NEW YORK STATE | Department of Health | Medicaid Redesign Team

Managed Long Term Care (MLTC) Clinical Advisory Group Sub-Team Meeting for Fully Medicare Integrated MLTC Product Lines

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Meeting Agenda

- Welcome and Introductions
- Key Opportunities for Fully Medicare Integrated MLTC Plans – Medicaid Advantage Plus (MAP), Fully Integrated Dual Advantage (FIDA), and Programs of All Inclusive Care for the Elderly (PACE)
- Discussion of VBP structures for MAP, FIDA and PACE
  - Levels, attribution, provider relationships and structure
- Quality measures
  - Measure set review
  - Feasibility considerations

Welcome and Introductions

- Welcome to MLTC Clinical Advisory Group (CAG) Sub-team meeting to discuss VBP for fully Medicare integrated MLTC product lines (MAP, FIDA, and PACE)!
  - The MLTC CAG recommended the formation of this sub-team at its last CAG meeting on August 17, 2017.
  - Material from the August 17 meeting is available at the Department of Health's VBP Resource Library at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/.

- We greatly appreciate your participation in this sub-team and hope to make this a productive and interactive session!
  - Our purpose today is to discuss approaches for VBP for MAP, FIDA, and PACE and the quality measures to be recommended for use in VBP arrangements for these plans.

Opportunities for VBP in MAP, FIDA, and PACE

Opportunities for VBP in MAP, FIDA, and PACE

- MAP, FIDA, and PACE Introduction
- Opportunities for “Proof of concept” for MLTC
  - Inclusive of Medicare
- Review key features of VBP
  - Attribution, Levels, Types of VBP Contractors
- Discuss VBP Approaches for MAP, PACE, and FIDA

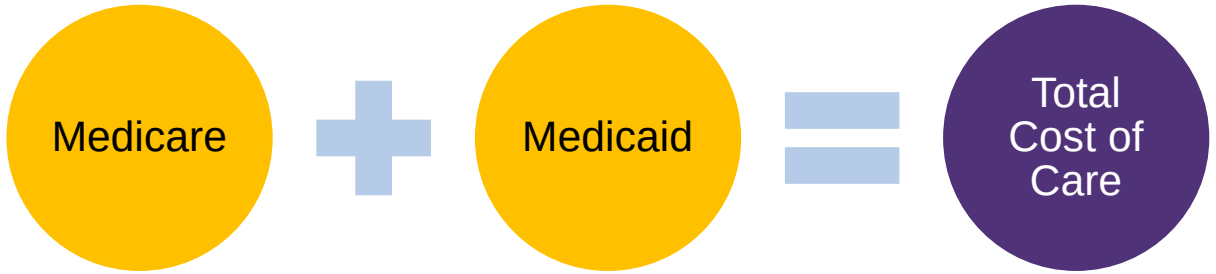
Fully Medicare Integrated MLTC Product Lines

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.
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.
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.

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

Opportunity for “Proof of Concept”

- Goal for MLTC VBP Arrangements



- MAP, FIDA, and PACE are Fully Integrated MLTC Products
  - Opportunity for proof of total cost of care concept for MLTC
    - Full spectrum of care coordination is enabled
    - Potential for more comprehensive quality measurement
    - Provider innovation supported by reinvestment of shared savings

Key Features of VBP

Key Features of VBP

- **Level –** The degree to which the provider or group of providers party to the VBP arrangement is exposed to risk
- **VBP Contractor** – Provider or group of providers entering a VBP contract with a managed care plan
- **Attribution** – VBP Contractor responsible for the cost and quality of the care for a group of assigned members
- **Target Budget or Prospective Global Payment** – Method for benchmarking episodic, bundled, or total cost of care for VBP Contractors in a VBP contract

Other Important Issues to Consider

Role of Care Coordination

- Care coordination & integration are at the center of a total cost of care arrangement
- MAP, FIDA, and PACE have differing care coordination models at the plan level
- Some coordination/organization may be necessary at the provider/VBP Contractor level

Provider Networks

- Created among providers as separate entities from the managed care plan
- IPAs and partnerships can be established among independent providers
- Provider networks can be used to help improve cost effectiveness of care delivery

Medicare Data Integration

- Permits sharing of cost information for the calculation of total cost of care budgets
- Necessary for the use of quality measures for acute and primary care services
- Allows for fully integrated care and innovation

VBP Levels for MAP, FIDA, and PACE

MAP, FIDA, and PACE can choose different levels of VBP with their VBP Contractors. Level 0 is available only to partially capitated MLTC plans where Medicare integration is not possible.

VBP Levels for Mainstream and Fully Capitated MLTC Plans			
Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP
Bonus and/or withhold for [illegible]	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)
Payme[illegible]ed to budg[illegible]	FFS Retrospective Reconciliation	FFS Retrospective Reconciliation	Prospective total budget payments
Limi[illegible]bon[illegible] payment or withhold	↑ **Upside Only**	↑ **Upside** & ↓ **Downside Risk**	↑ **Upside** & ↓ **Downside Risk**

