NEW YORK STATE | Department of Health | Medicaid Redesign Team

VBP Workgroup Meeting

May 16, 2017

Agenda

I. VBP Managed Long Term Care (MLTC) Arrangement

II. Children's Clinical Advisory Group (CAG) Update

III. Quality Measure Phase In Timeline

IV. Innovator Update

V. VBP Pilots Update

VI. VBP Roadmap Update

VII. VBP Workgroup Next Steps

I. VBP Managed Long Term Care (MLTC) Arrangement

- Clinical Advisory Group (CAG) Recommendation
- Quality Measures

MLTC VBP Arrangement CAG Recommendation

MLTC CAG Membership

MLTC CAG Members		
Cindy Lovetro, RN, LNHA	Elizabeth Zicari, RN, BSN, CENP	Dan Heim
Premila M. Kumar, MD	Len Parisi, MA, FNAHQ, CPHQ	Sam Shutman
Patricia Hanniford, RN, MPH	Luz Liebeskind, CPA	Karen Lipson
Joseph Tomaino, MS, RN	John McKeon, CPA	Brian Ellsworth
Douglas Tucker, MD	Yoel Bernath	Al Cardillo
Carol Cassell	Jim Curcio	Debora LeBarron, RN, BS
Eric Price	Christy Johnston	Judy Farrell, MPA
Steven Herbst, MHLA	Marisa Bass, MBA	Sandra Richardson
Paulette Wunsch, JD, LLM	Megan Sherman	Mark Kissinger
Tara Buonocore-Rut, MHA, LNHA	Dylan Ascolese, MAM	Christina Gahan
Carla Williams, MPA	Elizabeth Rosado	Sean Doolan, Esq.
Evelyn Dooley-Seidman, MD	Annette Horvath, RN MS	Linda Spokane
Joseph Booth, MD	Darrell P. Wheeler, PHD, MPH, ACSW	Sal Skeivys, MD
Anne Calvo, BSN, MPS	Jack Resnick, MD	Stephanie Piel, Esq.
Susan Dunnigan, RN	Anne Schettine, RN	Anthony Fiori
Rochelle Eggleton, MBA	Raina Josberger	Karen Smoler Heller
Bridget Gallagher, BSN, MSN	Doug Fish, MD	Laura Haight, MSES
Laurie Neander, MHA	Chaya Back, RN	Valerie Grey

CAG Recommendation: MLTC VBP Arrangement

Population Included

- Includes members enrolled in Managed Long Term Care plans.*

Defined Services

- All services available through MLTC plans including: Care Management; Home Care, including Nursing, Home Health Aide, Occupational, Physical and Speech Therapies; Dental Services; Rehabilitation Therapies; Audiology/Hearing Aids; Respiratory Therapy; Nutrition; Medical Social Services; Personal Care (such as assistance with bathing, eating, dressing, etc.); Podiatry (foot care); Non-emergency transportation to receive medically necessary services; Home Delivered and/or meals in a group setting (such as a day center); Medical Equipment; Social Day Care; Consumer Directed Personal Assistance Services; Prostheses and Orthotics; Social/Environmental Supports (such as chore services or home modifications); Personal Emergency Response System; Adult Day Health Care; Optometry; Private Duty Nursing**
- Nursing Home Care

* The initial emphasis in the transition to VBP is expected to be partially capitated MLTC plans due to member volume. For partially capitated plans, Medicare costs are not required to be included in VBP arrangements until linkage with Medicare data is possible. For plans that are already fully integrated with Medicare, the Department of Health (DOH) will work with the CAG to develop a VBP option.
** The full list of MLTC services is included here. The December 2016 CAG report contained a high-level summary of major services intended to reflect the totality of benefits covered by MLTC plans. However, given the relatively new and ongoing development of MLTC the Department of Health (DOH) will consider a range of VBP alternatives that may or may not include every service, as long as they are strategically focused on creatively addressing the needs of the population.

VBP Quality Measures for MLTC

Measure Feasibility

Measure Feasibility focused on 9 factors:

- **Specification** – Does the measure have clear specification for data sources and methods for data collection and reporting?
- **Reasonable Cost** – Does the measure impose an inappropriate burden on health care systems?
- **Confidentiality** – Does the data collection violate accepted standards of member confidentiality?
- **Logistical Feasibility** – Is the required data available for the specified reporting source?
- **Auditability** – Is the measure susceptible to manipulation or “gaming” that would be undetectable in an audit?
- **NYS Guidelines** – Does the measure conflict with current accepted NYS guidelines?
- **Duplicate Measures** – Does the measure conflict with, or is a duplicate of, other measures in the same or related set?
- **High Performance** – Has statewide performance already topped out on this measure?
- **Sample Size** – Is there sufficient sample size at the VBP contractor level?

