Demonstrating and Measuring Quality in the New Managed LTSS Paradigm

NCQA, Elder Services of Merrimack Valley, CareSource
n4a Annual Conference & Tradeshow
July 30, 2017

Agenda

OPENING COMMENTS

AAA PERSPECTIVE & INSIGHTS

MCO PERSPECTIVE & INSIGHTS

NCQA MEASURE DEVELOPMENT

CLOSING

Q&A

What we do, and why

OUR MISSION

To improve the quality of health care

OUR METHOD

Measurement

We can't improve what we don't measure

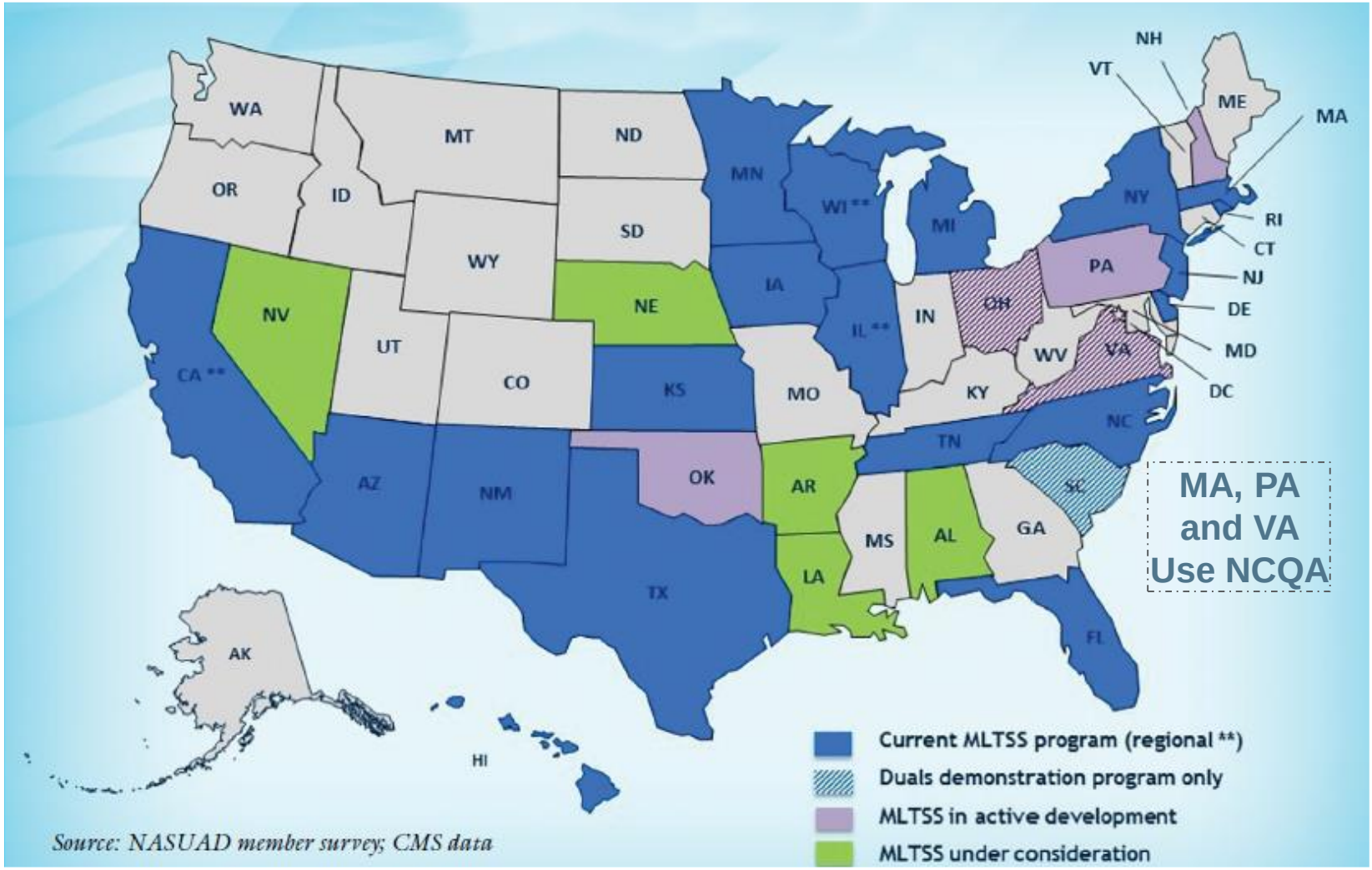
Transparency

We show how we measure so measurement will be accepted

Accountability

Once we measure, we can expect and track progress

Managed Long-Term Services & Supports Adoption



Research & Development Timeline

Timeline			
2011 – 2013	**2013 - 2015**	**2015 - 2017**	**2017 - 2021**
SCAN/NCQA	**SCAN/Hartford/ CMS**	**SCAN/Hartford/ CMS/NCQA**	**SCAN/Hartford/ NCQA**
Developed & Tested Quality Framework & Standards: • Identified Performance Measure Gaps	**Case Studies**: • Identified best practices in goal setting & data exchange • Assessed use of Patient Reported Outcomes Measures (PROMS) **Measure Development:** CMS	**LTSS Learning Collaborative:** • Pilot standards for coordinating LTSS • Develop Support Tools **Measure Testing:** CMS **Standards for Case Mgmt. - LTSS Accreditation:** • Launched July 2016	**Ongoing LTSS Integration Into Accreditation Programs:** • Measures Development • Seek NQF Endorsement

NCQA Research: http://www.ncqa.org/hedis-quality-measurement/research

AAA Perspective & Insights

Elder Services of the Merrimack Valley

Demonstrating and Measuring Quality in the New Managed LTSS Paradigm

Christine Tardiff, MSN, RN
July 30, 2017

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Experience/Perspective related to performance measurement

STEPS TO ESTABLISH PERFORMANCE MEASUREMENTS

- Clearly defining outcomes (agency, state, contracted partners)
- Determining Quality metrics