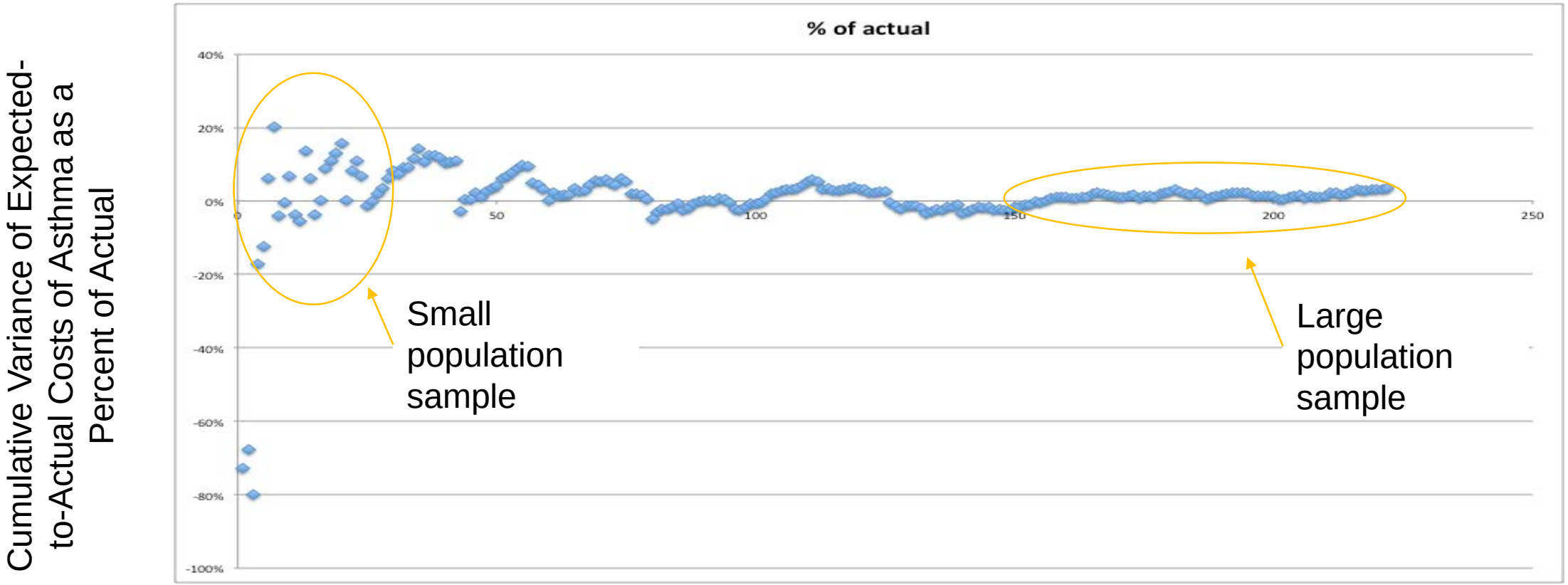
- Before engaging in risk-based arrangements with downside potential, MAP, FIDA, and PACE plans and VBP Contractors should consider scale and size of attributed member population.
- Larger sample sizes are recommended for higher levels of risk in VBP (Levels 2 and 3) and for quality measure use. Larger sample sizes (e.g. 1,000) help to “smooth out” unusual variations.

Scale and Size Considerations for Risk Levels in VBP

- The size of the attributed population matters – larger samples provide a better understanding of cost trends and population behaviors
- It is not recommended to contract risk-based VBP arrangements for small population groups
- Severity adjustment does work when applied properly (on larger population samples)

Scale and Size Considerations for Risk Levels in VBP

The Effect of Sample Size on Financial Results – Large Populations "Smooth Out" Variations



Types of VBP Contracting Entities – VBP Contractors

1. Independent Practice Associations (IPA)
2. Accountable Care Organizations (ACO)
3. Individual Providers
   - Hospital Systems
   - Federally Qualified Health Centers (FQHC) and large medical groups
   - Long-term Care (LTC)
   - Smaller providers including community based organizations (CBOs)

1. Individual provider could either assume all responsibility and upside/downside risk or make arrangements with other providers; or
2. Managed Care Organizations (MCOs) may want to create a VBP arrangement through individual contracts with these providers

VBP Approaches for MAP, FIDA, and PACE

VBP Approach for MAP - Roadmap Levels 1, 2, 3

VBP Contractors

- IPAs/ACOs
- Independent Providers (PCPs, LTC)

Who can take the lead in a VBP contract? Are providers sufficiently independent from plans?

Attribution

- PCP in collaboration with LTC
- Or to IPA/ACO

What role does the PCP play in care decisions? What provider takes primary responsibility for cost and quality of care?

Care Coordination

- PCP-LTC Providers with MAP Plan

How well integrated are PCPs and LTC providers to offer complete care?

VBP Approach for FIDA – Roadmap Levels 1, 2, 3

VBP Contractors	• IPAs/ACOs • Independent Providers (PCPs, LTC)	Who can take the lead on a VBP contract? Are providers sufficiently independent from plans?
Attribution	• PCP in collaboration with LTC • Or to IPA/ACO	What role does the PCP play in care decisions? What provider/s can take primary responsibility for cost and quality of care?
Care Coordination	• Interdisciplinary Team (IDT) • PCP a voluntary member of IDT	What role does the IDT play in leading care decisions? How can the PCP be incentivized to participate?

VBP Approach for PACE – Global Payment Level 3

VBP Contractors

- PACE Plans
- Most direct care provided by PACE employees or on contract with PACE

Are PACE providers sufficiently independent to enable Plan to VBP Contractor arrangements?

Attribution

- To the PACE

How often are PCPs community based? And how do they participate in care?

Care Coordination

- Interdisciplinary Team (IDT)
- PCP a mandatory member of IDT

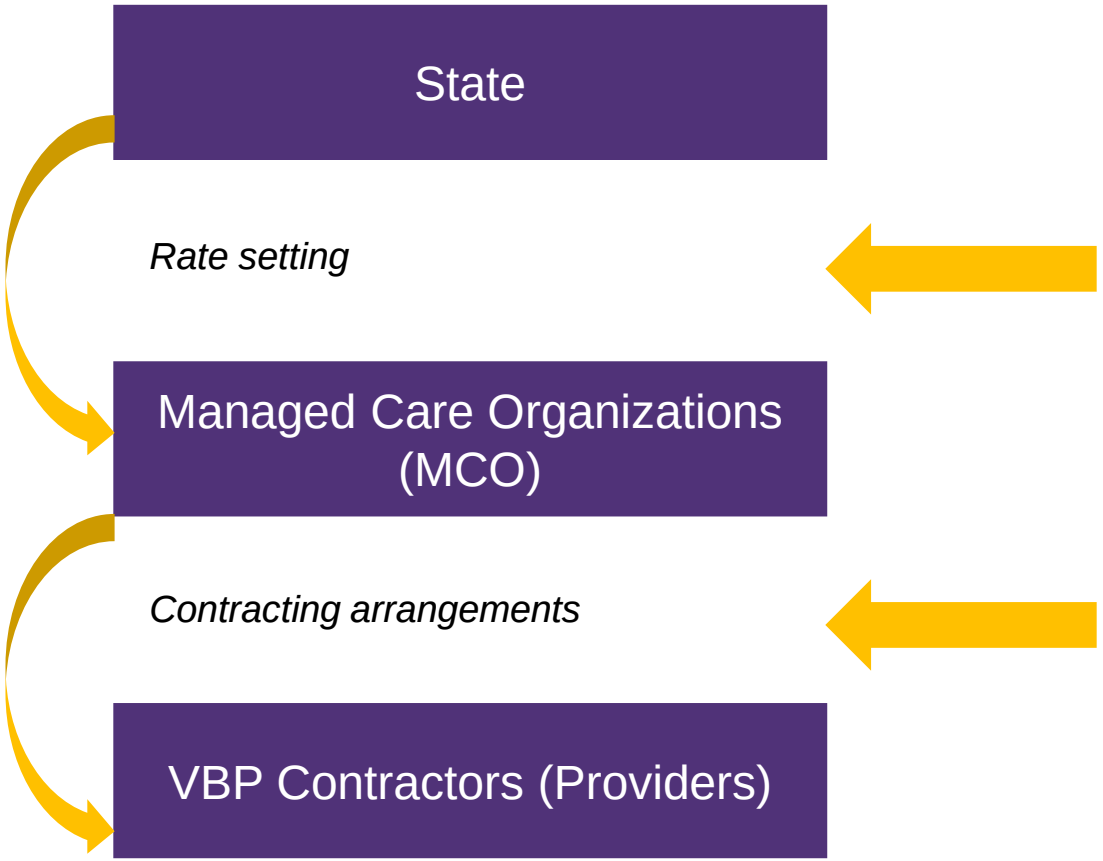
VBP Approach for PACE is the least traditional. PACE is a program and is already at full risk for the cost of care for their members.

