sepsis
  - o Urinary Tract infection

- NYS based this measure on CMS' Nursing Home Value Based Purchasing Demonstration (http://innovation.cms.gov/initiatives/Nursing-Home-Value-Based-Purchasing/)

PAH, continued

- Statewide Planning and Research Cooperative System (SPARCS)
  - All-payor hospital file
  - Primary discharge diagnosis
- DOH will calculate PAH for all plan-provider combinations.
  - Plans will submit attribution files by September 8, 2017
    - Assigns members to a provider organization (CHHA, LHCSA, SNF)
  - Baseline (2016) attribution
  - One row per member
  - State will run the PAH measure based on attribution file and report 2016 results to plan by mid-October

PAH Timeline

For measurement year 2017:

- Attribution files submitted by March 2018
- 2017 SPARCS available to DOH by end of August 2018
- October 2018, PAH rates by provider organization will be reported by DOH to the plans

Looking Ahead to 2018

Looking Ahead to 2018

- Recommend VBP measures for 2018
  - Recommend measures to VBP workgroup in September 2017
  - Issue VBP measure guidelines & QI methodology to the field in December 2017
    - VBP Measurement Year 2018 commences January 1, 2018
- Develop Level 2 approaches for MLTC
- Develop VBP approaches for fully Medicare integrated MLTC product lines

MLTC VBP Annual Measure Review

Measurement Year 2018

Goals for Annual Measure Review for 2018

- Review recommended considerations for the CAG for MY 2018 VBP measure discussion
- Conduct measure review in two parts:
  1. Review measure themes of MY 2017 MLTC Category 1 and 2 VBP measures to identify missing/future themes for the addition/subtraction of measures
  2. Review possible measure changes
     - Categorization – Categories 1,2, and 3
     - Classification – Pay for Reporting (P4R) or Pay for Performance (P4P)

Considerations for MLTC VBP Measures for MY 2018

In recognition of the late start for MY 2017, it is suggested that CAG recommendations take into consideration:

1. Minimizing additional collection requirements and duties;
2. Limiting measure specification changes to ones needed to comport with national stewards or OQPS;
3. Recognizing the feasibility challenges of Category 2 measures as currently recommended by the CAG and the VBP Working Group; and,
4. Focusing on measurement goals and gaps over a longer time horizon (e.g., MY 2019).

Review of Key Measure Themes and Gap Identification

1. Review of MY 2017 Category 1 Measure Themes
   - Are any essential themes missing?

2. Review MY 2017 Category 2 Nursing Home Measure Themes
   - Are any essential themes missing?

3. Review Other MY 2017 Category 2 Measure Themes
   - Are any essential themes missing?

VBP Themes for Category 1 Measures for Community Care (Based on the MLTC QI)

Critical Prevention – 4 Measures

- Emergency Room Use
- Falls
- Flu Vaccination
- Hospitalization

Quality of Life – 2 Measures

- Controlling Pain
- Behavioral Health (e.g., Loneliness, Distress)

Functional Improvement – 4 Measures

- Pain Intensity
- Nursing Facility Level of Care Score
- Urinary Incontinence
- Shortness of Breath

VBP Themes for Category 2 Measures for Nursing Home Care (Based on the Nursing Home QI)

Critical Prevention – 6 Measures

- Pressure Ulcers
- Falls
- Flu & Pneumonia Vaccination
- Weight Loss
- Urinary Tract Infection

Quality of Life – 3 Measures

- Controlling Pain
- Behavioral Health (e.g., Depression)
- Antipsychotic Medication Use

Functional Improvement – 2 Measures

- Help with Activities of Daily Living
- Bladder/Bowel Control

VBP Themes for Other Category 2 Measures (For General Use)

Personal Choice/Satisfaction – 4 Measures

- Addressing care decisions if member is unable to make them
- Involving members in making decisions about their own care
- Home health aides reliable and on time
- Satisfaction with home health aides

Medication Review – 2 Measures

- Use of high-risk medications
- Comprehensive medication review

Review of Measure Categorization and Classification for Recommended Use

1. Review of Measure Categorization Framework
   - Category definitions for categories 1, 2, and 3
2. Review of Recommended Classification Framework for Measure Use
   - P4R versus P4P
3. Review MLTC Feasibility Concerns for MY 2017
   - Issues and concerns with measure use flagged during State feasibility review
4. Discussion of Measure Categorization and Recommended Use for MY 2017
   - Are there any changes for MY 2018?