- Establishing reporting mechanisms (what, how, who's of data collection)
- Developing a process for quality review/quality improvement

BENEFITS ACHIEIVED

- Heightened understanding and buy-in of Quality Improvement Process (Senior Leadership, Managers, Front Line Staff)
- Increased collaboration towards shared goals
- Real time modifications to the intervention/program based on data
- Validation of intervention/program integrity

Current Performance Metrics Internal

- **Direct Service Provider Quality Metrics**
  - Accessibility
  - Coordination, Effectiveness, Productivity, Consistency, Timeliness of services
- **Consumer Satisfaction Quality Metrics**
  - Direct Service Provider Quality and Outcomes
  - Consumer Satisfaction with Care Manager, Direct Service Provider
- **Staff Satisfaction Quality Metrics**
  - Direct Service Provider availability
  - Service Coordination
  - Provider responsiveness
  - ASAP staff satisfaction with Direct Service Provider
- **Program Quality Metrics**
  - Program specific metrics (EOEA designation review)

Current Performance Metrics Partner Specific

- **Executive Office of Elder Affairs (EOEA)**
  - Waiver Metrics
    - Defined by program requirements – timeliness, assessments

- **Senior Care Options (SCOs) – Care Transitions Program**
  - Engagement
    - Completed assessments, unable to contact/refusers, home visit within 72hrs of discharge
  - Post Acute Utilization
    - Discharges to SNF post hospitalization
  - Acute Care Utilization
    - 30 day readmissions, ED Visits, ED visits within last 30 days post hospitalization

- **Grant Programs (Community Hospital Acceleration, Revitalization & Transformation-CHART)**
  - Acute Care Utilization
    - 30 day readmissions, ED visits within last 30 days post hospitalization
  - Engagement
    - Completed assessments, unable to contact/refusers, tracking of touchpoints-calls, home visits

