Taking Stock of New HCBS Quality Measures

CMS, State, and Health Plan Perspectives

National HCBS Conference

December 10, 2020

Agenda

/ CMS HCBS quality framework and strategy

/ HCBS-CAHPS and MLTSS quality measures

/ Systematic assessment of State and Health Plan technical assistance (TA) needs

/ State and Health Plan Perspectives

/ Panel Discussion

Panelists

Debra Lipson

Senior Fellow

Mathematica

Jennifer Bowdoin

Director, Division of Community Systems Transformation

Centers for Medicare & Medicaid Services (CMS)

David Kelley, M.D.

Chief Medical Officer

Pennsylvania Department of Human Service

Office of Medical Assistance Programs

Laura E. Chaise

Vice President

Long Term Services and Supports and Medicare-Medicaid Plans

Centene Corporation

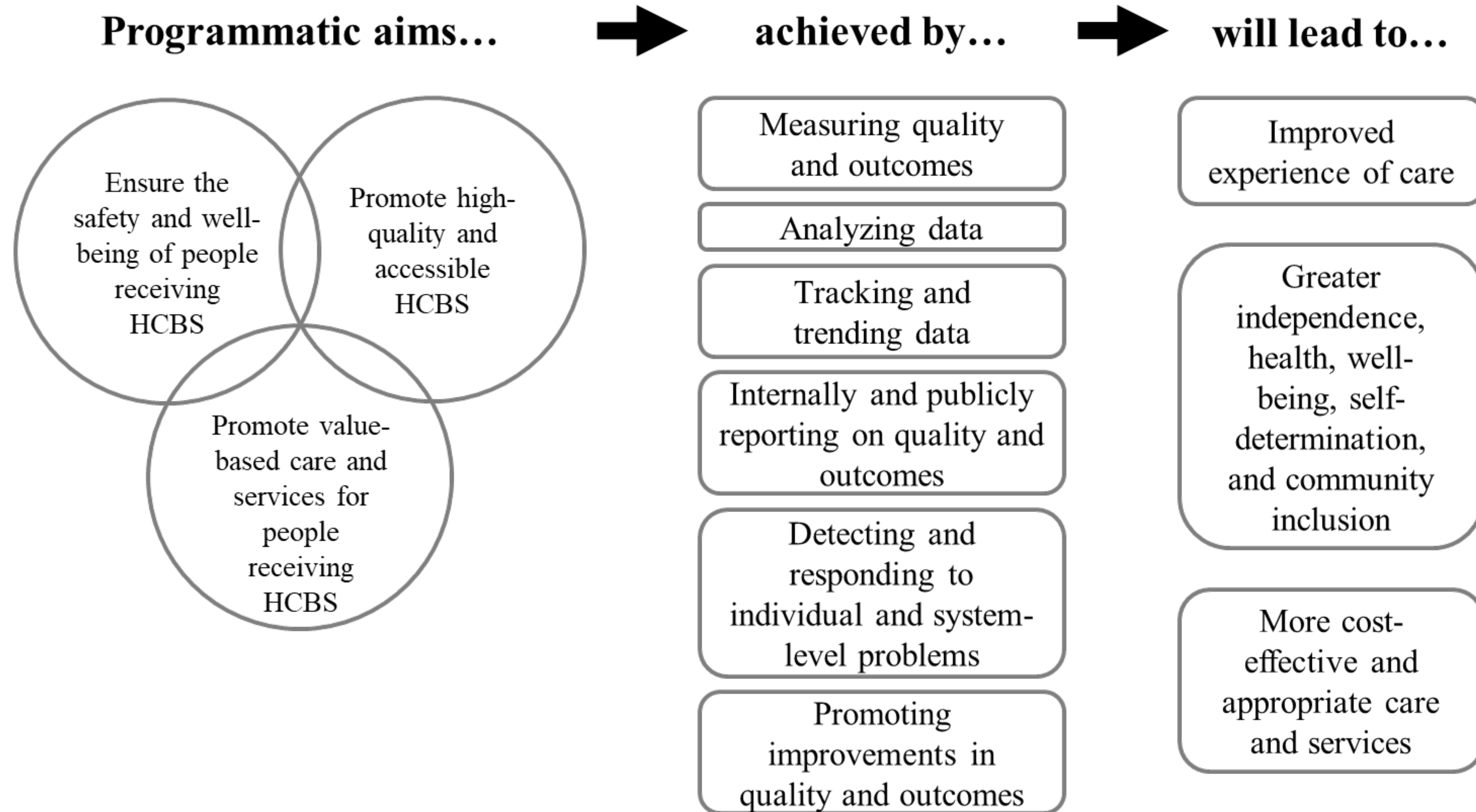
Jennifer Bowdoin,

Division of Community Systems Transformation,

CMS

Mathematica

HCBS Quality Framework



CMS HCBS Quality Strategy Elements

1. Promote development and use of standardized, validated, and meaningful quality measures
2. Align, coordinate, and address gaps in federal and state measurement, reporting, and monitoring requirements, activities, and systems
3. Develop, implement, and support use and availability of a comprehensive set of quality improvement, quality assurance, and technical assistance strategies, activities, and tools
4. Improve oversight and enforcement, address gaps in regulations and oversight/enforcement, and better support states to comply with federal regulations, policies, and guidance
5. Support development, testing, and implementation of value-based purchasing and alternative payment models

