NEW YORK STATE | Department of Health | Medicaid Redesign Team

MLTC VBP Finance Webinar Questions Follow-Up

Q: Will the $50M in VBP quality funding in 2020-21 be allocated based on PAH attributed to both nursing home and home care members? (Slide 15)

DOH will allocate the $50M using a combination of scores from the MLTC Community PAH and the Nursing Home PAH. The scores will be weighted on a plan-by-plan basis according to the proportion of membership a plan has in each care setting.

Q: We understood that there is an alternative strategy for contracting with small membership home care agencies, in addition to the one suggested on slide 22:

We understood that, instead of requiring agencies to partner with each other, MLTC plans could contract directly with each CHHA/LHCSA that serves <30 of a given plan's members by measuring performance based on the agency's total MLTC patient census (across all plans). Is that correct?

Yes that is correct. OQPS gives each plan the LHCSA/CHHA rate across the census of members for the MLTC plan, so plans will have that and can use it however they prefer.

Q: The treatment of small membership nursing homes on slide 22 is inconsistent with our understanding of how nursing home PAH data is calculated and accordingly how nursing homes with small membership should be treated in contracting. We understand that the nursing home PAH data is *not* based on attributed members. Instead, it is based on long-stay residents, facility-wide. Very few nursing homes have less than 30 long-stay residents facility-wide. According to the NHQI data, only 23 nursing homes have sample sizes too small to calculate the PAH measure (the sample size threshold is not clearly stated in the PAH measure specs, but we believe it is 30). Given that nursing home performance data is based on facility-wide results, is there a need to aggregate small membership nursing homes? If so, is the aggregation trigger based on less than 30 members or less than 30 long-stay residents facility-wide? Will OQPS being calculating the PAH measure for those homes, and if so, will it be based on membership or long-stay residents?

This is true, NH PAH is based on overall facility performance, not the performance for the specific group of plan members covered by the VBP agreement. Yes, there are a small # of SS homes, but we are willing to aggregate, if needed. Yes, OQPS will aggregate, since these are unadjusted rates, we will just sum numerators and denominators from SS home (only based on long-stay) – we will NOT be risk-adjusting results.

Q: We believe that the first Q&A on slide 21 is partially inaccurate. It is our understanding based on discussions with OQPS that the nursing home PAH data is risk adjusted (unlike the home care PAH data). Therefore, the nursing home data does allow for comparisons among providers (whereas the home care data does not). Please let us know if our understanding is incorrect.

The NH risk-adjusted PAH rates are available on Open Data as part of the Nursing Home Quality Initiative (NHQI). We recently made the unadjusted NH PAH rates available on Open data and encourage plans to use the unadjusted PAH rates in order to complete year-to-year comparisons for a particular facility. Using risk-adjusted rates does not allow for year-to-year comparisons.

Q: What is the measurement period for the Year 1 penalty? 1st quarter of CY 2018? (slide 18)

First quarter of 2018. Jan 1, 2018 – March 31, 2018.

Q: Is the following an accurate characterization of the penalty calculation? If an MLTC makes total payments to SNFs and CHHAs in the amount of $100, then $10 is required to be paid via Level 1 arrangements in SFY18-19. If only $5 are paid in Level 1 arrangements, then a penalty of 0.5% of the difference (i.e., $5) will be imposed. The penalty will be 25 cents.

Yes, the penalty calculation above is correct. One caveat is that the measurement period for the first year will only be from Jan 1, 2018 – March 31, 2018 as indicated above.

Q: According to slide 9, for Level 1, plans will be measured only on contracting with LHCSAs, CHHAs, and SNFs. Does this mean that under Level 2 arrangements, plans will be measured against payments to other providers? If so, which providers?

Level 2 arrangements for partially capitated MLTC plans and providers should begin to address the entire continuum of care, including all Medicaid covered services provided by MLTC partial plans. Until such time as Medicare costs can also be included in VBP arrangements for partially capitated MLTC plans, Level 2 arrangements should also reflect a continuing commitment to coordination and cost-control for Medicare services such as acute and primary care as is embodied by the inclusion of the PAH measure. More specific information on Level 2 for partially capitated plans is forthcoming.

Q: How will the $50M be built prospectively into rates?

Amounts of funding will be determined based upon a performance period that is prior to the rate period. Rate adjustment amounts will be included as a prospective adjustment to those rates according to the timeline included within the finance webinar presentation.