Categorizing and Prioritizing Quality Measures

CATEGORY 1
Approved quality measures that are clinically relevant, reliable and valid, and feasible.

CATEGORY 2
Measures that are clinically relevant, valid, and probably reliable, but where the feasibility could be problematic. These measures should be investigated during the 2017 pilot program.

CATEGORY 3
Measures that are insufficiently relevant, valid, reliable and/or feasible.

The measure classifications provided on the following slides are recommendations for the 2017 Measurement Year (MY). During 2017, the Clinical Advisory Groups (CAGs) and the VBP Workgroup will re-evaluate measures for MY 2018. Measure reclassification will be considered on an annual basis.

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) 2017, all MLTC Category 1 measures 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.

MLTC – Measure Feasibility Summary

As outlined in the December 2016 Value Based Payment Recommendation Report, the MLTC CAG recommended 26 measures be classified as Category 1 and 11 measures classified as Category 2 for the MLTC Quality Measure Set.

The following proposed changes are based on Department of Health (DOH) feasibility review:

Measure Disposition	Rationale for Change	Count
Unchanged		10
Category 1 Measure Added	Added to facilitate a Level 1 arrangement that rewards avoidable hospitalization	1
Move to Category 2	Member volume a concern as nursing home benefits for many remain outside of MLTC	11
	Concerns related to survey administration	4
	Requires clinical data from medical record review	1
Move to Category 3	Requires Medicare data	9
	Not actionable for VBP	2
Total		**38**

MLTC: Category 1 Quality Measure List

All Cat 1 Measures in MY 2017 are designated P4P

CAG #[1]	Measure	Measure Source/ Steward [2]	State Recommended Category	State Recommended Classification	Rationale for Change
1	Percentage of members who did not have an emergency room visit in the last 90 days*	UAS – NY/New York State	1	P4P	*No Change*
2	Percentage of members who did not have falls resulting in medical intervention in the last 90 days*	UAS – NY/New York State	1	P4P	*No Change*
3	Percentage of members who did not experience uncontrolled pain*	UAS – NY/New York State	1	P4P	*No Change*
4	Percentage of members who were not lonely and not distressed*	UAS – NY/New York State	1	P4P	*No Change*
5	Percentage of members who received an influenza vaccination in the last year*	UAS – NY/New York State	1	P4P	*No Change*
7	Percentage of members who remained stable or demonstrated improvement in pain intensity*	UAS – NY/New York State	1	P4P	*No Change*

[1] CAG # based on the measure identifier included in the December 2016 Long-Term Care Value Based Payment Recommendation Report
[2] 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

All Cat 1 Measures in MY 2017 are designated P4P

CAG #	Measure	Measure Source/ Steward	State Recommended Category	State Recommended Classification	Rationale for Change
8	Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care (NFLOC) score*	UAS – NY/New York State	1	P4P	*No Change*
9	Percentage of members who remained stable or demonstrated improvement in urinary continence*	UAS – NY/New York State	1	P4P	*No Change*
10	Percentage of members who remained stable or demonstrated improvement in shortness of breath*	UAS – NY/New York State	1	P4P	*No Change*
New	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	1	P4P	Measure can be used in Level 1 VBP arrangements to reward VBP Contractors for reducing hospitalizations. Added to Cat 1.

* Included in the NYS DOH MLTC Quality Incentive measure set
± SPARCS denotes Statewide Planning and Research Cooperative System

MLTC: Category 2 Quality Measure List

CAG #	Measure	Measure Source/ Steward [1]	State Recommended Category	State Recommended Classification	Rationale for Change
6	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*	MLTC Survey/New York State	2	P4R	Moved from Category 1 – Concerns related to survey administration and sample size issues
11	Percent of long stay high risk residents with pressure ulcers+	MDS 3.0/CMS	2	P4R	Moved from Category 1 – Member volume a concern as nursing home benefits for many remain outside of MLTC
12	Percent of long stay residents who received the pneumococcal vaccine+	MDS 3.0/CMS	2	P4R	Moved from Category 1 – Member volume a concern as nursing home benefits for many remain outside of MLTC
13	Percent of long stay residents who received the seasonal influenza vaccine+	MDS 3.0/CMS	2	P4R	Moved from Category 1 – Member volume a concern as nursing home benefits for many remain outside of MLTC
14	Percent of long stay residents experiencing one or more falls with major injury+	MDS 3.0/CMS	2	P4R	Moved from Category 1 – Member volume a concern as nursing home benefits for many remain outside of MLTC
15	Percent of long stay residents who have depressive symptoms+	MDS 3.0/CMS	2	P4R	Moved from Category 1 – Member volume a concern as nursing home benefits for many remain outside of MLTC