Strengthening the Infrastructure for Quality Measurement and Reporting

- Maintaining existing quality measures
- Developing new standardized quality measures to address measure gaps
- Developing tools and capabilities to support HCBS quality measurement and reporting
- Helping states to implement standardized quality measures

Debra Lipson
Senior Fellow
Mathematica

Overview of HCBS CAHPS and MLTSS Quality Measures

HCBS experience of care measures

- **HCBS CAHPS® (Consumer Assessment of Healthcare Providers and Systems)**
  - Cross-disability experience survey for adults in state Medicaid HCBS programs. CMS developed the survey for voluntary use by state Medicaid programs, including fee-for-service HCBS programs and managed long-term services and supports (MLTSS) programs
- **Survey consists of 69 core items that ask beneficiaries to report on their experiences with:**
  - Getting needed services
  - Communication with providers
  - Case managers
  - Choice of services
  - Medical transportation
  - Personal safety
  - Community inclusion and empowerment
- https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/cahps-home-and-community-based-services-survey/index.html

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Exhibit 1. National Quality Forum-Endorsed Measures Derived From the HCBS CAHPS Survey

Scale Measures
1. Staff are reliable and helpful
2. Staff listen and communicate well
3. Case manager is helpful
4. Choosing the services that matter to you
5. Transportation to medical appointments
6. Personal safety and respect
7. Planning your time and activities
Global Ratings Measures
8. Global rating of personal assistance and behavioral health staff
9. Global rating of homemaker
10. Global rating of case manager
Recommendations Measures
11. Would recommend personal assistance/behavioral health staff to family and friends
12. Would recommend homemaker to family and friends
13. Would recommend case manager to family and friends
Unmet Needs Measures
14. Unmet need in dressing/bathing due to lack of help
15. Unmet need in meal preparation/eating due to lack of help
16. Unmet need in medication administration due to lack of help
17. Unmet need in toileting due to lack of help
18. Unmet need with household tasks due to lack of help
Physical Safety Measure
19. Hit or hurt by staff

https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbscahps-data-analysis-guide

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MLTSS Quality Measures

- 8 quality measures specified for managed care plans providing long-term services and supports (LTSS)
  - Developed by Mathematica and NCQA under a contract with CMS, 2015-2019
  - Rigorously field tested with health plans, and found to be statistically valid and reliable
- 4 person-centered assessment and care planning measures included in HEDIS as of 2019 – *first LTSS measures in HEDIS*
- 1 rebalancing measure endorsed by the National Quality Forum
  - Minimizing Institutional Length of Stay
- Technical Specifications, FAQs, webinar slides and other resources
  - https://www.medicaid.gov/medicaid/managed-care/managed-long-term-services-and-supports/index.html

MLTSS quality measures

/ Person-centered assessment and planning

1. Comprehensive Assessment and Update (HEDIS)
2. Comprehensive Care Plan and Update (HEDIS)
3. Shared Care Plan with Primary Care Practitioner (HEDIS)
4. Re-Assessment/Care Plan Update After Inpatient Discharge (HEDIS)
5. Screening, Risk Assessment, and Plan of Care to Prevent Future Falls

/ LTSS Use and Rebalancing

6. Admission to an Institution from the Community
7. Minimizing Institutional Length of Stay (NQF #3457)
8. Successful Transition After Long-Term Institutional Stay

Systematic assessment of State and Health Plan Technical Assistance (TA) needs

HCBS-CAHPS

Pros

- Nationally standardized measures allows cross-state comparisons
- Cross-disability: one survey for all LTSS population groups
- Flexible administration: in person or telephone
- Actionable information for quality improvement

Cons

- Duplicates some NCI and NCI-AD survey items and measures
- Complicated programming of computer-assisted telephone interviewing (CATI) survey tool
- Long survey, some repetitive questions
- Low response rates require large sample sizes
- Few vendors familiar with HCBS issues and populations

HCBS CAHPS TA needs

/ Technical support

- Programming support, help in building composite scores
- Sampling guidelines to ensure representativeness of respondents
- Methods for increasing beneficiary participation
- Lists of qualified survey vendors

/ Online resources for survey interviewers

- Online training programs for state and survey vendor staff
- Resources on screening for cognitive ability, cultural competence, mandatory abuse and neglect reporting rules in each state, among other issues

MLTSS quality measures

Pros

- Nationally standardized measures allows cross-state comparisons
- Inclusion of 4 measures in HEDIS; HEDIS vendors or EQROs validate plan-reported measures
- 3 measures of rebalancing outcomes
- Actionable information for quality improvement; potential use in value-based payment arrangements