Categorizing and Prioritizing Quality Measures for MY 2017

CATEGORY 1
Approved quality measures that are clinically relevant, reliable and valid, and feasible.

CATEGORY 2
Measures that are clinically relevant, valid, and probably reliable, but where the feasibility could be problematic. These measures require further investigation before being fully implemented.

CATEGORY 3
Measures that are insufficiently relevant, valid, reliable and/or feasible.

The measure classifications provided on the following slides are recommendations for the 2017 Measurement Year (MY). During 2017, the CAGs and the VBP Workgroup will re-evaluate measures for MY 2018. Measure reclassification will be considered on an annual basis.

Category 1 Measures for MY 2017

- Category 1 quality measures as identified by the CAGs and accepted by the State are to be reported by VBP Contractors.
- The State classified each Category 1 measure as P4P or P4R. For measurement year (MY) 2017, all MLTC Category 1 measures were designated as P4P.

Pay for Performance (P4P)

- Measures designated as P4P are intended to be used in the determination of shared savings for which VBP Contractors are eligible
- Performance on the measures can be included in both the determination of the target budget and in the calculation of shared savings for VBP Contractors

Pay for Reporting (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 & 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 via contracting.

Category 2 and 3 Measures for MY 2017

Category 2

- Category 2 measures have been accepted by the State based on agreement of measure importance, but were flagged for concerns regarding implementation feasibility.
- For MLTC, Category 2 measures include measures selected from the Nursing Home Quality Initiative and the NYS MLTC Survey by the CAG, as well as several medication review measures used in other programs.
- MLTC Category 2 measures will need further investigation before being fully implemented in VBP. Information on a measure testing approach, data collection, and reporting requirements will be provided at a later date.
- MLTC plans with a significant number of long-stay nursing home members may opt to use the Category 2 Nursing Home Quality Initiative measures.

Category 3

- Category 3 measures were identified as unfeasible at this time or as presenting additional concerns including accuracy or reliability when applied to the attributed member population for the VBP arrangement. These measures will not be tested in pilots or included in VBP at this time.

MLTC: Category 1 Quality Measure List MY 2017

All Cat 1 Measures in MY 2017 are designated P4P

CAG #[1]	Measure	Measure Source/ Steward [2]	Current Use Recommendation	Measure Theme
1	Percentage of members who did not have an emergency room visit in the last 90 days*	UAS – NY/New York State	P4P	*Critical Prevention*
2	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*
3	Percentage of members who did not experience uncontrolled pain*	UAS – NY/New York State	P4P	*Quality of Life*
4	Percentage of members who were not lonely and not distressed*	UAS – NY/New York State	P4P	*Quality of Life*
5	Percentage of members who received an influenza vaccination in the last year*	UAS – NY/New York State	P4P	*Critical Prevention*
7	Percentage of members who remained stable or demonstrated improvement in pain intensity*	UAS – NY/New York State	P4P	*Functional Improvement*

[1] CAG # based on the measure identifier included in the December 2016 Long-Term Care Value Based Payment Recommendation Report
[2] UAS – NY denotes the Uniform Assessment System for New York for MLTC members
* Included in the NYS DOH MLTC Quality Incentive measure set

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MLTC: Category 1 Quality Measure List MY 2017