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

MLTC: Category 2 Quality Measure List

CAG #	Measure	Measure Source/ Steward	State Recommended Category	State Recommended Classification	Rationale for Change
16	Percent of long stay low risk residents who lose control of their bowel or bladder+	MDS 3.0/CMS	2	P4R	Moved from Category 1 – Member volume a concern as nursing home benefits for many remain outside of MLTC
17	Percent of long stay residents who lose too much weight+	MDS 3.0/CMS	2	P4R	Moved from Category 1 – Member volume a concern as nursing home benefits for many remain outside of MLTC
18	Antipsychotic use in persons with dementia - MDS+	Pharmacy Quality Alliance	2	P4R	Moved from Category 1 – Member volume a concern as nursing home benefits for many remain outside of MLTC
19	Percent of long stay residents who self–report moderate to severe pain+	MDS 3.0/CMS	2	P4R	Moved from Category 1 – Member volume a concern as nursing home benefits for many remain outside of MLTC
20	Percent of long stay residents whose need for help with daily activities has increased+	MDS 3.0/CMS	2	P4R	Moved from Category 1 – Member volume a concern as nursing home benefits for many remain outside of MLTC
21	Percent of long stay residents with a urinary tract infection+	MDS 3.0/CMS	2	P4R	Moved from Category 1 – Member volume a concern as nursing home benefits for many remain outside of MLTC

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

MLTC: Category 2 Quality Measure List

CAG #	Measure	Measure Source/ Steward	State Recommended Category	State Recommended Classification	Rationale for Change
22	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	2	P4R	Moved from Category 1 – Concerns related to survey administration and sample size issues
23	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	2	P4R	Moved from Category 1 – Concerns related to survey administration and sample size issues
24	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	2	P4R	Moved from Category 1 – Concerns related to survey administration and sample size issues
25	Care for Older Adults – Medication Review	National Committee for Quality Assurance (NCQA)	2	P4R	Moved from Category 1 – Requires clinical data from medical record review
28	Use of High–Risk Medications in the Elderly	NCQA	2	P4R	*No Change*

* Included in the NYS DOH MLTC Quality Incentive measure set

MLTC: Category 3 Quality Measure List

CAG #	Measure	Measure Source/ Steward	State Recommended Category	State Recommended Classification	Rationale for Change
26	Potentially Avoidable Complications (PAC)	Altarum Institute (Formerly HCI3)	3	–	Moved from Category 1 – Requires Medicare data
27	Medication Adherence: Always adherent, 80% or more of the time adherent, Less than 80% of the time adherent	UAS – NY/New York State	3	–	Moved from Category 2 – Measure not actionable for VBP – Limited performance improvement possible due to current high performance
29	CMS Five–star Quality Rating for Staffing	CMS	3	–	Moved from Category 2 – Measure not actionable for VBP – Staffing measures and requirements are not outcome measures
30	Acute Care Hospitalization During the First 60 Days of Home Health	CMS	3	–	Moved from Category 2 – Requires Medicare data
31	Acute Care Hospitalization	CMS	3	–	Moved from Category 2 – Requires Medicare data
32	Emergency Department Use with Hospitalization	CMS	3	–	Moved from Category 2 – Requires Medicare data

MLTC: Category 3 Quality Measure List

CAG #	Measure	Measure Source/ Steward	State Recommended Category	State Recommended Classification	Rationale for Change
33	Proportion of patient with cancer admitted to the ICU in the last 30 days of life	American Society of Clinical Oncology	3	–	Moved from Category 2 – Requires Medicare data
34	Inpatient and ICU Days per Decedent During the Last Six Months of Life, by Gender and Level of Care Intensity	Dartmouth Atlas of Health Care	3	–	Moved from Category 2 – Requires Medicare data
35	Total Medicare Spend in last year / 6 months of life	Dartmouth Atlas of Health Care	3	–	Moved from Category 2 – Requires Medicare data
36	Proportion with more than one emergency room visit in the last days of life	American Society of Clinical Oncology	3	–	Moved from Category 2 – Requires Medicare data
37	Hospital–Wide All–Cause Unplanned Readmission Measure	CMS	3	–	Moved from Category 2 – Requires Medicare data