Cons

- Mismatch between MLTSS assessment core elements and mandatory state assessment instruments
- Need to amend MLTSS contracts to require specific assessment and care planning activities
- 3 measures require claims data on prior hospital stays or other acute care services (Medicare pays for 75% of NF admissions)
- Lack of ongoing TA and data infrastructure to report and compare plan performance
- Abstracting information from case management records is resource intensive

MLTSS quality measure TA needs

- 1:1 TA help from measure experts, updated FAQs
- State learning collaboratives/peer exchange
- LTSS quality measure pathway guides
- Tools and resources on validating plan-reported measures
- How to use the measures to improve quality and in VBP
- Statistical support, help with risk adjustment
- TA resources and training materials for health plan staff
- External entity to construct measures by linking Medicaid-Medicare data
- Central database to collect, store and compare MLTSS plan scores
- Funds to support plan/provider electronic record exchange

David Kelley, MD

Pennsylvania Medicaid

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National HCBS Conference
Taking Stock of New HCBS Quality Measures

December 10, 2020

Pennsylvania Department of Human Services
David Kelley, MD, MPA, Chief Medical Officer
Office of Long-Term Living
Office of Medical Assistance Programs
c-dakelley@pa.gov

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DEPARTMENT OF HUMAN SERVICES

Agenda

- Overview of Pennsylvania's Department of Human Services Community HealthChoices program
- Quality strategy
- LTSS quality measure results
- Challenges
- Future plans

WHAT IS COMMUNITY HEALTHCHOICES (CHC)?

A Medicaid managed care program that will include physical health benefits and long-term services and supports (LTSS). The program is referenced to nationally as a managed long-term services and supports program (MLTSS).

WHO IS PART OF CHC?

- Individuals who are 21 years of age or older and dually eligible for Medicare and Medicaid.
- Individuals who are 21 years of age or older and eligible for Medicaid (LTSS) because they need the level of care provided by a nursing facility.
  - ✓ This care may be provided in the home, community, or nursing facility.
  - ✓ Individuals currently enrolled in the LIFE Program will not be enrolled in CHC unless they expressly select to transition from LIFE to a CHC managed care organization (MCO).

WHAT ARE THE GOALS OF CHC?

GOAL 1

Enhance opportunities for community-based living.

GOAL 2

Strengthen coordination of LTSS and other types of health care, including all Medicare and Medicaid services for dual eligibles.

GOAL 3

Enhance quality and accountability.

GOAL 4

Advance program innovation.

GOAL 5

Increase efficiency and effectiveness.

IDENTIFYING NEEDS

SCREENING, COMPREHENSIVE NEEDS ASSESSMENT AND REASSESSMENT

- CHC-MCOs must:
  - screen each new participant who are community well duals within 90 days of the start date
  - conduct a comprehensive needs assessment of every participant who is determined NFCE
  - conduct a comprehensive assessment when the participant makes a request, self-identifies as needing LTSS, or if either the CHC-MCO or the Independent Enrollment Broker (IEB) identifies that the participant has unmet needs, service gaps or a need for service coordination
  - conduct a reassessment at least every 12 months unless a trigger event occurs

Community HealthChoices

SERVICE COORDINATION

- Every participant receiving LTSS will choose a service coordinator.
- The service coordinator will coordinate Medicare, LTSS, physical health services, and behavioral health services.
- They will also assist in accessing, locating and coordinating needed covered services and non-covered services such as social, housing, educational and other services and supports.
- The service coordinator will also facilitate the person-centered planning team.
- Each participant will have a person-centered planning team that includes their doctors, service providers, and natural supports.
- Service coordination is an administrative function of the CHC-MCO.

SERVICE PLANNING

CARE MANAGEMENT PLANS

A care management plan is used to identify and address how the participant's physical, cognitive, and behavioral health care needs will be managed.

PERSON-CENTERED SERVICE PLANS (PCSP)

All LTSS participants will have a PCSP. The PSCP includes both the care management plan and the LTSS services plan.

PCSPs are developed through the person-centered planning team process, which includes the participant, service coordinator, participant's supports, and participant's providers.

COORDINATION WITH MEDICARE

Promoting improved coordination between Medicare and Medicaid is a key goal of CHC. Better coordination between these two payers can improve participant experience and outcomes.

- Dually eligible participants will continue to have all of the Medicare options they have today, including Original Medicare and Medicare Advantage managed care plans. The implementation of CHC will not change the services that are covered by Medicare.

- All CHC-MCOs are required to offer a companion Dual Eligible Special Needs Plans, also known as D-SNPs to its dually eligible participants. D-SNPs are a type of Medicare Advantage plan that coordinates Medicare and Medicaid services.

