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MLTC Clinical Advisory Group Draft Report

OVERVIEW

On September 12th, the New York State Department of Health (DOH) released the draft of the Managed Long Term Care (MLTC) Clinical Advisory Group (CAG) Report for 2017 for public comment. As part of New York State's commitment to transitioning at least 80 percent of managed care payments to value-based payment (VBP) arrangements by 2020 as part of the Delivery System Reform Incentive Payment (DSRIP) program, DOH convened CAGs, composed of clinicians and subject matter experts, to create guidelines and recommend quality measures for various VBP arrangement subtypes.

The MLTC CAG met twice in 2017 to provide ongoing recommendations regarding implementation of VBPs for MLTC providers, including:

- Adjustments to the MLTC VBP quality measure set for Measurement Year (MY) 2017;
- Recommendations for MLTC VBP quality measure set for MY 2018;
- Implementation guidance for Level 1 MLTC VBP arrangements; and
- Considerations for the development of Level 2 and higher MLTC VBP arrangements.

The draft report is available here. Comments are due by September 25th to vbp@health.ny.gov.

PROPOSED FINAL GUIDANCE FOR MY 2017

Unlike Level 1 arrangements for other populations, Level 1 MLTC VBP arrangements are not required to establish shared savings from a target budget. Instead, they may establish pay-for-performance (P4P) arrangements under which providers receive a bonus for meeting goals on VBP quality measures.

In its initial meetings, the CAG defined a set of VBP quality measures and sorted them into three categories based on clinical relevance, validity, reliability and feasibility, as follows:

- Category 1: Approved quality measures that are clinically relevant, reliable and valid, and feasible;
- Category 2: Approved quality measures that are clinically relevant, valid, and probably reliable, but where the feasibility issues require further investigation before full implementation is possible; and
- Category 3: Measures that are insufficiently relevant, valid, reliable and/or feasible, and are not recommended for VBP.

The CAG further classified Category 1 and 2 measures by whether they are suitable for use as P4P metrics or only as pay-for-reporting (P4R) metrics. Although the State recommends in general that MLTC plans and VBP contractors follow these classifications, they may choose to establish additional measures or to use P4R measures as P4P measures in their contract.

In this update, the CAG reviewed the MY 2017 MLTC VBP measure set to discuss possible changes to final measure guidance. The CAG made no changes to Category 1 MLTC VBP measures, and made the following changes to Category 2 measures:

- Added the potentially avoidable hospitalizations (PAH) measure from the Nursing Home Quality Initiative (NHQI) to the Category 2 measures as a P4P measure;

- Classified all Category 2 NHQI measures as P4P; and
- Moved the "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" survey measure from Category 2 to Category 3.

RECOMMENDATIONS FOR MY 2018 MEASURE SET

To limit the implementation burden on MLTC plans and VBP contractors during the first full year, the CAG recommended maintaining the final MY 2017 measure set without changes in MY 2018.

RECOMMENDATIONS FOR THE DEVELOPMENT OF VBP IN MLTC

The CAG discussed possible ways to develop Level 2 and higher MLTC VBP arrangements, focusing on their potential use by fully capitated MLTC plans, which are responsible for the total cost of care for their enrollees. These include Medicaid Advantage Plus (MAP), Program of All-Inclusive Care for the Elderly (PACE), and Fully Integrated Duals Advantage (FIDA) plans. These plans might be able to meaningfully set target budgets for VBP contractors. However, they also face several problems, including low enrollment and program design that might mean VBP contractors are duplicating coordination and integration services provided by plans.

As such, the CAG made the following recommendations:

- Levels 2 and 3 in MLTC VBP should be equivalent to Levels 1 and 2 in mainstream VBP, so that Level 2 involves setting a target budget for covered services with upside-only risk and Level 3 involves a target budget with upside and downside risk. If accepted, this recommendation could allow MLTC plans to meet VBP Roadmap requirements without taking downside risk.
- As acute and long-term care for MLTC members become more integrated, the State should explore whether to switch the focus of VBP attribution from home care providers and nursing homes to primary care providers.
- The State should convene a MAP, PACE and FIDA stakeholder meeting to help align its VBP approaches.
- Initially, the State should limit the development of Level 2 or higher arrangements to larger MAP, PACE or FIDA plans. There are five such plans with more than 1,000 members.
- The current MLTC VBP quality measure set for partially capitated plans, including the PAH measure, should also be used for MLTC VBP for fully capitated MLTC product lines until additional measures appropriate for the dually eligible population become available for use.