MLTC Arrangement Next Steps

- Submit feedback/comments related to the MLTC arrangement to pcrown@kpmg.com by May 30th
- Reconvene the CAG to continue discussions related to long term care for PACE and MAP

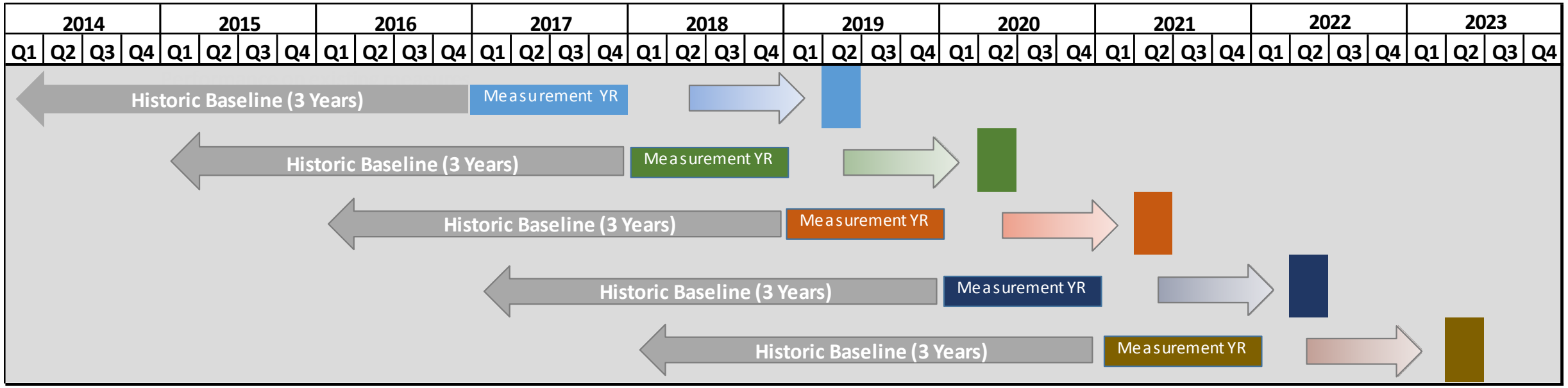
II. Children's Clinical Advisory Group (CAG) Update

Children's CAG Update from May 2, 2017

- Review of Matrix of North Star Goals and Key Indicators, Primary Care Strategies, and Healthcare Measures.
- Discussion of draft recommendations on VBP Principles and Payment Models, Measures, and Additional Work/Deliberation
- Review of measures recommended for inclusion in a universal TCGP/IPC and Pediatric Primary Care Capitation Measure set.
- **Next steps:** Clinical Advisory Group members to review draft Matrix, Recommendations, and Measures and send comments prior to subsequent call to finalize Measures and Recommendations for Workgroup for Measurement Year 2018.

III. Quality Measure Phase In Timeline

Timeline for integration of Category 1 P4P measures into VBP Quality Adjustment:



VBP Quality Adjustment	MY17	MY18	MY19	MY20	MY21
QIP (including overlap with VBP Quality Measures)	All QIP components	Increasing alignment with VBP measure set			
VBP Quality Measures (non-QARR)*	-	Increasing alignment with QARR measure set			
PACs**	TCGP and IPC	Increasing # to include other arrangements			

* It is the intention of the NYS DOH to integrate all new VBP quality measures from Measurement Year (MY) 2018 on into the QARR measure set.