CHC STATEWIDE POPULATION

454,045
CHC POPULATION

93%
DUAL-ELIGIBLE

15%
66,561
Duals in Waivers

63%
285,018
NFI Duals

15%
69,036
Duals in Nursing Facilities

6%
26,293
Non-duals in Waivers

2%
7,137
Non-duals in Nursing Facilities

20%
IN WAIVERS

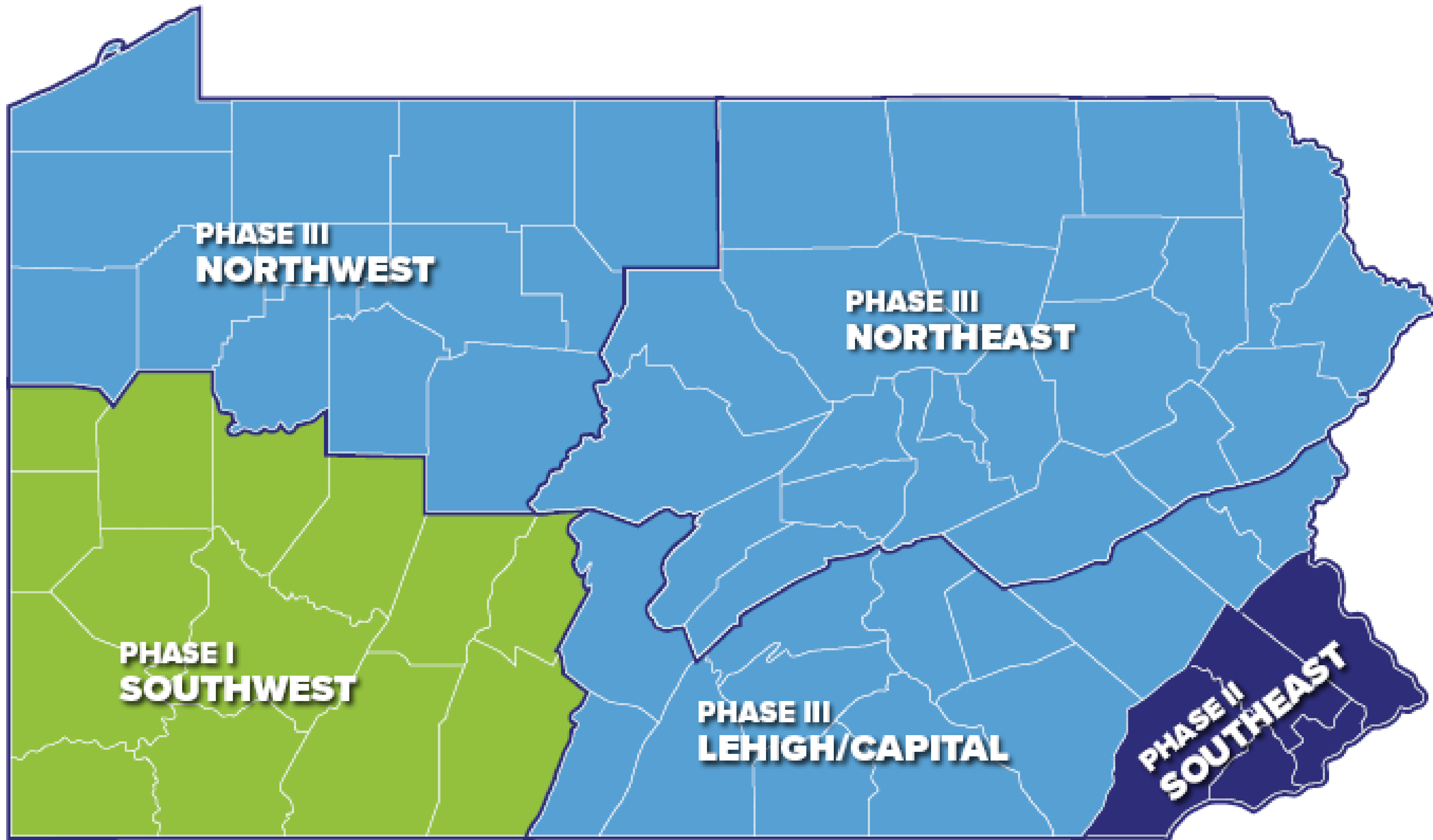
17%
IN NURSING FACILITIES

Community HealthChoices

CHC STATEWIDE POPULATION (2015-2018)

Population	2015	2018	Change	
NFCE Dual Waiver	49,759	66,561	+16,802	+134%
NFCE Dual NF	77,610	69,036	-8,574	-11%
NFCE Non-Dual Waiver	15,821	26,293	+10,472	+166%
NFCE Non-Dual NF	7,314	7,137	-177	-2%
NFI Dual	270,114	285,018	+14,904	+106%
Total CHC Population	420,618	454,045	+33,931	+108%
Total HCBS	65,580	92,854	+27,274	+142%
Total NF	84,924	76,173	-8,751	-10%

Community HealthChoices



PHASE 1 JANUARY 2018 • PHASE 2 JANUARY 2019 • PHASE 3 JANUARY 2020

Community HealthChoices

MANAGED CARE ORGANIZATIONS

- The selected offerors were announced on August 30, 2016.

