CMS/ACL HCBS Quality Part 2:
Developing & Implementing a Recommended Set of Quality Measures

Division of Community Systems Transformation/ Disabled and Elderly Health Programs Group/Center for Medicaid & CHIP Services

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Welcome

- ## Session purpose
  - To discuss challenges and opportunities related to creating a scalable set of recommended HCBS measures that can be feasibly implemented at multiple levels within the HCBS system and can be practically administered across payer systems

- ## Session overview
  - Introductions
  - Draft recommended measure set
  - Mockup of a draft measure
  - Feedback and discussion

Draft Recommended Measure Set

Purpose

- Intended as a resource for <u>voluntary</u> use by states, managed LTSS plans, providers, and other entities to:
  - Support more consistent use of HCBS quality measures;
  - Create opportunities for those entities to have comparative quality data on their HCBS programs and services; and
  - Reduce some of the burden that states and others experience in identifying and using HCBS quality measures

Scope

- To be included in the measure set, a measure must:
  - Be clearly defined and expressed as a rate, proportion, or ratio that is calculated with:

    (1) a numerator that counts the number of processes or outcomes that qualify for the measure, and

    (2) a denominator, which counts the number of people eligible for the process or for whom the outcome is relevant.

  - Have clearly defined exclusion criteria that can be used to identify who should be removed from the measure population
  - Be focused on HCBS or populations receiving HCBS

Organization

- Two parts
  - Starter set – small number of measures intended to be adopted in their entirety as a group
  - Extended set – additional measures that states and others can select from
  - Both parts are organized by National Quality Forum HCBS measurement domains*
- Includes both "phase 1" measures (ready for implementation now) and "phase 2" measures (could be integrated into the measure set later)
  - Phase 2 measures include measures that are still undergoing testing, MLTSS measures that need to be re-specified for fee-for-service, etc.

*National Quality Forum (NQF). "Quality in Home- and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement." Final Report. Washington, DC: NQF, September 2016. http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx

Measure Selection Criteria

- Importance to Measure and Report*
  - Extent to which the specific measure focus is important to making significant gains in quality and improving outcomes for a specific high-impact aspect of care where there is variation in or overall poor performance

- Scientific Acceptability of the Measure Properties*
  - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results across HCBS populations when implemented

- Feasibility*
  - Extent to which the specifications (including measure logic) require data that are readily available or that could be captured without undue burden and can be implemented for performance measurement

- Usability and Use*
  - Extent to which states, HCBS programs, managed LTSS plans, or other entities are using or could use performance results for both accountability and performance improvement

* Adapted from: Centers for Medicare & Medicaid Services (CMS). "Blueprint for the CMS Measures Management System." Version 14.1, February 2019. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.html; and National Quality Forum (NQF). "Measure Evaluation Criteria and Guidance for Evaluating Measures for Endorsement." September 2018. http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=88439.

Measure Selection Criteria (cont.)

- Related and Competing Measures*
  - Extent to which there are related measures (i.e., measures that address either the same topic or the same population) and/or competing measures (i.e., measures that address the same topic and the same population) in the measure set

- Level at Which Measure Can Be Applied
  - Whether the measure can be applied at the statewide, delivery system, and/or population levels.

- Type of Measure
  - Whether the measure is a structural, process, or outcome (including intermediate outcome) measure

* Adapted from: Centers for Medicare & Medicaid Services (CMS). "Blueprint for the CMS Measures Management System." Version 14.1, February 2019. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.html; and National Quality Forum (NQF). "Measure Evaluation Criteria and Guidance for Evaluating Measures for Endorsement." September 2018. http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=88439.

