NEW YORK STATE | Department of Health | Medicaid Redesign Team

VBP Bootcamp

Managed Long Term Care

January 9, 2018

Agenda

Area	Details
Timing	One, 1-hour class
	Class 1
Setting	Smaller classroom setting with pauses in the presentation to: a) Field questions from the audience b) Clarify roadmap language, intent, meaning and VBP terms
Topics	**Top 10 Provider Considerations** **VBP Arrangement Exploration & What it Means for a Provider** - Review of the concept/intention of the MLTC VBP Arrangement **Getting started at Level 1 for MLTC** - Review contracting guidance **Quality Measures Recommended for Use in MLTC VBP Arrangements**
Speakers	**DOH** - Erin Kate Calicchia

MLTC Class Syllabus

Intended Audience:	**The MLTC course (consisting of one class) is intended for MLTC plans and long-term care providers transitioning to VBP.**
Course Description:	This course is intended to prepare participants to enter into an entry level VBP arrangement for MLTC. The course will review the key principles of a Level 1 arrangement for MLTC and will include a review of quality measures and examples of MLTC VBP arrangements.
Class 1 Overview	
Specifically, this class will highlight the top 10 things providers need to know related to MLTC in VBP. Additionally, the class will review the key principles of a Level 1 VBP arrangement. The class will also explore examples of an MLTC VBP arrangement, as well as MLTC quality measures. In addition, the class will present MLTC contracting guidance for providers looking to contract VBP.	

Top 10 Provider Considerations

Top 10 Provider Considerations

1. Licensed Home Care Service Agencies (LHCSAs), Certified Home Health Agencies (CHHAs) and Skilled Nursing Facilities (SNFs) are defined as “VBP Contractors” for initial implementation.

2. Final recommended measures for 2018 are the same as for 2017, except that the Potentially Avoidable Hospitalizations (PAH) measure for SNFs has been added. The measures can be found on the DOH VBP Resource Library page at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/

3. All Category 1 Pay-for-Performance (P4P) measures are already in use in the current MLTC Quality Incentive (MLTC QI).

4. The Office of Quality and Patient Safety (OQPS) will calculate the Category 1 Measures for plan-provider membership combinations submitted on the attribution file.

5. The PAH, a temporary proxy for Medicare costs, is a required measure for LHCSAs, CHHAs and SNFs.

Top 10 Provider Considerations (continued)

6. For SNFs, OQPS will calculate the PAH at a facility level.

7. Plans and providers can focus on reducing avoidable hospitalization across the board and for the six conditions that define the PAH measure (sepsis, urinary tract infection, heart failure, electrolyte imbalance, anemia, and respiratory infection).

8. Category 2 measures can be used for SNFs and come from the Nursing Home Quality Initiative (NHQI).

9. More advanced VBP includes calculation of target budgets and options for shared savings/risk with the goal of achieving total cost of care arrangements.

10. The alignment of the State's VBP approaches with Medicare and the linkage to Medicare data continues to be a priority.

VBP Arrangement Exploration & What it Means for a Provider

VBP MLTC Key Principles and Level Setting

Vision Behind the Arrangements

- Flexibility for Providers and MCOs
- Local circumstances differ:
  - Provider readiness
  - Demographics & geography
- Health care is very heterogeneous

Financial and regulatory incentives drive…

a delivery system which realizes…

cost efficiency and quality outcomes: *value*

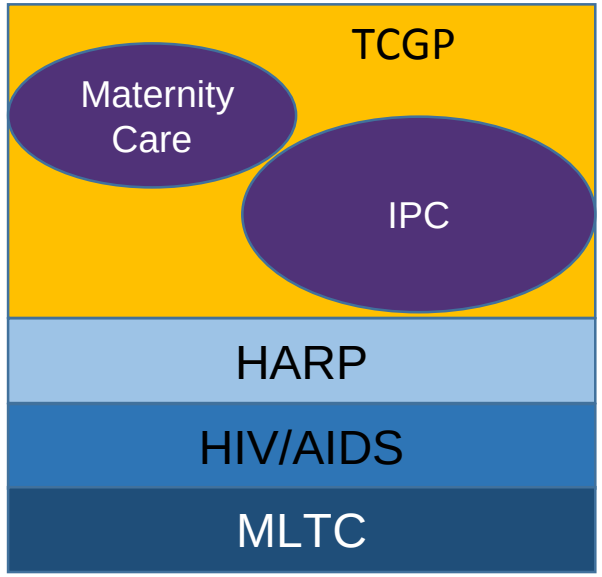
Healthy people	Population health: prevention, screening, health education, monitoring
People with acute conditions	Rapid, effective, efficient and patient-centered diagnosis, treatment, rehabilitation and follow-up
People with chronic conditions	Patient-directed, continuous, effective, efficient disease management, including secondary prevention, a focus on lifestyle & social determinants, and quality of life-focused care coordination