- www.AmerihealthCaritasCHC.com

- www.PAHealthWellness.com

UPMC Community HealthChoices

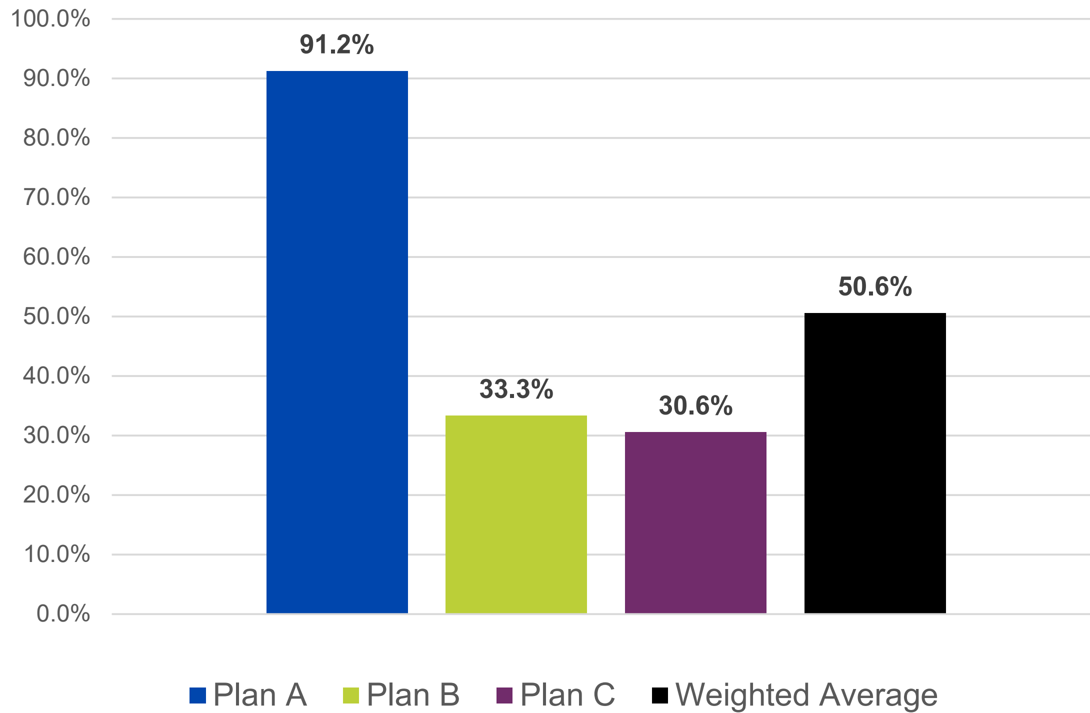
- www.upmchealthplan.com/chc

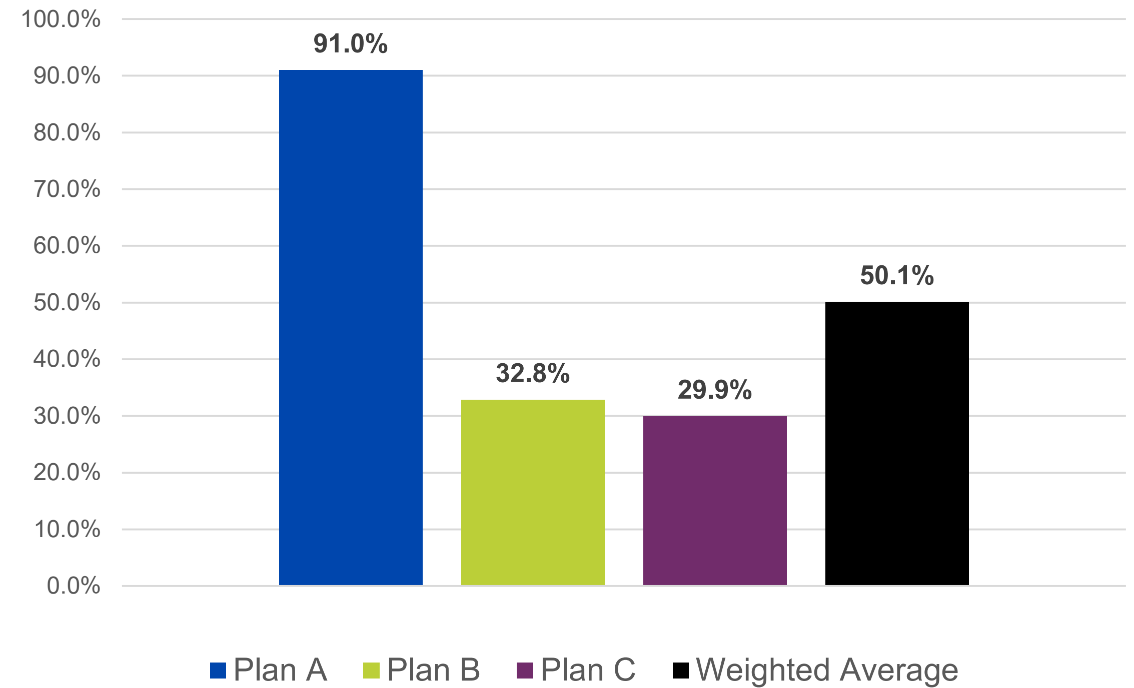
Quality Strategy

- Why invest in developing LTSS quality measures?
  - Evaluation of quality specific to LTSS program
  - Need to evaluate service coordination and care management
  - Assure person-centered care plan meeting needs of individual
- Current CHC measures used:
  - Four NCQA LTSS HEDIS® measures
  - Home and Community Based Services Consumer Assessment of Healthcare Providers and Services (HCBS-CAHPS) survey
- How are results used?
  - Overall program evaluation
  - Internal review by senior leadership PeopleStat meetings
  - Quarterly Quality Review meetings with all three CHC MCOs
  - Individual meetings with senior leadership from DHS and each MCO
  - Results shared in public meetings with stakeholders

