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Managed Long Term Care (MLTC) Clinical Advisory Group Meeting

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Meeting Purpose and Agenda

Purpose:

To provide program updates and discuss the quality measures for Measurement Year 2024

Agenda:

- Welcome, Introductions, and Staffing Updates
- Program Updates
- 1115 Waiver Updates
- MLTC VBP Quality Measures for MY 2024
- CAG Feedback and Questions

Welcome, Introductions, and Program Updates

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The Managed Long Term Care Clinical Advisory Group

- **An ongoing commitment to engage stakeholders.**
- **Meets regularly on an annual basis to:**
  - Review significant changes to the MLTC VBP program.
  - Provide recommendations and feedback to guide the development of the MLTC VBP quality measure set for the upcoming MLTC VBP measurement year.
  - Provide recommendations and feedback to guide the continued improvement of the MLTC VBP program.

Program Updates - Fully Capitated MLTC

- Calculation of rates for PAH and other Category 1 measures (except for the stable/improved over-time measures) resumed for MY2022. VBP Category 1 stable/improved over-time measures resumed in contracting starting in MY2023.
- Starting with MY2022, quality measures will only be calculated on an annual basis (e.g., MY2023 will reflect a measurement period of January 1st – December 31st, 2023). Results will be distributed in Q3 of the following year (October 2024 for MY2023 results).
- Plans are encouraged to continue to submit VBP arrangements for MAP & PACE consistent with standards outlined in the VBP Roadmap.
- Principles and standards of the VBP Roadmap remain the same.

New York Health Equity Reform (NYHER) 1115 Waiver Amendment Update

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Waiver Amendment Overview

New York is in the final stages of negotiating its New York Health Equity Reform (NYHER) 1115 Waiver Amendment Update with CMS.

Overall Goal: *"*To advance health equity, reduce health disparities, and support the delivery of social care."

- New York seeks to build on the investments, achievements, and lessons learned from the DSRIP to scale delivery system transformation, improve population health and quality, deepen integration across the delivery system, and advance health-related social need (HRSN) services.
- Importantly, the amendment will allow for the standardization and collection of data that will allow the state to stratify measures to evaluate impacts on underserved communities, enhance Medicaid services to best serve all populations, and implement social risk adjustment.
- This would be achieved through targeted and interconnected investments that will augment each other, be directionally aligned, and be tied to accountability. These investments focus on:

Population Health

Social Care Networks

Strengthening the Workforce

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Health Equity Regional Organization (HERO)

A single statewide independent entity that will convene and collaborate with a diverse and comprehensive range of stakeholders to inform the State's plan to reduce health disparities, advance health equity, and support the delivery of HRSN services. Activities include:

Data Aggregation

- Bring together and distribute information on health outcomes, health care utilization and social care needs to support population health improvement activities under the waiver

Regional Needs Assessment & Planning

- Work with partners in each region to identify regional health equity goals/priorities, service delivery and workforce-related gaps contributing to health disparities, and target health and social needs-related interventions that address regional needs and priorities

VBP Design & Development

- Work with newly aggregated data and feedback from regional partners to identify VBP goals and models that address the health and social needs of the region and address the most impactful health equity priorities

Program Evaluation

- Perform an ongoing review of waiver programs and access to new services to support continuous improvement in program design and implementation and quantify the impact on underlying regional health equity priorities

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Population Health & Health Equity Improvement Overview

Proposed Goals:

- Build on the achievements, such as PCMH, of the Delivery System Reform Incentive Program (DSRIP);
- Improve population health and health equity, with a particular focus on reducing health disparities for children, pregnant and postpartum individuals, and high-risk adults;
- Further care coordination and the integration of behavioral health, specialty care, and HRSN services; and
- Move toward advanced payment models that leverage multi-payor alignment

Proposed Components:

- Primary Care Delivery System Model
- Stabilizing Safety Net Providers & Advancing Accountability

Primary care forms the foundation of a high-performing health care system and population health.

At a time when Medicare and Medicaid beneficiaries most need accessible, affordable, high-quality primary care to meet their rising needs and coordinate their care journey through increasingly fragmented expensive systems, primary care faces existential challenges to its core functions and modes of operation (NASEM 2021).

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Population Health & Health Equity Improvement Overview

Primary Care Delivery System Model

Multi-Payor Alignment to Advance Primary Care

- New York will implement a statewide approach to advancing primary care that invests in primary care and enables Medicaid primary care providers to move toward advanced VBP arrangements, complementary to those found in upcoming CMMI models
  - This will have a special focus on care for children and moving further towards VBP
- **Eligibility:** All Patient-Centered Medical Home (PCMH) primary care practices
- **Structure:**
  - *Years 1-2:* All PCMH practices would receive enhanced PMPMs for their Medicaid Managed Care members
  - *Year 3:* Transition enhanced payments to a bonus payment structure, linking payments to quality and efficiency
- After Year 3, this funding would be transitioned to an advanced value-based payment model

Making Care Primary (MCP) is a new, voluntary **Medicare** primary care model for which CMS is starting to accept applications. Through MCP, investments in primary care are increased so patients can access more seamless, high-quality, whole-person care.