Developing a Quality Rating System for Medicaid & CHIP Managed Care

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Medicaid & CHIP Managed Care 2016 Final Rule

- The Final Rule, issued on May 6, 2016, was the first significant update to the Medicaid and CHIP managed care regulations since 2003 and includes provisions to:
  - Improve beneficiary experience;
  - Enhance quality improvement activities;
  - Advance program and fiscal integrity;
  - Strengthen states' delivery system reform efforts; and
  - Align Medicaid with Medicare Advantage (MA), Marketplace, and private coverage.
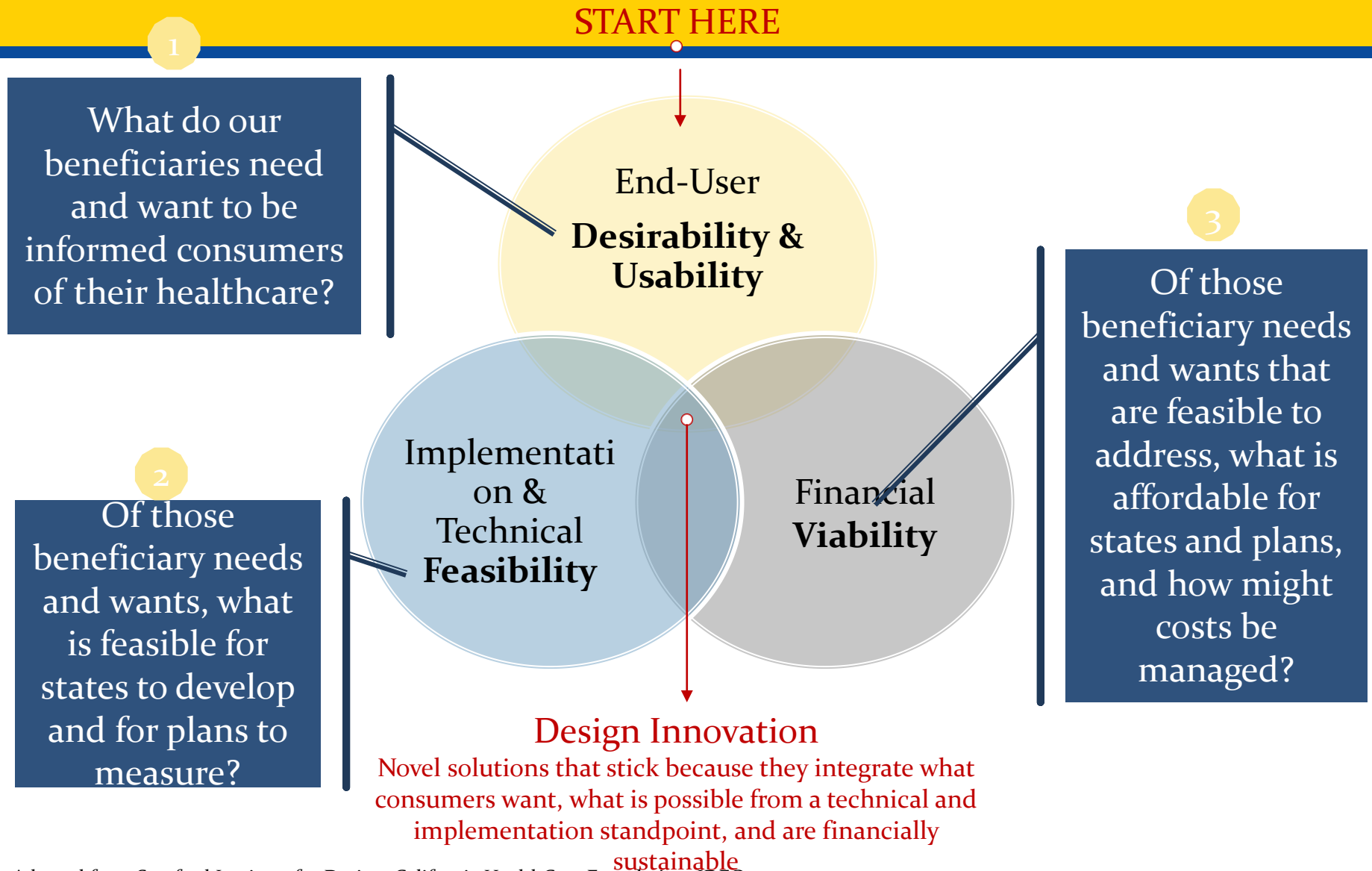
2016 Final Rule: Medicaid and CHIP (MAC) QRS

- The Final Rule requires that all states contracting with a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) adopt the MAC QRS developed by CMS or an alternative quality rating system *(42 CFR §438.334(a))* .