All Cat 1 Measures in MY 2017 are designated P4P

CAG #	Measure	Measure Source/ Steward	Current Use Recommendation	Measure Theme
8	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*
9	Percentage of members who remained stable or demonstrated improvement in urinary continence*	UAS – NY/New York State	P4P	*Functional Improvement*
10	Percentage of members who remained stable or demonstrated improvement in shortness of breath*	UAS – NY/New York State	P4P	*Functional Improvement*
New	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

* Included in the NYS DOH MLTC Quality Incentive measure set
± SPARCS denotes Statewide Planning and Research Cooperative System

Review of MLTC Category 2 Feasibility Issues for MY 2017

- Use of Nursing Home Measures
  - Member volume a concern as nursing home benefits for many remain outside of MLTC
  - Measures are used at the facility level
  - New York State computes per the Nursing Home QI and MLTC plans can use the measure
    - If the measure is added to Category 1 it must be reported by all VBP Contractors
- Use of Satisfaction/Choice Measures
  - Concerns related to survey administration at the plan/provider (e.g., sample size and random sampling methods)
- Use of Measures Outside of Existing QI Programs
  - Requires clinical data from medical record review
  - Other measures may not be appropriate for members 65 years and older
- Use of Broad Based Hospitalization Measures
  - Requires Medicare data

MLTC: Category 2 Quality Measure List MY 2017

CAG #	Measure	Measure Source/ Steward [1]	Current Use Recommendation	Measure Theme
6	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	Personal Choice/Satisfaction
11	Percent of long stay high risk residents with pressure ulcers+	MDS 3.0/CMS	P4R	Critical Prevention
12	Percent of long stay residents who received the pneumococcal vaccine+	MDS 3.0/CMS	P4R	Critical Prevention
13	Percent of long stay residents who received the seasonal influenza vaccine+	MDS 3.0/CMS	P4R	Critical Prevention
14	Percent of long stay residents experiencing one or more falls with major injury+	MDS 3.0/CMS	P4R	Critical Prevention
15	Percent of long stay residents who have depressive symptoms+	MDS 3.0/CMS	P4R	Quality of Life

[1] MDS 3.0/CMS denotes the Centers for Medicare and Medicaid Services Minimum Data Set for nursing home members
* Included in the NYS DOH MLTC Quality Incentive measure set
+ Included in the NYS DOH Nursing Home Quality Initiative measure set

MLTC: Category 2 Quality Measure List MY 2017

CAG #	Measure	Measure Source/ Steward	Current Use Recommendation	Measure Theme
16	Percent of long stay low risk residents who lose control of their bowel or bladder+	MDS 3.0/CMS	P4R	Functional Improvement
17	Percent of long stay residents who lose too much weight+	MDS 3.0/CMS	P4R	Critical Prevention
18	Percent of long stay residents with dementia who received an antipsychotic medication+	MDS 3.0/Pharmacy Quality Alliance	P4R	Quality of Life
19	Percent of long stay residents who self–report moderate to severe pain+	MDS 3.0/CMS	P4R	Quality of Life
20	Percent of long stay residents whose need for help with daily activities has increased+	MDS 3.0/CMS	P4R	Functional Improvement
21	Percent of long stay residents with a urinary tract infection+	MDS 3.0/CMS	P4R	Critical Prevention

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

MLTC: Category 2 Quality Measure List MY 2017

CAG #	Measure	Measure Source/ Steward	Current Use Recommendation	Measure Theme
22	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
23	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
24	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
25	Care for Older Adults – Medication Review	National Committee for Quality Assurance (NCQA)	P4R	Critical Prevention
28	Use of High–Risk Medications in the Elderly	NCQA	P4R	Critical Prevention

* Included in the NYS DOH MLTC Quality Incentive measure set

Applicability of Other Measures

- HEDIS Plan All-Cause Readmission Measure
  - Pros – validated, tested
  - Cons – measure is risk-adjusted as written, weights based on Medicare-only population, requires purchase of HEDIS, requires medical benefit
- Use of High-Risk Medication
  - Pros – validated, tested
  - Cons – requires purchase of HEDIS, requires medical and pharmacy benefit
- Potentially Preventable Readmissions (PPR)
  - OQPS tested 3M algorithm and a modified IMPACT Act measure on MLTC data
    - Pros – validated, tested
    - Cons – Many diagnosis included in the PPR measure are also included in the PAH measure, nearly 25% of plans would be considered small sample size.