Quality Measure Discussion

Quality Measure Discussion

- State – Plan – VBP Contractor Relationships
- Goals for quality measure use in VBP
- Categorizing and Prioritizing VBP Measures
- Overview of feasibility issues
- VBP measure discussion and selection

State – Plan – VBP Contractor Relationships



Examples of VBP Contractors:

- *Independent Practice Associations (IPA)*
- *Accountable Care Organizations (ACO)*
- *Large Individual Providers*

- Quality of **all** contracted care (whether VBP or not) is rewarded through up- and downwards adjustments of premiums received by MCOs from the State
- MCOs and VBP Contractors select quality measures to include in their VBP Contracts.
  - These are selected from the measure sets recommended for VBP but can include other measures at the preference of the contracting parties
- Quality Performance *during contract year* determines percentages of savings / losses shared with VBP Contractors

Goals of Quality Measure Selection for the Sub-Team

- Focused on outcomes of care, not process
  - Difference between the desired end result of high quality care and an interim step that captures activities undertaken by healthcare providers
    - Example – member maintains independent care skills versus member screened for depression
- Relate to person-centered care
  - Centered on the individual, not the systemic goals of the healthcare system
    - Example- member chooses/controls aspects of life plan versus nursing home diversion rate
- Captures key aspects of care continuum
  - Measure gaps that are identified as significant are addressed even if aspirational (for future)
    - Example – behavioral health intervention effectiveness measures
- Not too voluminous in number
  - Avoids measure "wash out" where providers are unable to focus on key desired outcomes and some measures work against others

Categorizing and Prioritizing Quality Measures for VBP

CATEGORY 1
Approved quality measures that are clinically relevant, reliable and valid, and feasible. The State classified each Category 1 measure as pay-for-performance (P4P) or pay-for-reporting (P4R). P4P are recommended for use for payment while P4R measures may need additional data or feasibility work.

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.

Measure reclassification will be considered on an annual basis.

Overview of Potential VBP Quality Measure Feasibility Issues for MAP, FIDA, and PACE

- Small sample size
  - Low member volume for plans makes the sample size for many measures too small for reporting, resulting in data limitations.
- Medicare and Medicaid data sharing/integration is need for NYS to calculate MAP, FIDA, and PACE measures.
- Use of Satisfaction/Choice Measures
  - Concerns related to survey administration at the plan/provider (e.g., sample size and random sampling methods) and survey fatigue.
- Healthcare Effectiveness Data and Information Set (HEDIS) measures
  - Require purchase of HEDIS technical specifications
  - Risk adjusted only on the basis of Medicare only population (not long-term care recipient specific)
  - Some measures may “age-out” at 65

Overview of Potential VBP Quality Measure Feasibility Issues for MAP, FIDA, and PACE (cont'd)

- The Centers for Medicare and Medicaid Services (CMS) is currently calculating the Medicare-based measures based upon data sent to them by the plans at a plan level.
  - Attribution to the provider level is necessary for the purposes of a VBP contract.
  - NYS could calculate the measures and VBP contracts could use them as soon as Medicare data becomes linked to Medicaid data.
  - For Medicare Advantage (MA) measures sample size is an issue as well because the sample is larger (for all MA) than for those that get long-term care through the integrated MAP plans.
- An important focus of long-term care is functioning, which is not captured in primary/acute care quality paradigms.

Measure Review & Selection

Sources of VBP Measures for MAP, FIDA, and PACE

Medicare Advantage

- CMS uses a set of measures for “5-Star” Ratings
- These focus on the medical and pharmacy benefits covered by Medicare
- Many are National Committee for Quality Assurance (NCQA) HEDIS measures

FIDA

- CMS and NYS have agreed to a list of measures for the FIDA plans
- Includes preventive and chronic condition care, pharmacy, some long-term care, and measures of care coordination and member satisfaction
- Many of the Medicare Advantage measures are in the FIDA set

PACE

- Three measures specific to PACE have been advanced through the National Quality Forum (NQF) for endorsement
- CMS is the steward for these measures and reporting cycles to CMS are being established
- Additional measures are under development

MLTC Quality Indicators

- Measures of long-term care used for NYS Medicaid
- Source for VBP measures for partially capitated MLTC plans
- Largely drawn from the UAS-NY to assess functioning but includes a member satisfaction survey component

Measure Selection Process for MAP, FIDA, and PACE

- For Long-Term Care Medicaid Services, the Sub-team could decide to:
  - Align with partially capitated plans for MLTC measures, which are from the MLTC Quality Incentive (QI);
  - For long-term care could examine measures from the larger MLTC quality indicators list and select additional measures; and/or,
  - Select other long-term care measures from measure stewards outside NYS.

- For primary and acute care, and some long-term care services, the Sub-team could decide to:
  - Identify measures from the MA and FIDA set; and/or,
  - Identify measures from other VBP arrangements including, Integrated Primary Care (IPC) or Total Care for the General Population (TCGP).
    - There is some overlap in measures

- Feasibility is considered for all measures before they are recommended.