  – The MAC QRS will align with the summary indicators of the Marketplace QRS (Clinical Quality Management; Member Experience; and Plan Efficiency, Affordability, and Management) *(42 CFR §438.334(b))*.

  – States will be required to collect data from each MCO, PIHP, and PAHP, and issue an annual quality rating for each MAC health plan. *(42 CFR §438.334(d))*

- States must prominently display each quality rating on the state's Medicaid website *(42 CFR §438.334(e))*.

- CMS must develop an External Quality Review (EQR) protocol for an optional EQR-related activity for assisting with plan rating *(42 CFR §438.358 (c)(6)).* States can receive Federal matching funds if their EQR Organization conducts the activity consistent with this protocol *(42 CFR §438.370).*

- The MAC QRS provision at *§438.334* is incorporated in its entirety into CHIP at *§457.1240(d)*
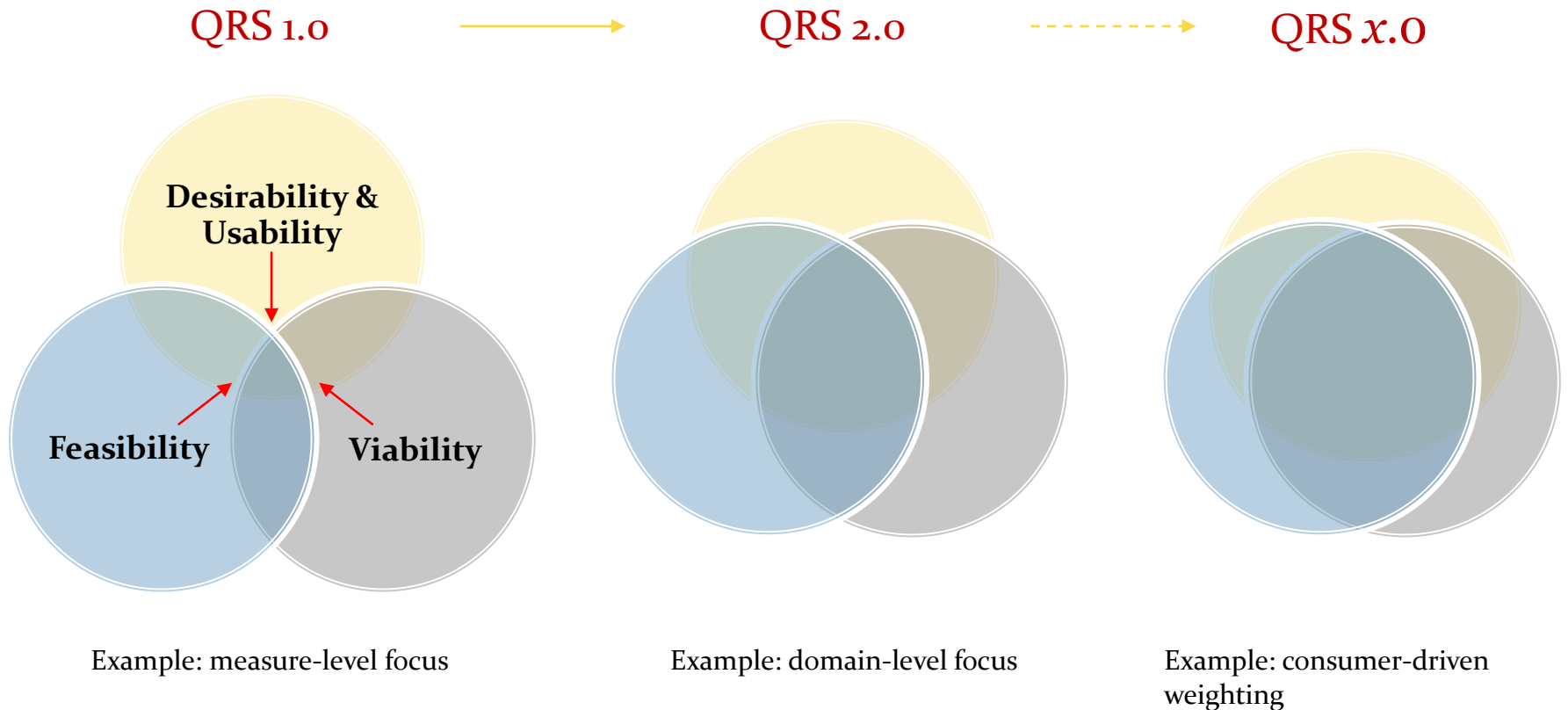
2016 Final Rule: Option to use an Alternative MAC QRS