Current Performance Metrics New Measurements

State-wide Initiatives

- **MHC LTSS HCBS MEASURES**
  - Demonstrate, with data, the ASAP value proposition
  - Review National and State of MA sources, data sets and measures
  - Analyze ASAP data set (SIMS-CDS) for potential measures
  - Analyze Medicare Utilization data/measures (New England QIN/QIO)
  - Develop measures
    - Reduce Incidences of Falls
    - Reduce Unmet Needs for ADL/IADL Functioning
    - Reduce Unmet Needs Caused by Social Determinant Factors
    - Improve Medication Adherence
    - Reduce Intensity of Depression and Anxiety and Improve Self-Declared Well-Being
    - Improve Self-Management of Substance Use Disorder
    - Reduce All Cause Hospitalizations
    - Reduce 90 day Hospital Readmissions
    - Reduce Emergency Room Visits
    - Increase Community Tenure
  - Design and run reports (Brown University, New England QIN/QIO, EOEA)

Current Performance Metrics New Measurements (cont.)

State-wide Initiatives

- MHC LTSS HCBS MEASURES
  - Future Measures
    - Measures for Caregivers
    - Measures for Consumer Experience

- ACCOUNTABLE CARE ORGANIZATIONS (ACO) LTSS CP
  - Quality
    - Well Visits, Oral Health
  - Member Experience
    - Service Delivery, Health & Wellness, Choice and Control (Consumer Choice), Effectiveness/Quality of Care
  - Integration
    - Utilization of CPs, Utilization of Flexible Services, Social Service Screenings, PCP visits
  - Avoidable Utilization
    - All Cause Readmissions, ED visits
  - Engagement
    - LTSS CP in 90 days

Current Performance Metrics New Measurements (cont.)

- NCQA Accreditation
  - **Process Measures**
    - Timeliness of Completion of Initial Assessment
    - Timeliness of determination of clinical eligibility by ASAP RN
  - **Outcome Measures**
    - Experience with Care Manager Services

Insights Gained

- **Buy-in, engagement at all levels of the organization**
  - Moving towards a more accountable culture
  - Getting staff to understand the "why"
- **Provide the education, support, tools that staff need to be successful**
- **Data reporting/analytics challenging**
  - Investments in resources, technology
- **Collaboration with partners is key**
  - Data collection/reporting
  - Shared goals
  - Information/Data sharing

MCO Perspective & Insights

CareSource

CareSource™

Managed Care and CBO Relationships

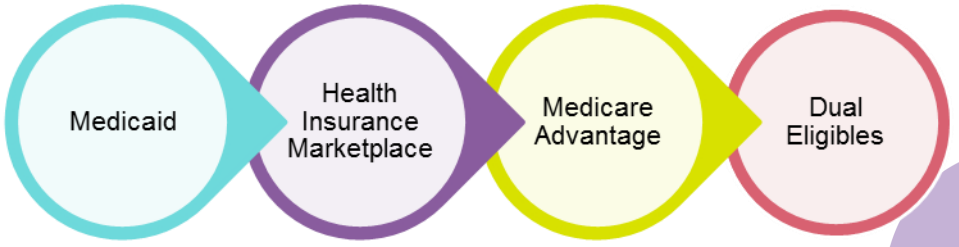
Meloney Hillier RN CMCN

Our MISSION

To make a lasting difference in our members' lives by improving their health and well-being.

CareSource®

- A nonprofit health plan and national leader in Managed Care
- 27-year history of serving the low-income populations across multiple states and insurance products
- Currently serving over 1.5 million members in Kentucky, Ohio, Indiana, West Virginia



1.52M
members

Complex Dual Populations: Perpetual Assessment

Like the member, an individualized, comprehensive plan of care will change over time. Processes and tools must adapt based on an enrollee's developing needs, key events, and personal goals.






Stratify Enrollee through Internal Systems

Assess Needs and Personal Goals

Confirm Stratification Level of Care

Develop Individualized Plan of Care

Implement Care Plan with Enrollee

Monitor Reassess Plan of Care Effectiveness

Diagnosis History and Utilization

Significant Events: Transitions of care, change in health status or functional needs, new diagnosis, change in caregiver status, new living environment