The Medicaid component will complement MCP through PCMH investments and aligned quality measures to enable primary care organizations to support multi-payor alignment and provide Medicare and Medicaid beneficiaries with integrated, coordinated, person-centered care that improves population health outcomes.

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Population Health & Health Equity Improvement Overview

Stabilizing Safety Net Providers & Advancing Accountability

Goal: Stabilize and transform targeted financially distressed voluntary hospitals to advance health equity and improve population health in communities with the most evidence of health disparities[1]

Structure: Provide incentive funding to stabilize Medicaid dependent financially distressed safety net hospitals and develop necessary capabilities to advance health equity; participate in advanced VBP arrangements; and deepen integration with primary care, behavioral health, and HRSN services

Incentive payments would be tied to transformational activities and quality improvement measures, including those related to health equity

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1) https://www.countyhealthrankings.org/explore-health-rankings/new-york/data-and-resources

Social Care Networks

DOH will award one Social Care Network (SCN) per region (with up to five awards in New York City), with up to 13 SCNs statewide. Each SCN will be a designated Medicaid provider and serve as the lead entity in their region for:

- Fiscal Administration
- Contracting
- Data Collection
- Referral Management
- CBO Capacity Building

HRSN Screening and Navigation Services: *All Medicaid members* will be screened for HRSNs and eligible for navigation to existing federal, state, and local social programs

Targeted High-Need Populations Eligible for Enhanced HRSN Services

- Medicaid High Utilizers, including those experiencing homelessness
- Individuals with serious chronic conditions (e.g., two or more chronic conditions, HIV/AIDS) and enrolled in a Health Home
- Individuals with Substance Use Disorder, Serious Mental Illness, or Intellectual and Developmental Disabilities
- Pregnant persons, up to 12 months postpartum
- Children aged 0-6
- Children under 18 with chronic conditions
- Foster care youth, juvenile justice-involved, and those under kinship care
- Post-release criminal justice-involved individuals with serious chronic conditions

Housing Supports

Nutrition

HRSN Transportation

HRSN Case Management

Social Care Networks HRSN Services

Standardized HRSN Screening

- Screening Medicaid Members using questions from the CMS Accountable Health Communities HRSN Screening Tool and key demographic data

Housing Supports

- Navigation
- Community transitional services
- Rent/utilities
- Pre-tenancy and tenancy sustaining services
- Home remediation
- Home accessibility and safety modifications
- Medical respite

Nutrition

- Nutritional counseling and classes
- Home-delivered meals
- Medically tailored meals
- Fruit and vegetable prescription
- Pantry stocking

Transportation

- Reimbursement for HRSN public and private transportation to connect to HRSN services and HRSN case management activities

Case Management

- Case management, outreach, referral management, and education, including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees
- Connection to clinical case management
- Connection to employment, education, childcare, and interpersonal violence resources
- Follow-up after services and linkages

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Strengthen the Workforce

The NYHER amendment will invest in workforce initiatives to support advancing health equity and addressing high demand workforce shortages to improve access to and quality of services

Elements:

Career Pathways Training Programs

Development of training programs to support recruitment and career pathways for new and existing health care workers who commit to work for Medicaid enrolled providers for three years

Workforce Investment Organizations (WIOs)

High-performing Workforce Investment Organizations (WIOs) will manage training programs for incumbent workers and workers newly entering the workforce, with a focus on high-demand direct care titles that provide health, behavioral health, and social care

Student Loan Repayment

Loan forgiveness for primary care physicians, psychiatrists, nurse practitioners, pediatric clinical nurse specialists, and dentists who make a four-year commitment to work for Medicaid-enrolled providers that serve at least 30% Medicaid and/or uninsured individuals.

Questions

2024 MLTC Fully Capitated Plans Measure Set – MAP

MAP Required Category 1 Measures – MY 2024

Measures	Measure Source/ Steward	Classification
Eye Exam for Patients With Diabetes (EED)*^	NCQA/ HEDIS	P4R
Kidney Health Evaluation for Patients With Diabetes (KED)*^	NCQA/ HEDIS	P4R
Colorectal Cancer Screening - Electronic (COL-E)*^	NCQA/ HEDIS	P4R
Antidepressant Medication Management – Effective Acute Phase Treatment & Effective Continuation Phase Treatment*	NCQA/ HEDIS	P4R
Follow-up After Hospitalization for Mental Illness*^ (FUM)	NCQA/ HEDIS	P4R
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (IET)	NCQA/ HEDIS	P4R

* Included in the TCGP measure set
^ Included in the Health and Recovery Plan (HARP) measure set

*To Be Retired MY2025 ^Measure Revised for MY2024 *Revised for MY2024 –ECDS Reporting ONLY
Centers for Medicare & Medicaid Services (CMS) National Committee for Quality Assurance (NCQA)

