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Managed Long-Term Care Clinical Advisory Group Recommendations on VBP Arrangements

OVERVIEW

On December 12th, the New York State Department of Health (DOH) posted a report on the Long-Term Care eligible subpopulation from the Managed Long-Term Care (MLTC) Value-Based Payment (VBP) Clinical Advisory Group (CAG). The CAGs were convened to provide recommendations about how to define various aspects of the VBP arrangements included in the Delivery System Reform Incentive Payment (DSRIP) program's VBP Roadmap.

The report describes proposed subpopulation and episode definitions, risk adjustment criteria, and quality measures for VBP arrangements for total care for the Long-Term Care eligible subpopulation. This document summarizes aspects of the MLTC CAG report.

The report is available here. Public comments will be accepted at dsrip@health.ny.gov through January 9th.

MANAGED LONG-TERM CARE CAG RECOMMENDATIONS

The MLTC CAG held a series of meetings on the Long-Term Care subpopulation. The CAG discussed key components of the MLTC VBP arrangement, including subpopulation definitions and quality measures.

Definition of the Long-Term Care Subpopulation

The Long-Term Care subpopulation targets individuals enrolled in Managed Long-Term Care plans. Long-Term Care eligible individuals include the following subgroups for whom MLTC enrollment is mandatory given their home care and nursing home care needs:

- Adults (21 years or older) who are dually eligible for Medicaid and Medicare and need community-based long-term care services for more than 120 days.
- Nursing home occupants who become permanent residents after July 1, 2015.

All services available through MLTC plans are included in the subpopulation VBP arrangement.

Value Based Payment and Long Term Care

Typically, savings generated by preventing avoidable hospitalizations result in savings for Medicare that cannot be captured by Medicaid providers. The introduction of specific joint initiatives by CMS and NYS—such as Fully Integrated Dual Advantage (FIDA) plans—can resolve this hindrance for Medicaid providers. To this end, the State intends to create an additional Quality Pool to reward MLTC providers who demonstrate higher rates of avoidable hospital use. Such arrangements could be treated as Level 1 VBP arrangements and would be eligible for financial incentives.

MLTC VBP contracts will be risk adjusted via the same methodology used by the State to calculate MLTC premiums. These risk adjustments will account for the specific profiles of the insured member population including its demographics, acuity, and functional capability.

Long-Term Care Quality Measures

The MLTC CAG reviewed current and new outcome measures that will be used to measure quality related to the Long-Term Care subpopulation for VBP arrangements. Measures have been sorted into three categories and assessed based on their clinical relevance, reliability and validity, and feasibility. During the CAG review, the third category of measures was eliminated as the measures were determined to be insufficiently relevant, valid, reliable and/or feasible.

A complete list of over 50 measures can be found here.

Category	Definition	Examples of Measures
Category 1	• Approved process and outcomes measures that are felt to be clinically relevant, reliable and valid, and feasible	• Percentage of members who did not have an emergency room visit in the last 90 days; • Percentage of members who were not lonely and distressed; • Percentage of members who did not have falls resulting in medical intervention in the last 90 days; and • Percentage of members who received a vaccination (influenza and pneumococcal).
Category 2	• Measures that are felt to be clinically relevant, valid, and probably reliable, but not feasible. • Category 2 measures will likely be investigated during pilots but will likely not be implementable in the immediate future.	• Medication Adherence (above or below 80% benchmark); • Acute Care Hospitalization; • Emergency Department Use with Hospitalization; • Total Medicare Spend in last year/6 months of life; and • Hospital-Wide All-Cause Unplanned Readmission Measure.
Category 3	• Measures that were decided to be insufficiently relevant, valid, reliable, and/or feasible.	• Percentage of members who rated their managed long-term care plan as good or excellent; • Improvement in Management of Oral Medications; and • Percentage of long-stay residents whose ability to move independently worsened.

The CAG will re-convene in 2017 to review and revise Category 1, 2 and 3 measures based on the experience in NYS during the pilot phase.