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Managing LTSS

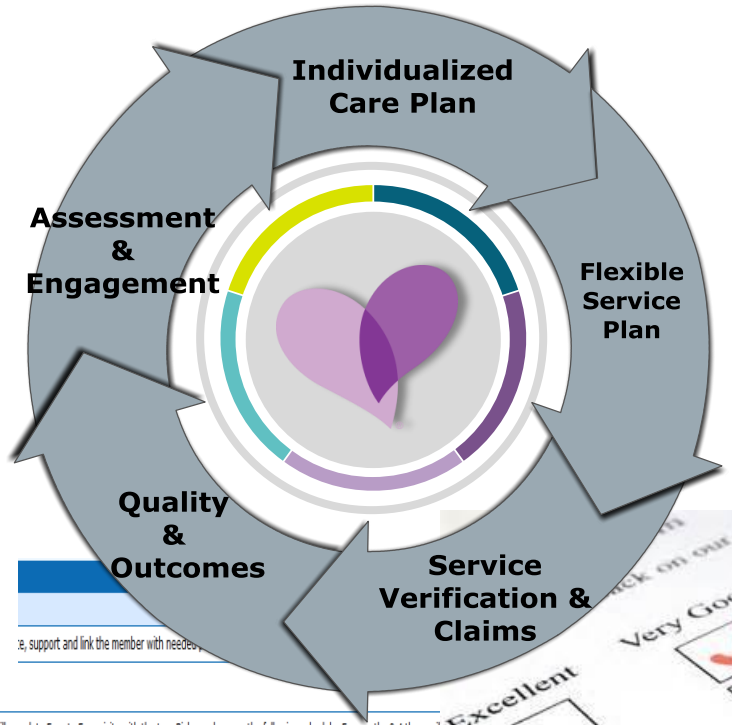
CareSource

Service Schedule

Member Information

Name: Helen Virginia
Address: 123 Test Street
Richmond, VA 23218
Subscriber ID: 107576455-00
Status: Active

Start Date	End Date	Service	Sun	Mon	Tues	Wed	Thur	Fri	Sat	Other	Provider
06/01/2016	05/31/2017	Assist with dressing. Assist with grooming. Assist with bathing.		Every week		Every week		Every week			Cornerstone Helping Hands of North East
06/01/2016	05/31/2017	Diabetic diet 14 meals weekly delivered on Tuesday. .			Every week						Mom's Meals-Purfoods
06/01/2016	05/31/2017	ERS with pendant. Billed the second Tuesday of each month.			2nd week of every month						Valued Relationships Inc- VRI
10/17/2016	11/30/2016	Medication management, including education. Collaboration with PCP. Disease management; including education. Dressing change. Stoma care.	Daily	Daily	Daily	Daily	Daily	Daily	Daily		Cornerstone Home Health of Northeast Ohio
10/20/2016	11/03/2016	Bariatric lift chair, chair approval price 560.00 Lifting Mechanism via Medicare coverage. Medicare beneficiary number 1234567890A-traditional Medicare.								One time service	Hocks Pharmacy Inc



ERS

CM/ICT/Waiver Service Coordinator will complete Face to Face visits with the Low Risk member, per the following schedule: For months 0-4 there wil