** The PAC measures are the only net new measures for MY 2017.

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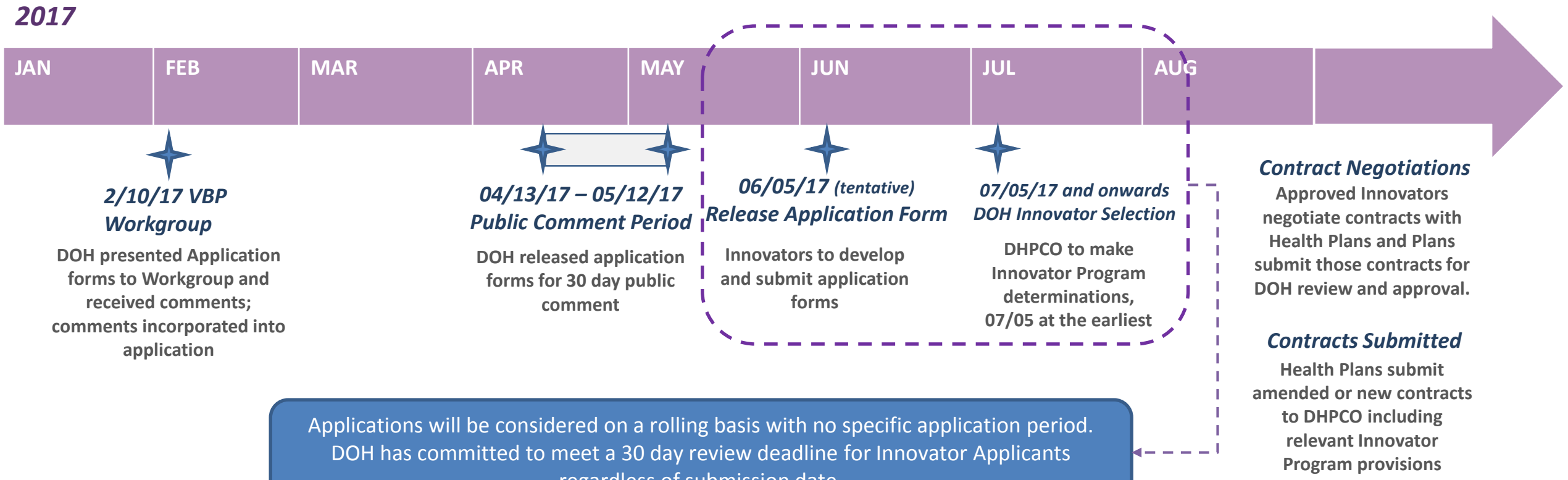
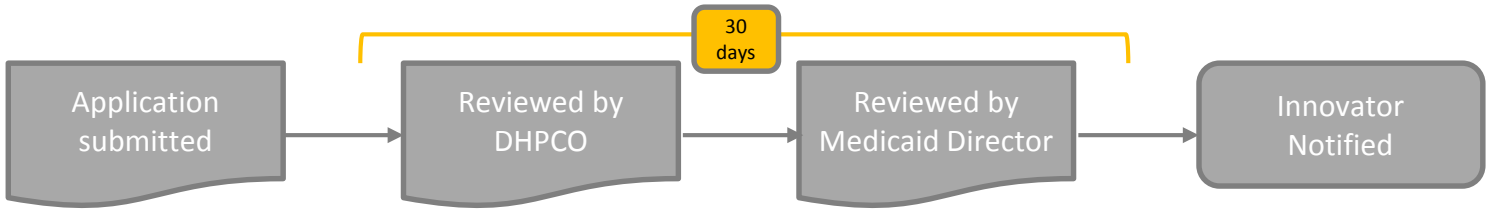
IV. Innovator Update

Innovator Program Timeline and Update



Applications will be considered on a rolling basis with no specific application period. DOH has committed to meet a 30 day review deadline for Innovator Applicants regardless of submission date.



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V. VBP Pilots Update

Final List of VBP Pilot Participants

Arrangement	Provider	Managed Care Organization	Level (Y1)
HARP	Maimonides Medical Center	Healthfirst PHSP, Inc.	1
	Mount Sinai Health Partners	Healthfirst PHSP, Inc.	1
IPC	Community Health IPA	Affinity Health Plan, Inc.	1
	Hudson Headwaters Health Network	New York State Catholic Health Plan, Inc.	1
TCGP	Greater Buffalo United ACO	Yourcare Health Plan, Inc.	1
	Somos Your Health IPA	Affinity Health Plan, Inc.	2
	Somos Your Health IPA	HealthPlus HP, LLC	2
	Somos Your Health IPA	New York State Catholic Health Plan, Inc.	2
	Somos Your Health IPA	Healthfirst PHSP, Inc.	2
	Somos Your Health IPA	United Healthcare of New York, Inc.	2
	Somos Your Health IPA	Wellcare of New York, Inc.	2
	St. Joseph's Hospital Health Center	New York State Catholic Health Plan, Inc.	1
	St. Joseph's Hospital Health Center	Molina Healthcare of New York, Inc.	1
Other agreements occurring between providers and MCOs			
School Readiness	Albany County Pediatric Providers	Capital District Physicians Health Plan, Inc.	N/A
		MVP Health Care, Inc.	
		New York State Catholic Health Plan, Inc.	
		United Healthcare of New York, Inc.	
		Wellcare of New York, Inc.	