- Different types of *outcomes* that are relevant
- Different role for the *member/patient*
- Different *models of care*
- Different *organizational forms*
- Different *payment models*

Source: NYS Department of Health website: VBP Bootcamp – Session 3

VBP Arrangements

There is no single path towards Value Based Payments. Rather, there are a variety of options that MCOs and providers can jointly choose from:



Arrangement Types

- **Total Care for the General Population (TCGP)**
- Episodic Care
  - **Integrated Primary Care (IPC)**
  - **Maternity Care**
- Total Care for Special Needs Subpopulations
  - **Health and Recovery Plans (HARP)**
  - **HIV/AIDS**
  - **Managed Long Term Care (MLTC)**

VBP Contractors can contract TCGP and may carve in Subpopulations as appropriate; nothing mandates that the Roadmap-defined arrangement types must be handled in standalone contracts.

What to consider as a provider when contracting for the Total Care for a Special Needs Subpopulation

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

- All services covered by the associated managed care plans are included, and all members fulfilling the criteria for eligibility to such plans are included.
  - Providers should identify who these specific members are and tailor approaches to reduce inefficiencies and potentially avoidable complications.
  - Specialized providers with expertise serving these populations will be in a strong position to generate shared savings.

- **For MLTC the longer run goal is to capture total cost of care. In the shorter run the NYS Roadmap allows for a pay-for-performance arrangement that focuses on avoidable hospitalization. Providers should approach VBP in a way that satisfies the shorter-run goal and sets them up for success in future total cost of care arrangements.**

In this arrangement the VBP Contractor assumes responsibility for the care of the specific population where co-morbidity or disability may require specific and costly care needs, so that the majority (or all) of the care is determined by the specific characteristic of these members.

Total Population

– TCGP

Subpopulation

(HIV/AIDs, HARP, **MLTC**, I/DD*)

*Total Care for the Intellectually/Developmentally (I/DD) Subpopulation will be available as an arrangement when the population is moved to managed care.

Where to Begin as a Provider

Partner Up and Identify Contracting Leads

A key question is who can lead in a VBP arrangement. One provider or group of providers becomes the “VBP Contractor.” Not all partners have to be equally at-risk or even a direct party to a VBP contract. Leads can take on the VBP contract and subcontract with others. In this way, smaller providers in the “downstream” may continue to be paid on a fee-for-service basis.

Provider Example

A group of LHCSAs forms a consortium and because many do not want to take on downside risk, they identify a large LHCSA to be the lead. The lead enters into a VBP contract on behalf of the whole group and includes the aggregate attributed members.

- A new care coordination portal is deployed across all of the agencies so that care can be more centrally managed. Together they implement a protocol for identifying and screening for members at-risk of significant decline (e.g., significant weight change, screen positive for depression). They also identify outliers/variations in personal care utilization patterns among their agencies.
- The application of the interventions across the pooled group of members brings about a reduction in hospitalization and some staffing efficiencies. The plan and the providers agreed to a shared savings agreement for the staffing shifts. For reducing hospitalizations and avoiding functional declines they garner a performance bonus. The savings from refining personal care utilization patterns and reducing significant functional declines allows for additional supports to be provided to the group facing potential decline. Both approaches set them up for the longer term and provide short-run benefits in the P4P environment.

Where to Begin as a Provider

Address Gaps in Care

Connectivity/Interaction with care providers that are not part of a formal care network is a basic expectation in mainstream managed care and it can be applied in MLTC as well. Although there are barriers to sharing Medicare savings with Medicaid providers, relationships across the care divide are advantageous.

Provider Example

After analyzing major reasons for hospitalization of its members, a large CHHA identifies a need to reduce the number of times primary care physicians (PCPs) referred members to a hospital when their own care providers had taken steps to shore up care at home. They launch an effort to connect/partner with some of their members' PCPs in order to work cooperatively.

- A follow-up protocol is put in place to ensure that when more intensive supports are needed, they are put in place by the CHHA. More advanced nursing support from a supervisory nurse who is center-based and equipped with virtual capacity and real-time data is also put in place for interaction with home care staff in the field. Updates are relayed to the doctor on a frequent cycle.
- Hospitalization is reduced and the need for additional support hours at home is somewhat offset by technology. The CHHA receives a performance bonus on six Category 1 measures per its VBP contract. Important relationships with PCPs are established that form the basis for mutually beneficial, total cost of care MLTC VBP Arrangements in the future.

Where to Begin as a Provider

Diversify/Individualize Support Options

Decoupling services that are currently billed/bundled together such as residency in a nursing home can allow for some flexibility in meeting member needs. Step-down or step-up care options can also forestall reliance on the most or more intensive institutional settings.