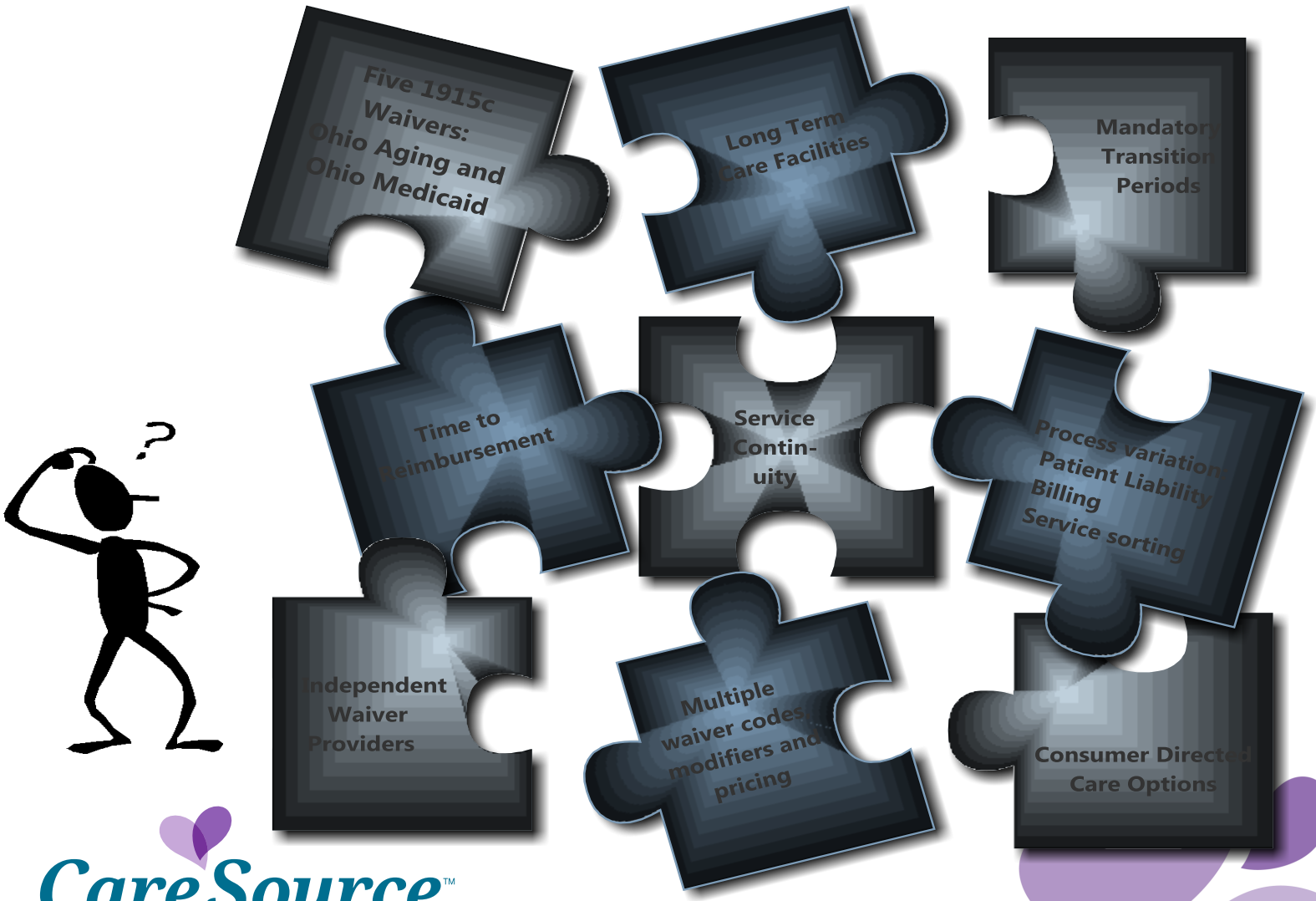
▿ Risk for ineffective health maintenance due to complex health conditions

▿ Case Manager facilitates and coordinates with obtaining appropriate care assistance

Chore Servies	Service Item	10/27/2015	
Inspect for pests	Service Item	10/28/2015	
Medication Management	Service Item	10/28/2015	
Waiver Nursing	Service Item	10/30/2015	

▸ Additional Plan Items

Solving the Puzzle



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Initial demonstration Challenges

- Over 100,000 members required reassessment based on risk stratification in 5-6 month period
- Managed Care and AAA coordination
- 5 Waiver programs combined into one program
- LTSS providers learning Managed Care
- Variations in vendor sophistication and clinical/operational competence
- New to MCP accreditation/care management standards (e.g. NCQA, CMSA)
- New populations, new requirements
- “Overwhelmed” with workload

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Visit and contact requirements

Risk Stratification	Initial visit	Ongoing visit
Intensive	15 days	every 30 day
High	30 days	every 60 days
Medium	60 days	every 90 days
Low	120 day	every 180 days
Monitoring	180 days	once per year

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Rebalancing in LTSS Rate Structure

Ohio MLTSS/duals demonstration:

Diversion Incentive: manage members in their home avoid Nursing Facility admissions

Transition Incentive: manage transitions from acute settings

NF Diversion is an annual Quality Withhold measure.