VBP Level 2 for MLTC

Key Features of More Advanced VBP in MLTC

1. Attribution of a group of members to a VBP Contractor
   - VBP Contractor is defined as a lead provider or group of providers (e.g., Independent Practice Association or IPA) that takes responsibility for the total cost and quality for a group of attributed members.
     - o VBP Contractor for MLTC is identified as home care agency or nursing home to correspond with the majority of costs for MLTC members. However, for fully integrated plans the preferred attribution may be to the Primary Care Physician.
2. Setting of target budgets and baselines for shared savings/losses
3. Establishing parameters around sharing of savings/losses among MLTC plans and VBP Contractors

Key Features of VBP Levels for Mainstream Plans

In addition to choosing which integrated services to focus on, the MCOs and contractors can choose different levels of Value Based Payments:

VBP Levels for Mainstream			
Level 0 VBP*	Level 1 VBP	Level 2 VBP	Level 3 VBP
Bonus and/or withhold for quality scores	Upside-only shared savings when quality scores are sufficient	Risk sharing (upside available when quality scores are sufficient)	Prospective capitation PMPM (with quality-based component)
Payment not tied to budget	FFS Retrospective Reconciliation	FFS Retrospective Reconciliation	Prospective total budget payments
Limited bonus payment or withhold	**↑ Upside Only**	**↑ Upside** & **↓ Downside Risk**	**↑ Upside** & **↓ Downside Risk**

* Level 0 is insufficient for CMS credit meeting NYS's VBP goals except for within MLTC.

Discussion of Key Features of VBP Levels for MLTC

In addition to choosing which integrated services to focus on, the MCOs and contractors can choose different levels of Value Based Payments:

VBP Levels for Mainstream			
Level 0 VBP*	Level 1 VBP	Level 2 VBP	Level 3 VBP
Bonus and/or withhold for quality scores	Upside-only shared savings when quality scores are sufficient	Risk sharing (upside available when quality scores are sufficient)	Prospective capitation PMPM (with quality-based component)
Payment not tied to budget	FFS Retrospective Reconciliation	FFS Retrospective Reconciliation	Prospective total budget payments
Limited bonus payment or withhold	**↑ Upside Only**	**↑ Upside & ↓ Downside Risk**	**↑ Upside & ↓ Downside Risk**
Options for VBP Levels for MLTC			
Level 1 MLTC*	Shared Savings?	Shared Risk?	Total Capitation?

* Level 0 is insufficient for CMS credit meeting NYS's VBP goals except for within MLTC.

VBP Level Details for Mainstream Arrangements

Component	Level 1	Level 2	Level 3
Target Budget	No specific methodology mandated, however, the contract should specify that a target budget will be used		
Shared Savings / Losses	Minimum of 40% of shared savings allocated to the provider	• Minimum of 20% of potential losses allocated to the provider • Minimum cap of 3% of the target budget can be applied in Year 1 and 5% in Year 2	Not Applicable
Social Determinants of Health (SDH)	Not Applicable	Implementation of at least one social determinant of health intervention	
Contracting with Community Based Organizations (CBOs)	Not Applicable	Contract with a minimum of one Tier 1 Community Based Organization	

Key:

Guidelines

Standards

Consideration of MLTC VBP Arrangement Details

Component	Level 1	Level 2	Level 3
Scope of Services	For Partially Capitated MLTCs - All Medicaid covered services for attributed members For Fully Medicare Integrated Product Lines – All covered services for attributed members		
Attribution	*To the most appropriate VBP Contractor (responsible for/encompassing total costs) – Home Care Agency, Nursing Home, PCP*		
Quality Measures	Reporting of all MLTC Category 1 measures Pilots to test Category 2 measures and provide meaningful feedback		
Contracts to include Target Budget, Shared Savings / Losses, SDH and CBO requirements similar to Mainstream VBP?			