MLTC: Category 1 Quality Measure List MY 2018

All Cat 1 Measures in MY 2018 are designated P4P

Measure	Measure Source/ Steward [1]	Current Use Recommendation	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 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
Percentage of members who received an influenza vaccination in the last year*	UAS – NY/New York State	P4P	Critical Prevention
Percentage of members who remained stable or demonstrated improvement in pain intensity*	UAS – NY/New York State	P4P	Functional Improvement

[1] UAS – NY denotes the Uniform Assessment System for New York for MLTC members
* Included in the NYS DOH MLTC Quality Incentive measure set

MLTC: Category 1 Quality Measure List MY 2018

All Cat 1 Measures in MY 2018 are designated P4P

Measure	Measure Source/ Steward	Current Use Recommendation	Measure Theme
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

* Included in the NYS DOH MLTC Quality Incentive measure set

MLTC: Category 1 Quality Measure List MY 2018

All Cat 1 Measures in MY 2018 are designated P4P

Measure	Measure Source/ Steward	Current Use Recommendation	Measure Theme
Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection* (For members in community care)	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+ (For members in nursing homes)	MDS 3.0++ /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
\+ Included in the NYS DOH Nursing Home Quality Initiative measure set
++MDS 3.0 denotes the Centers for Medicare and Medicaid Services Minimum Data Set for nursing home members

MLTC: Category 2 Quality Measure List MY 2018

Measure	Measure Source/ Steward	Current Use Recommendation	Measure Theme
Percent of long stay high risk residents with pressure ulcers+	MDS 3.0/CMS	P4R	Critical Prevention
Percent of long stay residents who received the pneumococcal vaccine+	MDS 3.0/CMS	P4R	Critical Prevention
Percent of long stay residents who received the seasonal influenza vaccine+	MDS 3.0/CMS	P4R	Critical Prevention
Percent of long stay residents experiencing one or more falls with major injury+	MDS 3.0/CMS	P4R	Critical Prevention
Percent of long stay residents who have depressive symptoms+	MDS 3.0/CMS	P4R	Quality of Life

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

MLTC: Category 2 Quality Measure List MY 2018

Measure	Measure Source/ Steward	Current Use Recommendation	Measure Theme
Percent of long stay low risk residents who lose control of their bowel or bladder+	MDS 3.0/CMS	P4R	Functional Improvement
Percent of long stay residents who lose too much weight+	MDS 3.0/CMS	P4R	Critical Prevention
Percent of long stay residents with dementia who received an antipsychotic medication+	MDS 3.0/Pharmacy Quality Alliance	P4R	Quality of Life
Percent of long stay residents who self–report moderate to severe pain+	MDS 3.0/CMS	P4R	Quality of Life
Percent of long stay residents whose need for help with daily activities has increased+	MDS 3.0/CMS	P4R	Functional Improvement
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 2018

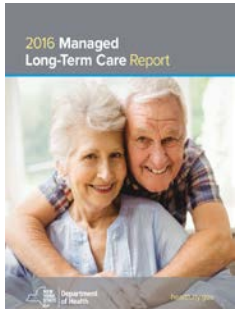
Measure	Measure Source/ Steward	Current Use Recommendation	Measure Theme
Percentage of members who responded that they were usually or always involved in making decisions about their plan of care*	MLTC Survey/New York State	P4R	Personal Choice/Satisfaction
Percentage of members who reported that within 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
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
Care for Older Adults – Medication Review	NCQA+	P4R	Critical Prevention
Use of High–Risk Medications in the Elderly	NCQA	P4R	Critical Prevention

* Included in the NYS DOH MLTC Quality Incentive measure set
+ National Committee for Quality Assurance (NCQA)

MLTC Quality Measures

Current Uses

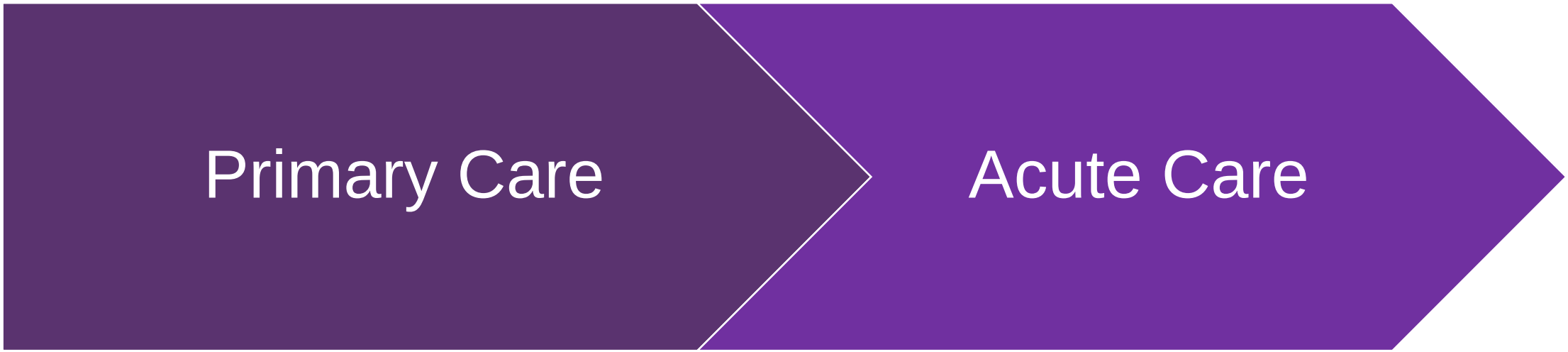
- 2016 MLTC Report - http://www.health.ny.gov/health_care/managed_care/mltc/reports.htm
  - o Comprehensive evaluation of plan performance and consumer satisfaction



- 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

Types of Care not Currently Addressed by the VBP Measures for MLTC Plan

- MAP, FIDA, and PACE cover the total spectrum of care provided to members
- MAP, FIDA, and PACE measures could address measure gaps for:



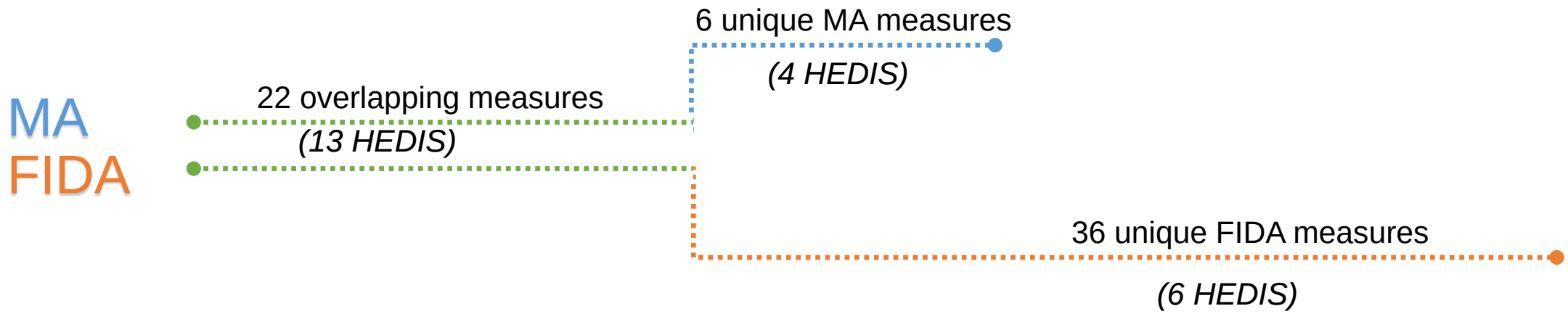
- VBP measures for partially capitated MLTC plans address only long-term care