7 provider organizations and **8 managed care organizations** will be working together on **13 distinct contracts,** contracting **3 types of arrangements** as part of the VBP Pilot Program.

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Areas of DOH Partnership with VBP Pilots

To effectively support Pilots as they begin to implement VBP arrangements, the DOH will engage Pilots in activities initiated by the State, including but not limited to, the following:

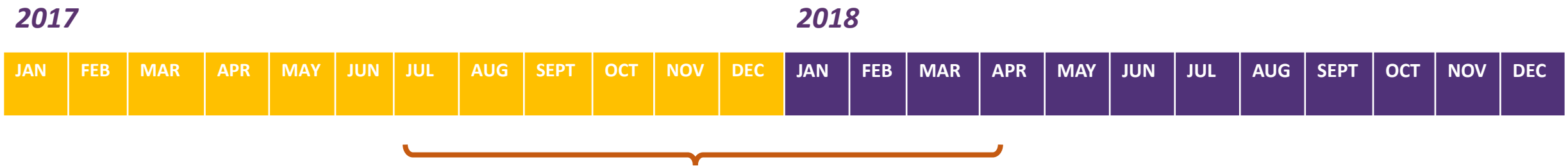
- **Monthly webinars** for core VBP Pilot support, focused on the following topics:
  - Performance measurement
  - Medicaid Analytics Performance Portal (MAPP) dashboards
  - Policy updates and pilot Q&A
- Assistance in implementing **data security systems**
- Active partnership in the **VBP Measure Feasibility Task Force**
- **Reporting on progress and lessons learned** as requested by the State
- Participation in **in-person meetings and workgroups** as necessary

Update: VBP Pilot Financing

VBP Pilots will receive financial benefits in the form of stimulus and performance adjustments

- To ensure that MCOs have adequate funding to facilitate stimulus and performance adjustments over the duration of the VBP Pilot Program (01/2017- 12/2018), DOH will fund the full two years of payments between July 2017 and March 2018 on a per member per month basis. Hence, participating MCOs will have received all program funds 9 full months before the end of the Program.
- Pilot adjustments are being built into the July 2017 MCO premium updates through a rate add-on

VBP Pilot Program Dates: 01/2017 – 12/2018



The full two years of VBP Pilot Program adjustments will be distributed over 9 months – between July 2017 and March 2018.

- Drafts of the rates should be provided to MCOs in July, with a 30 day plan review period

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Update: VBP Pilot Financing

May and June

VBP Contractors

- May: Completion of Data Exchange and Application Agreements (DEAAs) and Health Commerce System (HCS) accounts preparations
- Updated attribution data using 2015 encounters distributed
- Interim target budgets for IPC arrangements to be distributed

MCOs

- June: DEAA completion and HSC account preparation to begin
- Will receive 2015 attribution data from VBP contractors with whom appropriate Business Associate Agreements are in place
- Interim target budget for IPC arrangements to be distributed

July and August

VBP Contractors and MCOs

- Receipt of target budget calculations for TCGP and HARP
- Participation in VBP Measure Feasibility Workforce (June kick off)
- Begin preparations for System Security Plans (SSPs)

September and October

VBP Contractors and MCOs

- SSPs to be completed
- VBP Dashboards to go live in MAPP in October 2017 with PHI and non-PHI views; access to PHI available if SSPs completed

VI. VBP Roadmap Update: CMS Approval

CMS Roadmap Approval

CMS Approved the Year 2: June 2016 VBP Roadmap

- ❑ Represents the first VBP Roadmap update from CMS under the Trump administration
- ❑ CMS requests that "…the next version of the Roadmap include a strategy to work toward an alternative payment model that includes both upside and downside risk for providers."
- ❑ DOH would appreciate feedback and/or recommendations from workgroup members on CMS' request for payment model strategy for upside/downside risk providers.

VII. VBP Workgroup Next Steps

- Please submit comments and feedback related to the MLTC arrangement and CMS' request for payment model strategy to pcrown@kpmg.com by May 30th
- Next VBP Workgroup meeting will be held in June

  Date, time and location are forthcoming