Guidelines

Standards

From MLTC VBP Level 1 to Level 2

Guidelines

Standards

Component	MLTC VBP Level 1	MLTC VBP Level 2
Scope of Services	MLTC plans can make performance payments to any provider within their network.	Per VBP Roadmap MLTC VBP Arrangements are a Subpopulation Arrangement to include the total cost of care including all covered services for a member.
Attribution	Attribution files needed for quality measure use but not for setting of target budget or shared savings.	A VBP Contractor takes responsibility for the cost and quality of an attributed member's total care. Attribution guideline is home care or nursing home provider. Contracts should specify an attribution methodology but it can differ from guideline.
Quality Measures	Category I quality measures must be reported.	Contract must commit to reporting on all Category 1 quality measures and Category 2 quality measures if required.
Target Budget	Target budgets, shared savings/losses, and risk levels are not considered in MLTC VBP Level 1.	Contract should specify that a target budget will be used and give a methodology.
Shared Savings / Losses		Minimum of 40% of shared savings must be allocated to the provider or other features from Levels 2 and 3 from Mainstream?
Risk Level		The contract must describe the risk entailed in the arrangement. Will risk be required in MLTC Level 2?

Developmental Needs for More Advanced VBP in MLTC

1. Network formation – Groups of providers organizing to accept responsibility for total cost of care for a member
   - Care coordination & integration are at the center of a total cost of care arrangement
   - Assessment of provider ability to bear risk:
     - Lead providers can take overall responsibility for subsets of providers within a network, allowing smaller providers to stay in fee for service model.
     - Independent Practice Associations (IPAs) comprised of diverse types of providers can form to support total cost of care.
2. MLTC plan capacity – Many plans, some with limited financial capacity
3. Regulatory barriers – May prevent efficiencies in care delivery
4. Other – ?

Level 2 Approaches for Fully Medicare Integrated Plans

Fully Medicare Integrated MLTC Product Lines

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.
Program of All-inclusive Care for the Elderly (PACE)	• PACE plan is 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.
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.

Source: 2016 Managed Long-term Care Report
https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2016.pdf

Goals for Development of Level 2 Approaches for MAP, PACE, and FIDA

1. Review size and scale of MAP, PACE, and FIDA
   - Identify potential membership thresholds for Level 2 VBP for MLTC
2. Recommend a Level 2 VBP approach for MAP, PACE, and FIDA
3. Recommend a set of quality measures for use in MAP, PACE, and FIDA

Considerations for Level 2 VBP for MAP, PACE, and FIDA

1. Member volume thresholds for shared savings
   - For the Health and Recovery Plan (HARP) VBP subpopulation pilots a minimum membership of 1,000 members is recommended to ensure a sufficient statistical basis for shared savings
2. Does integration of Medicare allow for additional quality measures?
   - Are current measures deployed in MLTC QI applicable? Or are there key areas where additional measures are needed?
3. What are the key opportunities to demonstrate “proof of concept” to CMS to advance a Medicare alignment agenda?
   - FIDA currently a demonstration project

2016 Membership by Fully Integrated MLTC Product Line

A Small Number of Plans Cover More than 1,000 Members

Fully Medicare Integrated MLTC Product Lines by Membership Categories

Membership Category	Medicaid Advantage Plus (MAP)	Program of All-Inclusive Care for the Elderly (PACE)	Fully Integrated Duals Advantage (FIDA)
Plans with membership greater than 1,000	2	1	2
Plans with membership between 751-1,000	0	0	1
Plans with membership between 501-750	1	2	0
Plans with membership between 251-500	1	1	2
Plans with membership less than 250	3	5	12
Total number of plans	**7**	**9**	**17**

Note: Number of plans shown is for 2016. The number of participating plans may have changed In subsequent years.