- ✓ Community tenure is incorporated as P4P measure in care management delegated entity contracting.
- ✓ NF VBR contracting incorporates incentives for increased transition activity.
- ✓ Development of pay for performance contracting

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Exhibit A-1

Month/Metric Start Date	PMPM Low, Medium & Monitoring**	P4P Guarantee	Total P4P Opportunity
April 1, 2016: ED Visits, Initial Assessments	$PMPM	None	$5.00
October 1, 2016: Hospital Readmissions, Nursing Facility Diversion, Assessments (Annual), Individual Care Plan Development	$PMPM	None	$14.00
April 1, 2017: Service Plan Development and Utilization, Event based contacts, Ongoing Care Management	$PMPM	None	$20.00

*Reduced base PMPM incrementally implementing P4P opportunity

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Remedy Metrics

Performance Standard	Target
Assessment and Care Management: Service Plan Development & Maintenance: Individualized Care Plan Development & Maintenance:	80% is minimum compliance to avoid remedy
Hospital Readmission: Nursing Facility Diversion Measure	95% is minimum compliance to avoid remedy
Incident Management: Annual Evaluation Report: Corrective Action Plans (CAP): Staffing Ratios	100% is minimum compliance to avoid remedy

*Apply remedies if they fall below a standard % compliance with key metrics

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Outcomes

- Home Modification work group
  - Review all home modification or specialized equipment
- Developed new data sources:
  - P4P metrics,
  - daily vendor report
- Assessments
  - Reassessments
- Care plans – member centric
- Waiver Service plans
- Consumer advisory council meetings
- Care Coordination follow up on transitions

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Opportunities moving forward

- Quarterly ERQO audits
  - Changing requirements twice a year over the 3 year demonstration
- NCQA LTSS standards
  - developing standards that will meet NCQA and contract requirements CMS Requirements
    - Plan All Cause Readmissions - Observed Readmissions
    - Annual Flu Vaccine
    - Follow-up After Hospitalization for Mental Illness - 30 days
    - Reducing the Risk of Falling
    - Controlling Blood Pressure
    - Medication Adherence for Diabetes Medications
    - Consumer Advisory meetings
    - Assessment completion
  - State only measures
    - Nursing Facility Diversion
    - Long Term Care Overall Balance Measure

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Measure Development

NCQA

Dan Roman - Senior Research Associate

QUALITY MEASURE DEVELOPMENT: Medicaid Managed Long-term Services and Supports (MLTSS) Programs

Existing MLTSS Quality Measures

Standard national measures are medically oriented

- HEDIS Medicare Advantage measures
- Hospitalization for Ambulatory Care Sensitive Conditions (ACSCs) among HCBS users
- Necessary but insufficient

State-specific LTSS measures:

- Address some LTSS domains
- But imprecise, poorly specified, or not thoroughly tested
- Cannot be used for cross-state comparisons

Gaps remain for key domains

Key MLTSS Quality Domains

- Rebalancing – greater use of HCBS and avoidance of unnecessary institutional care
- Comprehensive, timely assessment
- Comprehensive, person-focused care planning
- Quality of life
- Community integration (employment, socialization)
- HCBS Experience of Care
- Integration of medical care and LTSS

Quality Measure Development Project History

Medicaid Managed Care TA & Oversight, 2012-2013

- CMCS, Division of Managed Care Plans
- Mathematica and NCQA
- Literature Review, Measure Scan, Technical Expert Panel
- Development of preliminary measure specifications

Quality Measure Development (QMD) for MLTSS, 2015-2017

- Multiple CMS Sponsors
- Mathematica and NCQA
- Measure testing and refinement of specifications
- Technical Expert Panel review and feedback
- Seek NQF endorsement, propose implementation plan

QMD Project Goals

- **Develop set of measures for use in creating national benchmarks of quality**
- **Conduct field testing on a set of MLTSS measures to assess:**
  - **Feasibility:** measure specifications are easy to understand and measure elements can be identified in claims or records
  - **Validity:** Do the measures accurately capture the intended care processes or outcomes (construct validity)? Do the measure scores correlate with other measures of quality (convergent validity)?
  - **Reliability:** For chart or record-based measures, is there high agreement when different individuals report results? Are the measures scores precise with minimal random error?
  - **Meaningful variation:** Are there statistically or clinically meaningful differences in results across reporting entities or different subpopulations?