MA, FIDA, and HEDIS Measure Sets and Overlap

28 Total Measures in MA

58 Total Measures in FIDA

Unique to FIDA		FIDA & MA		Unique to MA	
36		22		6	
HEDIS	*Non-HEDIS*	*HEDIS*	*Non-HEDIS*	*HEDIS*	*Non-HEDIS*
6	30	13	9	4	2



NOTE: Table excludes FIDA Part D and MAP Part D

Medicare Advantage Measures and Themes (1/2)

Measure Name	Steward/Data Source	Theme	Included in FIDA?	Included in MY 2018 VBP TCGP/IPC Measure Set?
Controlling Blood Pressure	NCQA/HEDIS	Chronic Condition Care	Yes	Yes
Diabetes Care – Blood Sugar Controlled [Hemoglobin A1c (HbA1c) Control (<8.0%)]	NCQA/HEDIS	Chronic Condition Care	Yes	Yes
Diabetes Care – Eye Exam	NCQA/HEDIS	Chronic Condition Care	Yes	Yes
Diabetes Care – Kidney Disease Monitoring [Medical Attention for Nephropathy]	NCQA/HEDIS	Chronic Condition Care	Yes	Yes
Osteoporosis Management in Women who had a Fracture	NCQA/HEDIS	Chronic Condition Care	No	No
Rheumatoid Arthritis Management	NCQA/HEDIS	Chronic Condition Care	Yes	No
Adult BMI Assessment	NCQA/HEDIS	Critical Prevention	No	No
Annual Flu Vaccine [Influenza Immunization]	AHRQ/CAHPS	Critical Prevention	Yes	Yes
Care for Older Adults – Medication Review	NCQA/HEDIS	Critical Prevention	Yes	No
Colorectal Cancer Screening	NCQA/HEDIS	Critical Prevention	Yes	Yes
Monitoring Physical Activity	HEDIS / Health Outcomes Survey (HOS)	Critical Prevention	Yes	No
Plan All-Cause Readmissions	NCQA/HEDIS	Critical Prevention	Yes	No

Acronyms: National Committee for Quality Assurance (NCQA); Healthcare Effectiveness Data Information Set (HEDIS); Agency for Healthcare Research and Quality (AHRQ)/ Consumer Assessment of Healthcare Providers & Systems (CAHPS)

Medicare Advantage Measures and Themes (2/2)

Measure Name	Steward/Data Source	Theme	Included in FIDA?	Included in MY 2018 VBP TCGP/IPC Measure Set?
Reducing the Risk of Falling	HEDIS / HOS	Critical Prevention	Yes	No
Care for Older Adults – Functional Status Assessment	NCQA/HEDIS	Functional Improvement	Yes	No
Improving Bladder Control	HEDIS / HOS	Functional Improvement	No	No
Improving or Maintaining Mental Health	HEDIS / HOS	Functional Improvement	Yes	No
Improving or Maintaining Physical Health	HEDIS / HOS	Functional Improvement	No	No
Care Coordination	AHRQ/CAHPS	Member Satisfaction	No	No
Customer Service	AHRQ/CAHPS	Member Satisfaction	Yes	No
Getting Appointments and Care Quickly	AHRQ/CAHPS	Member Satisfaction	Yes	No
Getting Needed Care	AHRQ/CAHPS	Member Satisfaction	Yes	No
Rating of Health Care Quality	AHRQ/CAHPS	Member Satisfaction	Yes	No
Rating of Health Plan	AHRQ/CAHPS	Member Satisfaction	Yes	No
Complaints about the Health Plan	Complaints Tracking Module (CTM)/ CMS	Plan Quality	Yes	No
Members Choosing to Leave the Plan	Medicare Beneficiary Database Suite of Systems	Plan Quality	Yes	No
Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	Plan Quality	Yes	No
Reviewing Appeals Decisions	IRE	Plan Quality	No	No
Care for Older Adults – Pain Assessment	NCQA/HEDIS	Quality of Life	Yes	No

Considering the 36 Unique FIDA Measures for VBP

Measures to rule out:

- Outcome measures rather than process measures are preferable for VBP as they better capture the quality of care provided.
  - o 14 process/access measures
- Measures of plan quality do not translate to the individual's care
  - o 3 plan quality measures
- Long term care quality in NY state is better captured by MLTC quality indicators
  - o 4 overlapping long term care measures
- Survey measures pose feasibility challenges
  - o 9 survey measures

Measures to consider:

- 3 care for chronic condition measures
- 3 systemic long term care measures

Three Possible FIDA NCQA HEDIS Measures to Consider

Measure Name	Measure Theme	Steward/Data Source
Antidepressant Medication Management*	Chronic Condition Care	NCQA/ HEDIS
Follow-up After Hospitalization for Mental Illness+	Chronic Condition Care	NCQA/ HEDIS
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*	Chronic Condition Care	NCQA/ HEDIS

** Measure included in the NYS VBP TCGP/IPC Measure Set for Measurement Year (MY) 2018*
+ Measure included in the NYS VBP Health and Recovery Plan (HARP) Subpopulation Measure Set for MY 2018

Three Possible FIDA Systemic Long Term Care Measures to Consider

Measure Name	Numerator Description	Denominator Description
Long Term Care Overall Balance	The number of Participants who did not reside in a NF for a long stay at the earliest point of their enrollment during the reporting period.	Total number of Participants continuously enrolled in the FIDA Plan for 6 months during the reporting period.
Community Reintegration	The number of Participants discharged to a community setting during the previous or current reporting period who did not return to the NF or a long stay during the current reporting period.	Total number of Participants who resided in a NF for a long stay during the previous reporting period and who were continuously enrolled during the previous and current reporting period.
Nursing Facility (NF) Diversion	The number of members who were classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period.	Total number of members who were continuously enrolled in the MMP for at least 5 out of the last 6 months during the previous reporting period ***and*** continuously enrolled in the MMP for at least 11 out of 12 months during the current reporting period.

These measures could be used at a provider level for the purposes of VBP.