Source: 2016 Managed Long-Term Care Report
https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2016.pdf

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Sample Measures Selected for Maximum Number of Plans for Calculated Measure

Member Counts for Measure Denominators in MAP Fall Below 100 for Many Measures

Medicaid Advantage Plus (MAP) for 2016			
Measure Reported	**# of Plans Reporting***	**Minimum Denominator**	**Maximum Denominator**
No Behavioral Problems	6 out of 7	95	3,840
Nursing Facility Level of Care Score	6 out of 7	95	3,840
No severe or more intense pain daily	6 out of 7	87	3,273
ADL bathing	6 out of 7	94	3,839
No emergency room visits	6 out of 7	87	3,273
ADL eating	6 out of 7	95	3,839
ADL locomotion	6 out of 7	93	3,823
No falls requiring medical intervention	6 out of 7	87	3,273
No shortness of breath	6 out of 7	87	3,273
Dental exam	6 out of 7	87	3,273

*Note: Remaining plan had a sample size that was too small to report for the subset of measures listed here.

Source: Managed Long-Term Care Performance Data: Beginning 2014 https://health.data.ny.gov/Health/Managed-Long-Term-Care-Performance-Data-Beginning-/cmqt-68bp

Sample Measures Selected for Maximum Number of Plans for Calculated Measure

Member Counts for Measure Denominators in PACE Fall Below 50 for Many Measures

Program of All-Inclusive Care for the Elderly (PACE) for 2016			
Measure Reported	**# of Plans Reporting**	**Minimum Denominator**	**Maximum Denominator**
No Behavioral Problems	9 out of 9	60	3,154
Nursing Facility Level of Care Score	9 out of 9	60	3,154
No severe or more intense pain daily	9 out of 9	39	2,666
ADL bathing	9 out of 9	60	3,151
No emergency room visits	9 out of 9	39	2,666
ADL eating	9 out of 9	60	3,153
ADL locomotion	9 out of 9	59	3,089
No falls requiring medical intervention	9 out of 9	39	2,666
No shortness of breath	9 out of 9	39	2,666
Dental exam	9 out of 9	39	2,666

Source: Managed Long-Term Care Performance Data: Beginning 2014 https://health.data.ny.gov/Health/Managed-Long-Term-Care-Performance-Data-Beginning-/cmqt-68bp

Sample Measures Selected for Maximum Number of Plans for Calculated Measure

Member Counts for Measure Denominators in FIDA Approach 30 for Many Measures

Fully Integrated Duals Advantage (FIDA) for 2016			
Measure Reported	**# of Plans Reporting***	**Minimum Denominator**	**Maximum Denominator**
No Behavioral Problems	13 out of 17	35	1,699
Nursing Facility Level of Care Score	13 out of 17	35	1,699
No severe or more intense pain daily	13 out of 17	31	1,590
ADL bathing	13 out of 17	35	1,698
No emergency room visits	13 out of 17	31	1,590
ADL eating	13 out of 17	35	1,693
ADL locomotion	13 out of 17	35	1,685
No falls requiring medical intervention	13 out of 17	31	1,590
No shortness of breath	13 out of 17	31	1,590
Dental exam	13 out of 17	31	1,590

*Note: Remaining 4 plans had a sample size that was too small to report for the subset of measures listed here.

Source: Managed Long-Term Care Performance Data: Beginning 2014 https://health.data.ny.gov/Health/Managed-Long-Term-Care-Performance-Data-Beginning-/cmqt-68bp

Thank you!

Please send questions and feedback to:

MLTCVBP@health.ny.gov.