Measure Development

NCQA

MLTSS Measures

Institutional Use/Rebalancing

Admission to an Institution from the Community

Description: Number of admissions to an institution among MLTSS enrollees residing in the community per 1,000 enrollee months.

Exploring feasibility of:

- Separate rates for short and long-term admissions
- Risk-adjustment for clinical conditions

Institutional Use/Rebalancing

Successful Discharge after Short-Term Stay

Description: Percentage of admissions to an institution that result in successful discharge to the community (community residence for 30 or more days) within 100 days of admission.

Exploring feasibility of:

- Risk-adjustment for clinical conditions

Institutional Use/Rebalancing

Successful Transition after Long-Term Stay

Description: The percentage of long-term stay (101 days or more) institutional residents who are successfully transitioned to the community (community residence for 30 or more days).

Exploring feasibility of:

- Risk-adjustment for clinical conditions

Comprehensive, Timely Assessment

Comprehensive Assessment Composite

Description: The percentage of MLTSS enrollees who have documentation of a comprehensive assessment within the appropriate time frame, including the following components:

- Specific core domains are documented
- Assessment done with in specified timeframe
- Documentation of involvement of family member, caregiver, guardian, or power of attorney in assessment (with beneficiary consent)

Comprehensive, Person-Focused Care Planning

Comprehensive Care Plan Composite

Description: The percentage of MLTSS enrollees who have documentation of a completed comprehensive care plan developed within the appropriate time frame.

- Specific core domains are documented
- Care plan completed with in specified timeframe
- Documentation of beneficiary agreement with care plan
- Documentation of family member or caregiver agreement with care plan (if applicable and with beneficiary consent)

Integration of Medical Care and LTSS

Shared Care Plan

Description: The percentage MLTSS beneficiaries with a care plan for whom all or part of the care plan was transmitted to the primary care provider within 30 days of development or update.

Comprehensive, Timely Assessment and Person-Focused Care Planning

Re-assessment and Care Plan Update After Discharge

Description: Percentage of MLTSS beneficiaries who received a reassessment and care plan update within 30 days of discharge from an acute care facility, nursing home, or other institution.

Comprehensive, Timely Assessment and Person-Focused Care Planning

Falls Screening, Assessment and Plan of Care

Description: Percentage of MLTSS enrollees age 18+ who had the following:

- Screening: screened for fall risk
- Assessment: at risk for future falls and received a fall risk assessment
- Plan of Care: at risk of future falls and received a plan of care to address falls

Preliminary Test Findings

- **Interviews with 12 MLTSS health plans held to solicit views on the feasibility, usability and importance of assessment, care plan and falls measures.**
- **All or most data elements are available, but in different locations in health plan data management systems, or in separate locations.**
  - Especially in “delegated models”: health plan contracts with case management agencies to conduct assessment, care planning, and care coordination
- **Reporting burden for chart-based measures**
  - Testing an approach to combine related measures and focus on timeliness of assessment and care plans, regardless of length of enrollment

MLTSS Measure Test Timeline

- **Interviews with health plan managers- spring 2016**
  – Results used to refine measure specifications, lower burden
- **Field testing and analysis**
  – 5 chart-based measures - July-December 2016
  – 3 institutional use measures – March-July 2017
- **Public Comment on Measure Information and Justification Forms – September 2016**
- **Summary Reports – January and August 2017**
- **Seek NQF endorsement for valid, reliable measures – 2018**
- **If appropriate, develop implementation plan**

CMS Sponsors and Project Team

CMS
CMCS, Division of Quality and Health Outcomes
CMCS, Division of Managed Care Plans
CMCS, Medicaid Innovation Accelerator Program Office
CMMI, Medicare-Medicaid Coordination Office
Center for Clinical Standards and Quality

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Announcements and links:

https://www.mathematica-mpr.com/our-publications-and-findings/projects/quality-measure-development-dual-enrollees-long-term-services-and-support

Closing

Q&A


Thank you