MAP, FIDA, and PACE Measure Selection

- Alignment with MLTC VBP measures selected for Long-Term Care for partially capitated plans?
- Identification of significant measure gaps and themes?
- Identification of aspirational measures based upon feasibility considerations?
  - Medicare data linkages for calculation at the provider level?
  - Require survey methods?
  - Require medical records?
  - New measure development because outcomes are not well captured by existing measurement science?
- Other key areas such as systemic change in long-term care balance or nursing home diversion?

Thank you!

Please send questions and feedback to:

MLTCVBP@health.ny.gov.

Appendix

- Background on VBP for MLTC
- Types of VBP Contractors
- Distribution of MAP Membership Across Plans
- Measure Classification
- Measure Sets for MA and FIDA

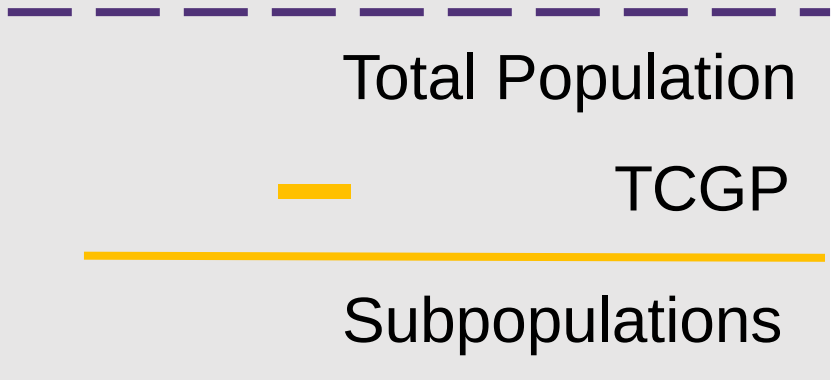
Background on VBP for MLTC

MLTC VBP Vision: Total Cost of Care *Including Medicare*

Goal: Improve population health through enhancing the quality of care for specific subpopulations that often require highly specific, intensive care.

- New York State Department of Health (DOH) has identified three subpopulations with their own distinct, dedicated managed care arrangements:
  - **MLTC;**
  - HIV/AIDS;
  - HARP.
- A fourth subpopulation, to include specialty services provided by the Office for Persons with Developmental Disabilities – I/DD – is under development as these services are not included in managed care.

In total cost of care subpopulation arrangements VBP Contractors take responsibility for all care needed by the Medicaid member.



Acronyms: HARP = Health and Recovery Plans; TCGP = Total Care for the General Population; I/DD = Intellectual/Developmental Disabilities

VBP for Partially Capitated MLTC Product Lines

- 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.

Types of VBP Contractors

VBP Contractors: Independent Practice Association

- An Independent Practice Association (IPA) is a corporation (nonprofit or for-profit) and/or Limited Liability Company (LLC) that contracts directly with providers of medical or medically related services, or another IPA in order to contract with one or more MCOs to make the services of such providers available to the enrollees of an MCO.
- Who negotiates the IPA contract?
  - What is the governance of the IPA?
  - Who should the individual provider look to if there are questions and/or concerns?

VBP Contractors: Independent Practice Association

- **IPAs facilitate network development and access**
  - Single signature authority
    - Typically for a category of services amongst competing providers (could be with providers across the care continuum)
  - Allows providers to maintain independence regarding governance and clinical decision-making
- **IPAs are not unions or guilds**
  - Antitrust concerns related to collective negotiation
  - To avoid antitrust concerns, IPAs are usually entities that share risk or are clinically integrated
- **IPAs can provide administrative services to providers who participate in the IPA and/or management services to MCOs**

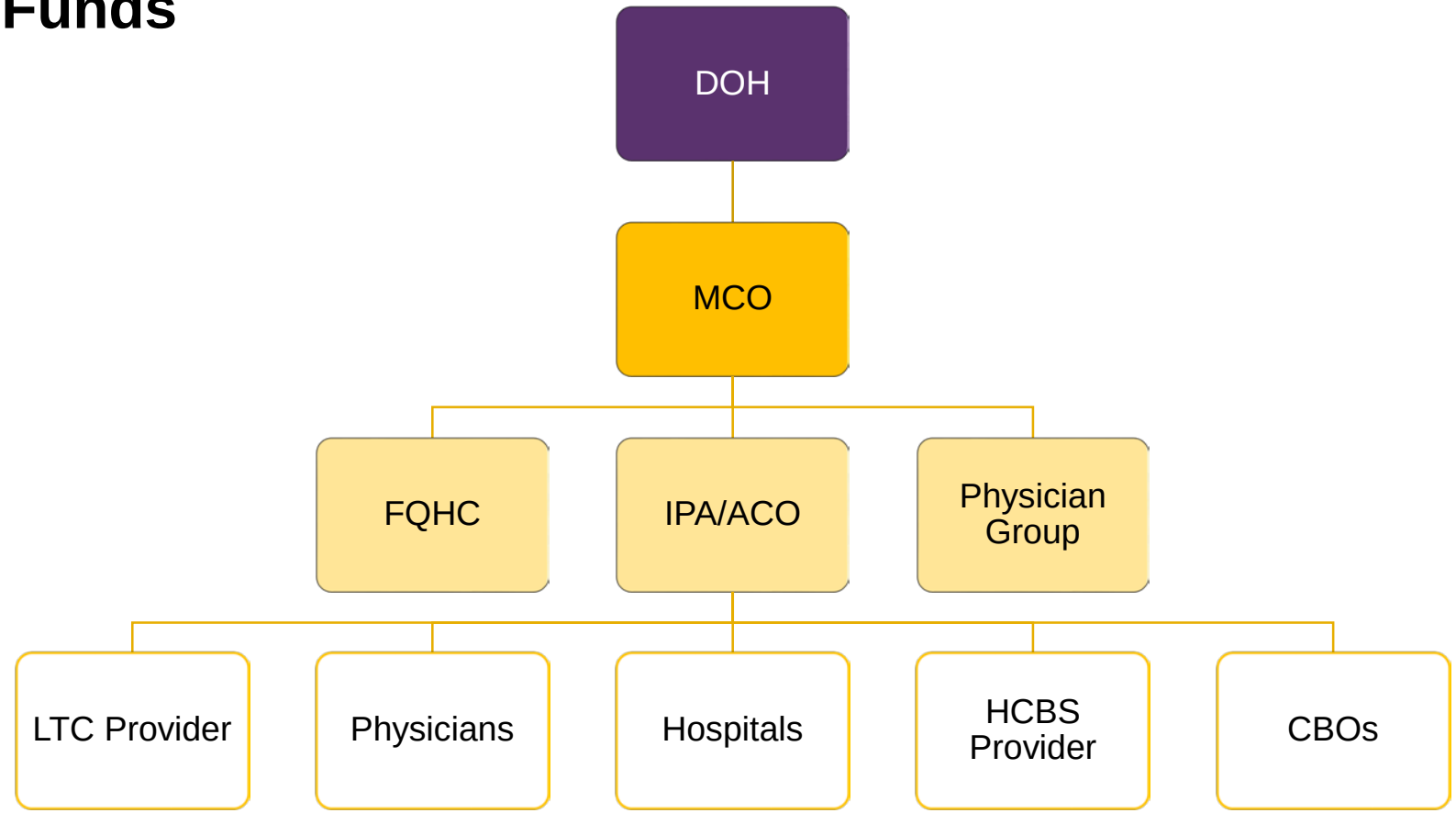
VBP Contractors: Accountable Care Organization