LTSS HEDIS® Measures CY 2019

LTSS HEDIS® Measures





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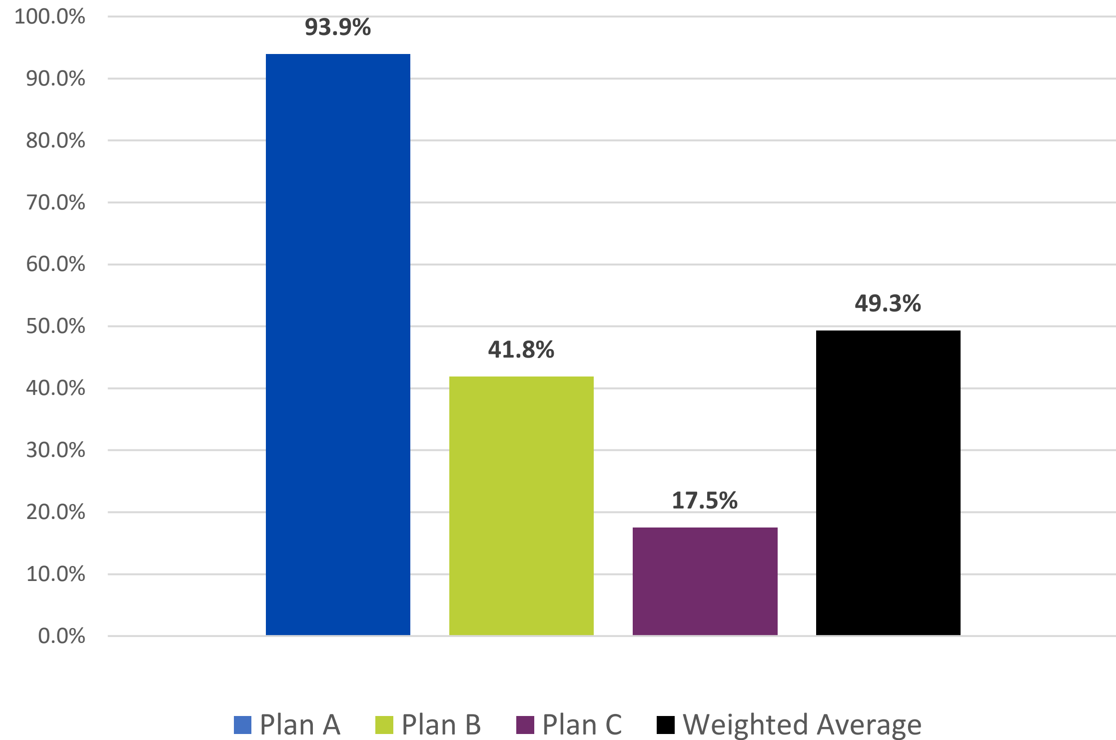
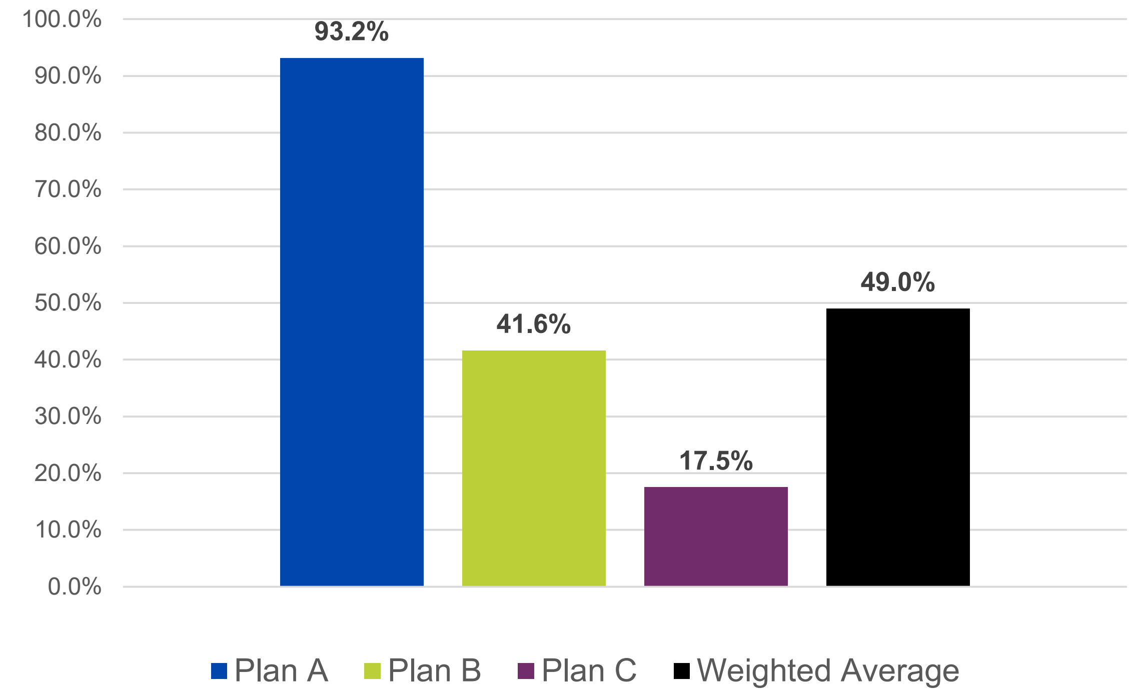
LTSS HEDIS® Measures