- To allow states flexibility given the unique patient populations covered by Medicaid and CHIP, states may request to use an alternative QRS (i.e., the use of different performance measures or different methodology) provided that:
  - The ratings generated by the alternative QRS yield information regarding health plan performance that is substantially comparable to that yielded by the CMS quality rating; and
  - The state receives CMS approval prior to implementing an alternative QRS or modifications to an approved alternative QRS.
- In creating an alterative QRS, states must:
  - Receive input from the state's Medical Care Advisory Committee,
  - Provide opportunity for public comment for at least 30 days, and
  - Document the public comment process used to obtain stakeholder feedback on the alternative QRS in the request to CMS.

Innovative Design that Sticks

START HERE

1 What do our beneficiaries need and want to be informed consumers of their healthcare?

End-User **Desirability & Usability**

3 Of those beneficiary needs and wants that are feasible to address, what is affordable for states and plans, and how might costs be managed?

2 Of those beneficiary needs and wants, what is feasible for states to develop and for plans to measure?

Implementation & Technical **Feasibility**

Financial **Viability**

Design Innovation
Novel solutions that stick because they integrate what consumers want, what is possible from a technical and implementation standpoint, and are financially sustainable

Adapted from Stanford Institute for Design, California HealthCare Foundation, IDEO

Evolution of MAC QRS Development

QRS 1.0 ———————————→ QRS 2.0 - - - - - - - → QRS *x*.0

Desirability & Usability

Feasibility   Viability

Example: measure-level focus

Example: domain-level focus

Example: consumer-driven weighting

What beneficiaries need and want will come into greater focus as design research progresses. Through technical assistance and with time, what is feasible for states and plans to implement will also increase. Over time, the Area of Overlap will Increase as the QRS Evolves

QRS 1.0 Scope and Focus

Desirability & Usability

- Integration of measures that are *important to* beneficiaries (customer service metrics) with measures that are *important for* beneficiaries (traditional quality measures)
- Integration of provider directory and value-added benefit information with health plan quality information

Feasibility

- Narrow the gap between states with and without QRS
- Focus on the transparent display of consistently defined measures that allows for intra-state comparison of plan performance (rather than on complex methodology that would be required for inter-state comparison)
- Working with states to pilot test potential QRS measures and methodologies before they are finalized through rulemaking to optimize reliability and feasibility

Viability

- Development of protocol for optional plan rating EQR activity for which states can receive Federal match
- "Plug and Play" functionality: release of measurement code that will operate with MMIS systems that states can use to implement QRS, at state option

MAC QRS Goals and Principles from 2017 TEP: Goals

Increase transparency in Medicaid and CHIP to provide beneficiaries with information on the performance of their plan options so they can select the plan that best meets their needs.

Enable states to understand and compare plan performance within their state to foster health plan improvements by providing a consistent set of health plan-level measures. These measures will complement the provider-level and state-level measures (e.g., Core Sets) they already collect.

Increase transparency in Medicaid and CHIP to promote health plan improvements.

Feedback and Discussion