Provider Example

A group of nursing homes partner and decide to branch out to offer home health services. They form an Independent Practice Association, or IPA, and bring in home care agencies and primary care practices to join the IPA. Together, the IPA partners decide to try to offer a more intensive support option for members who need additional help to stay in the community and stay out of the hospital.

- They arrange to offer a more intensive home-care model as an in-home option to provide nursing home or hospital level care. They bring in large-scale PCP partners and implement a “hospital at home” model by outfitting a travel van with the capability to provide services normally received in hospital, such as X-rays, other diagnostics, and IV administration.
- They reduce the need for hospitalization and benefit from a performance bonus. Due to the higher costs associated with nursing home admission for attributed members, they negotiate a rate with the MLTC plan to help support members at home with more intensive services that is based on the higher rate they would have received for these members had they been placed in a nursing home. This allows them some flexibility to tailor supports to individual needs.

Getting Started with Level 1

Contracting the Level 1 MLTC VBP Arrangement for Partially Capitated MLTC Product Lines

An MLTC Level 1 VBP Arrangement is a performance bonus agreement between an MLTC plan and a provider that is based on meeting performance targets for a set of specific quality measures agreed to in a VBP contract between an MLTC Plan and a provider or group of providers (the "VBP Contractor")*.

Key Principles for Level 1 Agreements:

- **Contracting Providers:** LHCSAs, CHHAs and SNFs are the primary VBP Contractors.
- **Defining the Level 1 MLTC Arrangement**: The NYS Roadmap allows MLTC plans and providers to contract a modified Level 1 P4P arrangement, where providers are awarded for meeting performance targets for select quality measure(s).
- **Inclusion of Quality Measures:** The MLTC Quality Measure Set includes a subset of measures currently used in the MLTC Quality Incentive and Nursing Home Quality Initiative. Level 1 MLTC VBP contracts must include the Category 1 VBP PAH measure as a P4P measure. Additional measures may be selected for inclusion in the contract as agreed upon by the contracting parties.

*Source: New York State Department of Health, Value Based Payment For Managed Long Term Care Plans: Level 1 Contracting https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/2017-07-12_mltc_lev1_contracting.pdf.

Level 1 MLTC VBP Arrangement Contract Checklist

The following questions must be addressed to meet the VBP contracting requirements outlined in the VBP Roadmap.

VBP Contracting Element	Relevant Question
Type of Arrangement (as per the Roadmap)	Does the contract match the Roadmap arrangement definition (e.g., MLTC Level 1 P4P for Partially Capitated Plan)?
Definition and Scope of Services	Does the contract specify the VBP Contractor and the services to be included in the arrangement (e.g., LHCSA, CHHA or SNF)? For multiple partners, does the contract designate a “lead” VBP Contractor?
Quality Measures/Reporting	Does the contract commit to using the Category 1 PAH measure as a P4P measure? Does the contract contain performance targets/benchmarks to be used for P4P? Does the contract specify a timeframe for measurement and payment? Are other Category 1 and 2 measures to be used in the agreement specified and targets identified? AND Are all specified measures used in accordance with OQPS methodological guidance?
Performance Payments	Does the contract specify a method for awarding and distributing performance payments?
Attribution	Does the contract describe the attributed population and method of attribution?

Review of Contract Templates

- Templates for a contract amendment to add an MLTC VBP Level 1 arrangement have been drafted and circulated to plans.
- When finalized, templates will be available in the VBP Resource Library.
- The use of templates is not mandated.
- Contract amendments must be approved by the Department.

What quality measures are recommended for use in MLTC VBP Arrangements?

Category 1 MLTC VBP Quality Measures

- For LHCSAs and CHHAs:
  - Category 1 measures are recommended for use in contracting with LHCSAs and CHHAs with 30 or more members.
  - All Category 1 measures will be calculated by OPQS.
- For SNFs:
  - The PAH measure will be calculated by OQPS at the facility level, not for a particular group of members.

Note: These measures will not be risk-adjusted and are not considered appropriate for provider-to-provider comparisons, including quality ranking or comparative scoring.

Visit the DSRIP VBP Resource Library to access the full 2017 MLTC Quality Measure Set.