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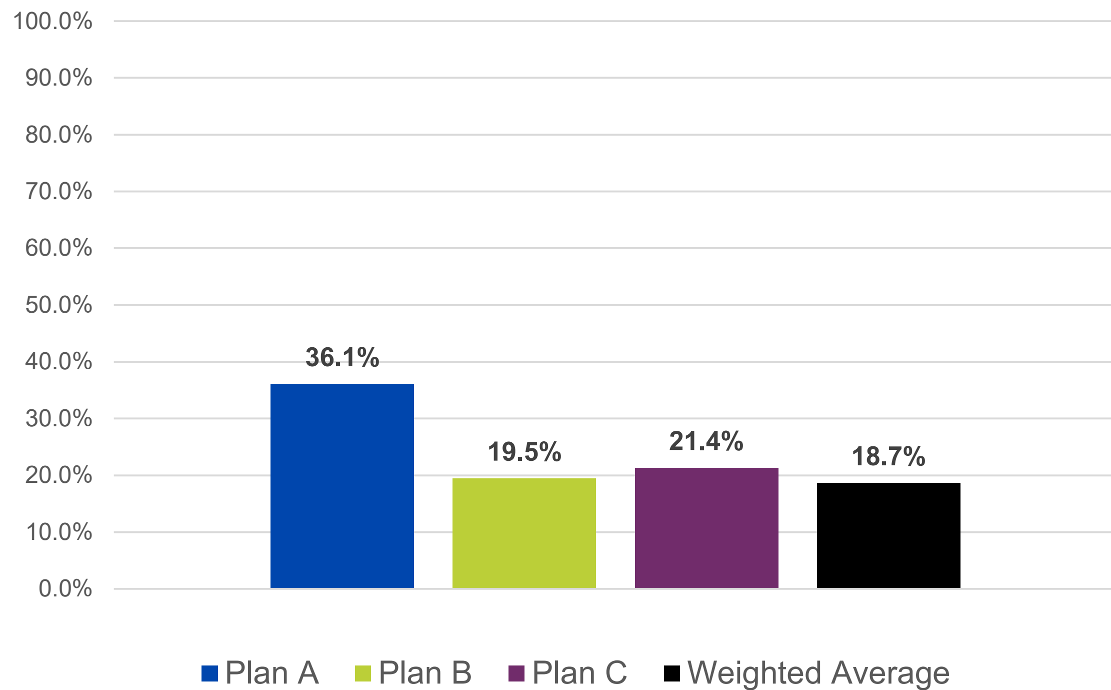
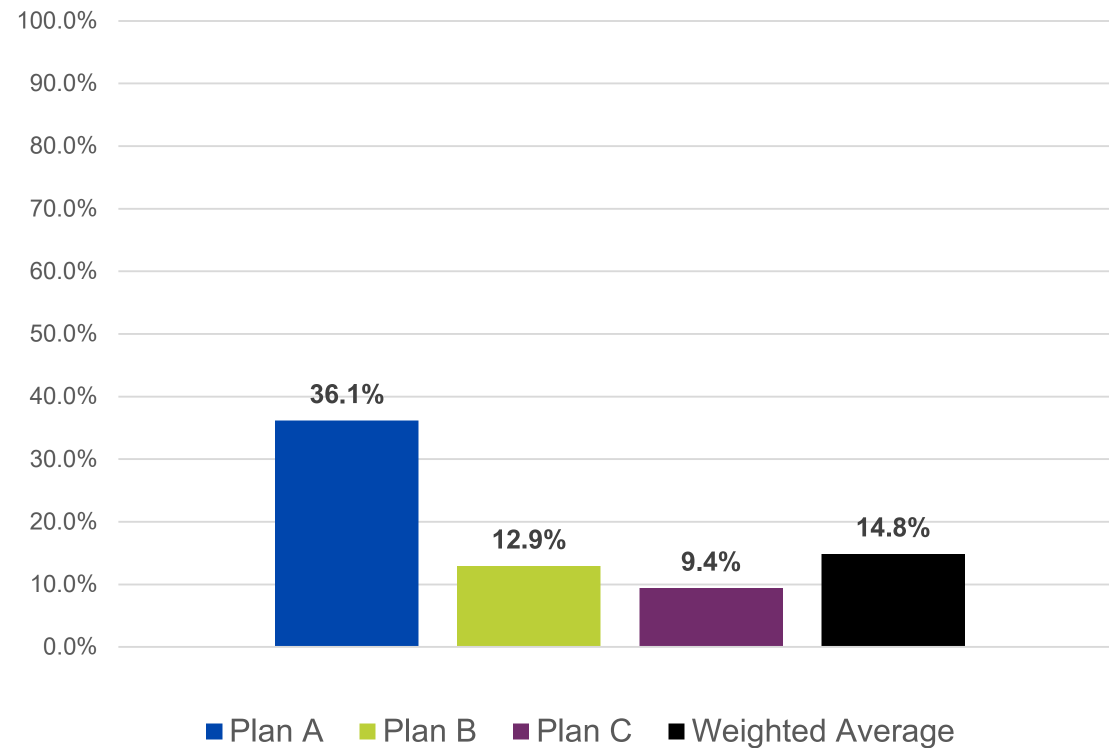
LTSS HEDIS® Measures