MY 2024 MLTC MAP and PACE – Category 1 Measures

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	P4P
Percentage of members who did not experience falls that resulted in major or minor injury in the last 90 days*	UAS – NY/ New York State	P4P
Percentage of members who received an influenza vaccination in the last year*	UAS – NY/ New York State	P4P
Percentage of members who remained stable or demonstrated improvement in pain intensity*	UAS – NY/ New York State	P4P
Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care (NFLOC) score*	UAS – NY/ New York State	P4P
Percentage of members who remained stable or demonstrated improvement in urinary continence*	UAS – NY/ New York State	P4P
Percentage of members who remained stable or demonstrated improvement in shortness of breath*	UAS – NY/ New York State	P4P
Percentage of members who did not experience uncontrolled pain*	UAS – NY/ New York State	P4P
Percentage of members who were not lonely and not distressed*	UAS – NY/ New York State	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	P4P

* Included in the NYS DOH MLTC Quality Incentive measure set
‡ Included in the NYS DOH Nursing Home Quality Initiative measure set
Acronyms: UAS – NY denotes the Uniform Assessment System for New York for MLTC members; SPARCS denotes the Statewide Planning and Research Cooperative System

MY 2024 MLTC MAP & PACE - Category 2 Measures

Measures	Measure Source/ Steward	Classification
Care for Older Adults – Medication Review	NCQA	P4R
Use of High–Risk Medications in the Older Adults	NCQA	P4R
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

* Included in the NYS DOH MLTC Quality Incentive measure set

Acronyms: UAS – NY denotes the Uniform Assessment System for New York for MLTC members; SPARCS denotes the Statewide Planning and Research Cooperative System

2024 MLTC Fully Capitated Plans Measure Set – PACE

PACE Required Category 1 Measures - MY2024

Measures	Measure Source/ Steward	Classification
Percentage of PACE Participants with an Advance Directive or Surrogate Decision Maker Documented in the Medical Record AND Percentage of PACE Participants with Annual Review of their Advance Directive or Surrogate Decision Maker Document	CMS	P4R
Percent of Participants Not in Nursing Homes	CMS	P4R
PACE Participant Emergency Department Use Without Hospitalization	CMS	P4R

MY2024 MAP & PACE – Category 1 Measures

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	P4P
Percentage of members who did not experience falls that resulted in major or minor injury in the last 90 days*	UAS – NY/ New York State	P4P
Percentage of members who received an influenza vaccination in the last year*	UAS – NY/ New York State	P4P
Percentage of members who remained stable or demonstrated improvement in pain intensity*	UAS – NY/ New York State	P4P
Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care (NFLOC) score*	UAS – NY/ New York State	P4P
Percentage of members who remained stable or demonstrated improvement in urinary continence*	UAS – NY/ New York State	P4P
Percentage of members who remained stable or demonstrated improvement in shortness of breath*	UAS – NY/ New York State	P4P
Percentage of members who did not experience uncontrolled pain*	UAS – NY/ New York State	P4P
Percentage of members who were not lonely and not distressed*	UAS – NY/ New York State	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	P4P

* Included in the NYS DOH MLTC Quality Incentive measure set
Acronyms: UAS – NY denotes the Uniform Assessment System for New York for MLTC members; SPARCS denotes the Statewide Planning and Research Cooperative System

MY2024 MLTC MAP & PACE – Category 2 Measures

Measures	Measure Source/ Steward	Classification
Care for Older Adults – Medication Review	NCQA	P4R
Use of High–Risk Medications in the Elderly	NCQA	P4R
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

* Included in the NYS DOH MLTC Quality Incentive measure set

Acronyms: UAS – NY denotes the Uniform Assessment System for New York for MLTC members; SPARCS denotes the Statewide Planning and Research Cooperative System

MLTC VBP Quality Measure Reporting for Full Cap Plans

For all measures specific to MAP and PACE that require Medicare data or follow CMS measure development for PACE

- Category 1 – P4R measures must be reported to the State on an annual basis. For MAP, plans will report measures for Plan/Provider-VBP Contractor attribution combinations.
- For PACE, PACE organizations will report measures for the PACE **ONLY** if the PACE has a VBP contract with an outside contractor.

The instructions for reporting will be added to the *2023-2024 Value Based Payment Reporting Requirements Technical Specifications Manual*

For all measures recommended for P4P use for VBP purposes for MAP and PACE

- Category 1 VBP measures selected by MAP and PACE plans and Providers/VBP Contractors from the MLTC VBP Quality Measure set will be calculated by the State for Plan/Provider-VBP Contractor combinations submitted to the State in the plan-submitted attribution file.
- Per the updated VBP roadmap, MAP and PACE arrangements ***must include at least two*** Category 1 P4P quality measures.
- All Category 2 MLTC VBP measures may be used at the discretion of the contractual parties.

CAG Feedback and Questions

CAG Feedback

Please share your thoughts on the VBP quality measure set for Measurement Year 2024.

Please submit your feedback by COB January 12, 2024 to: mltcvbp@health.ny.gov

Next Steps and Closing Remarks

- **Key Milestones**
  - January 2024– MY 2024 Measure Set Released
  - January 2024 – MLTC VBP Reporting Specifications will be released

- Questions and Comments
  - As always, questions and comments may be directed to **mltcvbp@health.ny.gov**

- Many thanks for participating in the MLTC CAG!

Appendix

MLTC VBP Quality Measure Data Reporting Timeline