- An Accountable Care Organization (ACO) is an organization of clinically integrated health care providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population; with a mechanism for shared governance; the ability to negotiate, receive, and distribute payments; and accountability for the quality, cost, and delivery of health care to the ACO's patients
  - Medicare-only ACO (approved by CMS) for Medicare population
  - Medicare ACO does not make you a Medicaid ACO and vice versa*
  - IPAs may be certified by DOH as an ACO

**There is an expedited approval process for Medicare ACOs to become Medicaid ACOs.*

Example of a Total Care for a Subpopulation VBP Arrangement

Flow of Funds



Distribution of MAP Membership Across Plans

Distribution of MAP Membership Across Plans

October 2017 Membership for Medicaid Advantage Plus (MAP)				
Membership less than 250	**Membership between 251-500**	**Membership between 501-750**	**Membership between 751-1,000**	**Membership greater than 1,000**
NYS Catholic Health Plan – Fidelis (103)		GuildNet Medicaid Advantage Plus (596)		MHI Healthfirst Complete Care (4,941)
Senior Whole Health (107)				Elderplan (1,292)
Empire BCBS HealthPlus MAP (2)				VNS Choice Plus (1,615)
Village Care (69)				

Source: NYS Department of Health, 2017 Monthly Medicaid Managed Care Enrollment, October 2017, https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

Distribution of PACE Membership Across Plans

October 2017 Membership for Program of All-Inclusive Care for the Elderly (PACE)				
Membership less than 250	**Membership between 251-500**	**Membership between 501-750**	**Membership between 751-1,000**	**Membership greater than 1,000**
Catholic Health – LIFE (236)		Independent Living for Senrios dba ElderONE (700)		CenterLight Health System – Comprehensive Care Management (3,057)
Eddy Senior Care (207)		ArchCare Senior Life (624)		
Complete Senior Care (126)		PACE CNY (564)		
Total Senior Care (107)				
Fallon Health Weinberg-PACE (116)				

Source: NYS Department of Health, 2017 Monthly Medicaid Managed Care Enrollment, October 2017, https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

Distribution of FIDA Membership Across Plans

October 2017 Membership for Fully Integrated Duals Advantage (FIDA)				
Membership less than 250	**Membership between 251-500**	**Membership between 501-750**	**Membership between 751-1,000**	**Membership greater than 1,000**
MetroPlus FIDA (187)	Elderplan FIDA Total Care (378)	GuildNet Gold Plus FIDA (629)	Healthfirst AbsoluteCare FIDA (963)	VNSNY CHOICE FIDA Complete (1,442)
SWH Whole Health FIDA (137)	Fidelis Care (315)			
AgeWell New York FIDA (177)				
VillageCareMAX Full Advantage FIDA (17)				
FIDA Care Complete (26)				
RiverSpring FIDA (9)				
Aetna Better Health (57)				
ICS Community Care Plus (128)				
North Shore-LIJ FIDA LIveWell (42)				

Source: NYS Department of Health, 2017 Monthly Medicaid Managed Care Enrollment, October 2017, https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

Measure Classification

Category 1 Measures

- 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) 2018, all MLTC Category 1 measures for partially capitated MLTC plans 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

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.
- 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.

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.

Measure Sets

Medicare Advantage Measures Descriptions (1/2)

Measure Name	Steward/ Data Source	Measure Description
Adult BMI Assessment	NCQA/HEDIS	Percent of plan members with an outpatient visit who had their “Body Mass Index” (BMI) calculated from their height and weight and recorded in their medical records.
Annual Flu Vaccine [Influenza Immunization]	AHRQ/CAHPS	Percent of plan members who got a vaccine (flu shot) prior to flu season.
Care Coordination	AHRQ/CAHPS	Percent of the best possible score the plan earned on how well the plan coordinates members’ care. (This includes whether doctors had the records and information they need about members’ care and how quickly members got their test results.)
Care for Older Adults – Functional Status Assessment	NCQA/HEDIS	Percent of plan members whose doctor has done a “functional status assessment” to see how well they are able to do “activities of daily living” (such as dressing, eating, and bathing). (This information about the yearly assessment is collected for Medicare Special Needs Plans only.
Care for Older Adults – Medication Review	NCQA/HEDIS	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year. (This information about a yearly review of medications is collected for Medicare Special Needs Plans only.
Care for Older Adults – Pain Assessment	NCQA/HEDIS	Percent of plan members who had a pain screening or pain management plan at least once during the year. (This information about pain screening or pain management is collected for Medicare Special Needs Plans only.
Colorectal Cancer Screening	NCQA/HEDIS	Percent of plan members aged 50-75 who had appropriate screening for colon cancer
Complaints about the Health Plan	CTM / CMS	How many complaints Medicare received about the health plan.
Controlling Blood Pressure	NCQA/HEDIS	Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure.
Customer Service	AHRQ/CAHPS	Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed.
Diabetes Care – Blood Sugar Controlled [Hemoglobin A1c (HbA1c) Control (<8.0%)]	NCQA/HEDIS	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.
Diabetes Care – Eye Exam	NCQA/HEDIS	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.
Diabetes Care – Kidney Disease Monitoring [Medical Attention for Nephropathy]	NCQA/HEDIS	Percent of plan members with diabetes who had a kidney function test during the year.