MLTC VBP Quality Measure Set for MYs 2017 & 2018

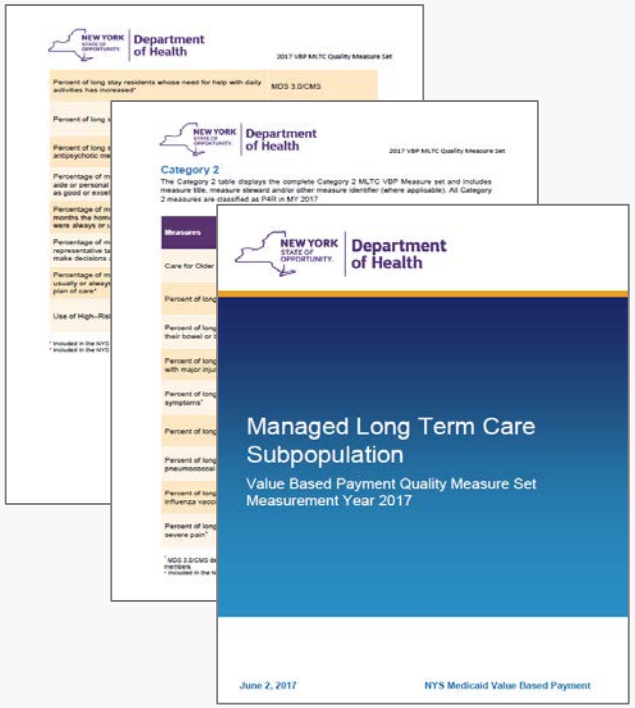
Category 1

Measures	Measure Source/ Steward	Classification
Percentage of members who did not have an emergency room visit in the last 90 days*	UAS – NY/New York State+	Cat 1 P4P
Percentage of members who did not have falls resulting in medical intervention in the last 90 days*	UAS – NY/New York State	Cat 1 P4P
Percentage of members who received an influenza vaccination in the last year*	UAS – NY/New York State	Cat 1 P4P
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	Cat 1 P4P
Percentage of members who remained stable or demonstrated improvement in pain intensity*	UAS – NY/New York State	Cat 1 P4P
Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care (NFLOC) score*	UAS – NY/New York State	Cat 1 P4P
Percentage of members who remained stable or demonstrated improvement in urinary continence*	UAS – NY/New York State	Cat 1 P4P
Percentage of members who remained stable or demonstrated improvement in shortness of breath*	UAS – NY/New York State	Cat 1 P4P
Percentage of members who did not experience uncontrolled pain*	UAS – NY/New York State	Cat 1 P4P
Percentage of members who were not lonely and not distressed*	UAS – NY/New York State	Cat 1 P4P
Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection^	MDS 3.0§/New York State with linkage to SPARCS data	Cat 1 P4P

* Included in the NYS DOH MLTC Quality Incentive measure set
\+ UAS – NY denotes the Uniform Assessment System for New York for MLTC members
‡ SPARCS denotes the 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

Category 2 MLTC VBP Quality Measures

- For SNFs:
  - Additional Category 2 measures can be benchmarked by using the facility performance rates published by OQPS.
  - Plans and providers should contemplate initiatives that will have facility-wide impact and partner on facility-led initiatives that are replicated in multiple contracts.
- Several other Category 2 measures can be tested for use:
  - These are related to medication review and pharmaceutical use; and
  - Satisfaction surveys where additional discussion needs to occur around how to translate measures to the provider level.



Visit the DSRIP VBP Resource Library to access the full 2017 MLTC Quality Measure Set.

MLTC VBP Quality Measure Set for MYs 2017 & 2018 (1/2)

Category 2

Measures	Measure Source/Steward	Classification
Percent of long stay high risk residents with pressure ulcers‡	MDS 3.0+/CMS	P4P
Percent of long stay residents who received the pneumococcal vaccine‡	MDS 3.0/CMS	P4P
Percent of long stay residents who received the seasonal influenza vaccine‡	MDS 3.0/CMS	P4P
Percent of long stay residents experiencing one or more falls with major injury‡	MDS 3.0/CMS	P4P
Percent of long stay residents who lose too much weight‡	MDS 3.0/CMS	P4P
Percent of long stay residents with a urinary tract infection‡	MDS 3.0/CMS	P4P
Care for Older Adults – Medication Review	NCQA§	P4R
Use of High–Risk Medications in the Elderly	NCQA	P4R
Percent of long stay low risk residents who lose control of their bowel or bladder‡	MDS 3.0/CMS	P4P
Percent of long stay residents whose need for help with daily activities has increased‡	MDS 3.0/CMS	P4P

+ MDS 3.0 denotes the Centers for Medicare and Medicaid Services Minimum Data Set for nursing home members
‡ Included in the NYS DOH Nursing Home Quality Initiative measure set
§ NCQA denotes the National Committee for Quality Assurance

MLTC VBP Quality Measure Set for MYs 2017 & 2018 (2/2)

Category 2

Measures	Measure Source/Steward	Classification
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
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
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
Percent of long stay residents who have depressive symptoms‡	MDS 3.0+/CMS	P4P
Percent of long stay residents with dementia who received an antipsychotic medication‡	MDS 3.0/Pharmacy Quality Alliance	P4P
Percent of long stay residents who self–report moderate to severe pain‡	MDS 3.0/CMS	P4P

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

Thank you!

Please send questions and feedback to:

mltcvbp@health.ny.gov