Medicare Advantage Measures Descriptions (2/2)

Measure Name	Steward/ Date Source	Measure Description
Getting Appointments and Care Quickly	AHRQ / CAHPS	Percent of the best possible score the plan earned on how quickly members get appointments and care.
Getting Needed Care	AHRQ / CAHPS	Percent of the best possible score the plan earned on how easy it is for members to get needed care, including care from specialists.
Improving Bladder Control	HEDIS / HOS	Percent of plan members with a urine leakage problem who discussed the problem with their doctor and got treatment for it within 6 months.
Improving or Maintaining Mental Health	HEDIS / HOS	Percent of all plan members whose mental health was the same or better than expected after two years.
Improving or Maintaining Physical Health	HEDIS / HOS	Percent of all plan members whose physical health was the same or better than expected after two years.
Members Choosing to Leave the Plan	Medicare Beneficiary Database Suite of Systems	The percent of plan members who chose to leave the plan in 2013. (This does not include members who did not **choose** to leave the plan, such as members who moved out of the service area.)
Monitoring Physical Activity	HEDIS / HOS	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.
Osteoporosis Management in Women who had a Fracture	NCQA/HEDIS	Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within 6 months.
Plan All-Cause Readmissions	NCQA/HEDIS	Percent of senior plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason. (Patients may have been readmitted back to the same hospital or to a different one. Rates of readmission take into account how sick patients were when they went into the hospital the first time. This “risk-adjustment” helps make the comparisons between plans fair and meaningful.)
Plan Makes Timely Decisions about Appeals	IRE	Percent of plan members who got a timely response when they made an appeal request to the health plan about a decision to refuse payment or coverage.
Rating of Health Care Quality	AHRQ / CAHPS	Percent of the best possible score the plan earned from members who rated the quality of the health care they received.
Rating of Health Plan	AHRQ / CAHPS	Percent of the best possible score the plan earned from members who rated the health plan.
Reducing the Risk of Falling	HEDIS / HOS	Percent of plan members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.
Reviewing Appeals Decisions	IRE	This measure/rating shows how often an Independent Reviewer thought the health plan’s decision to deny an appeal was fair. This includes appeals made by plan members and out-of-network providers. (This rating is not based on how often the plan denies appeals, but rather *how fair* the plan is when they do deny an appeal.)
Rheumatoid Arthritis Management	NCQA/HEDIS	Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.

36 Unique FIDA Measures (Not included in MA) {1/3}

Measure Name	Measure Theme	Measure Steward/Data Source	VBP Consideration
Assessments	Care Coordination, Assessments	CMS/State defined process measure	Process Measure
Documentation of Care Goals	Care Coordination, Assessments	CMS/State defined process measure	Process Measure
Person- Centered Service Plan (PCSP)	Care Coordination, Assessments	CMS/State defined process measure	Process Measure
Self- direction Participant- level Measure	Care Coordination, Assessments	State- specified measure	Process Measure
SNP (Special Needs Plan) 6: Coordination of Medicare and Medicaid Benefits	Care Coordination, Assessments	NCQA/ SNP Structure & Process Measures	Process Measure
Care Transition Record Transmitted to Health Care Professional	Care Transitions	AMA-PCPI‡	Process Measure
Discharge follow-up	Care Transitions	CMS/State defined process measure	Process Measure
Medication Reconciliation After Discharge from Inpatient Facility	Care Transitions	NCQA/ HEDIS	Process Measure
Real Time Hospital Admission Notifications	Care Transitions	CMS/State defined process measure	Process Measure
SNP 4: Care Transitions	Care Transitions	NCQA/ SNP Structure & Process Measures	Process Measure
Antidepressant Medication Management*	Chronic Condition Care	NCQA/ HEDIS	Viable for VBP
Follow-up After Hospitalization for Mental Illness+	Chronic Condition Care	NCQA/ HEDIS	Viable for VBP
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*	Chronic Condition Care	NCQA/ HEDIS	Viable for VBP
Comprehensive Medication Review	Long Term Care (LTC)	Pharmacy Quality Alliance Part D Reporting Data	LTC Overlap

* *Measure included in the NYS VBP TCGP/IPC Measure Set for MY 2018*
\+ *Measure included in the NYS VBP HARP Subpopulation Measure Set for MY 2018*
‡ *AMA-PCPI: American Medical Association-convened Physician Consortium for Performance Improvement (AMA-PCPI).*

36 Unique FIDA Measures (Not included in MA) {2/3}

Measure Name	Measure Theme	Measure Steward/Data Source	VBP Consideration
Help with Transportation	Long Term Care	AHRQ/CAHPS	Survey
Improvement/ Stability in Activities of Daily Living (ADL) Functioning	Long Term Care	State- specified measure	LTC Overlap
Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Long Term Care	CMS	LTC Overlap
Percent of Residents Experiencing One or More Falls with a Major Injury	Long Term Care	CMS	LTC Overlap
Risk stratification based on LTSS or other factors	Long Term Care	CMS/State defined process measure	Process Measure
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Satisfaction/ Plan Quality	CMS Call Center data	Survey
Getting Information about Prescription Drug Coverage and Cost	Satisfaction/ Plan Quality	AHRQ/CAHPS	Survey
Getting Needed Prescription and Non-Prescription Drugs	Satisfaction/ Plan Quality	AHRQ/CAHPS	Survey
Non-Part D Appeals Upheld	Satisfaction/ Plan Quality	FIDA Administrative Hearing Unit	Plan Quality
Participant Access and Performance Problems	Satisfaction/ Plan Quality	CMS Participant database	Plan Quality
Participant Governance Board	Satisfaction/ Plan Quality	CMS/State defined process measure	Plan Quality
Rating of Plan for Coverage of Prescription Drugs	Satisfaction/ Plan Quality	AHRQ/CAHPS	Survey
Access to Primary Care Doctor Visits	Prevention	NCQA/HEDIS	Process Measure

36 Unique FIDA Measures (Not included in MA) {3/3}

Measure Name	Measure Theme	Measure Steward/Data Source	VBP Consideration
Access to Specialists	Prevention	AHRQ/CAHPS	Survey
Being Examined on the Examination table	Prevention	AHRQ/CAHPS	Survey
Breast Cancer Screening*	Prevention	NCQA/ HEDIS	Process Measure
Getting Care Quickly	Prevention	AHRQ/CAHPS	Survey
Health Status/Function Status	Prevention	AHRQ/CAHPS	Survey
Long Term Care Overall Balance Measure	Systemic Long Term Care	State- specified measure	Viable for VBP
Long Term Care Rebalancing Measure	Systemic Long Term Care	State- specified measure	Viable for VBP
Nursing Facility Diversion Measure	Systemic Long Term Care	State- specified measure	Viable for VBP
Participants Referred to Preadmission Screening Teams or Money Follows the Person (MFP) Program	Systemic Long Term Care	State- specified measure	Process Measure

** Measure included in the NYS VBP TCGP/IPC MY 2018 Measure Set*