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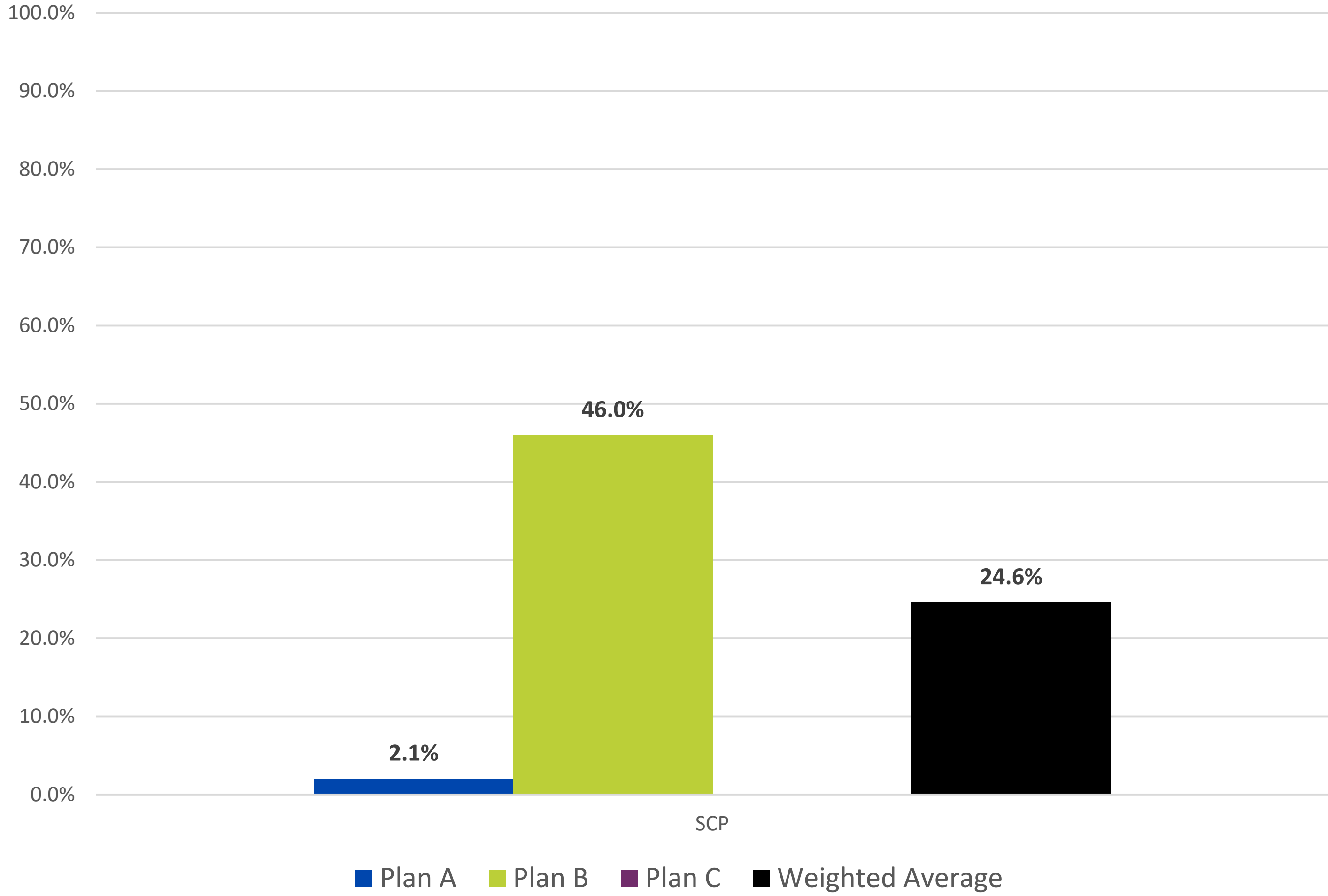
LTSS HEDIS® Measures



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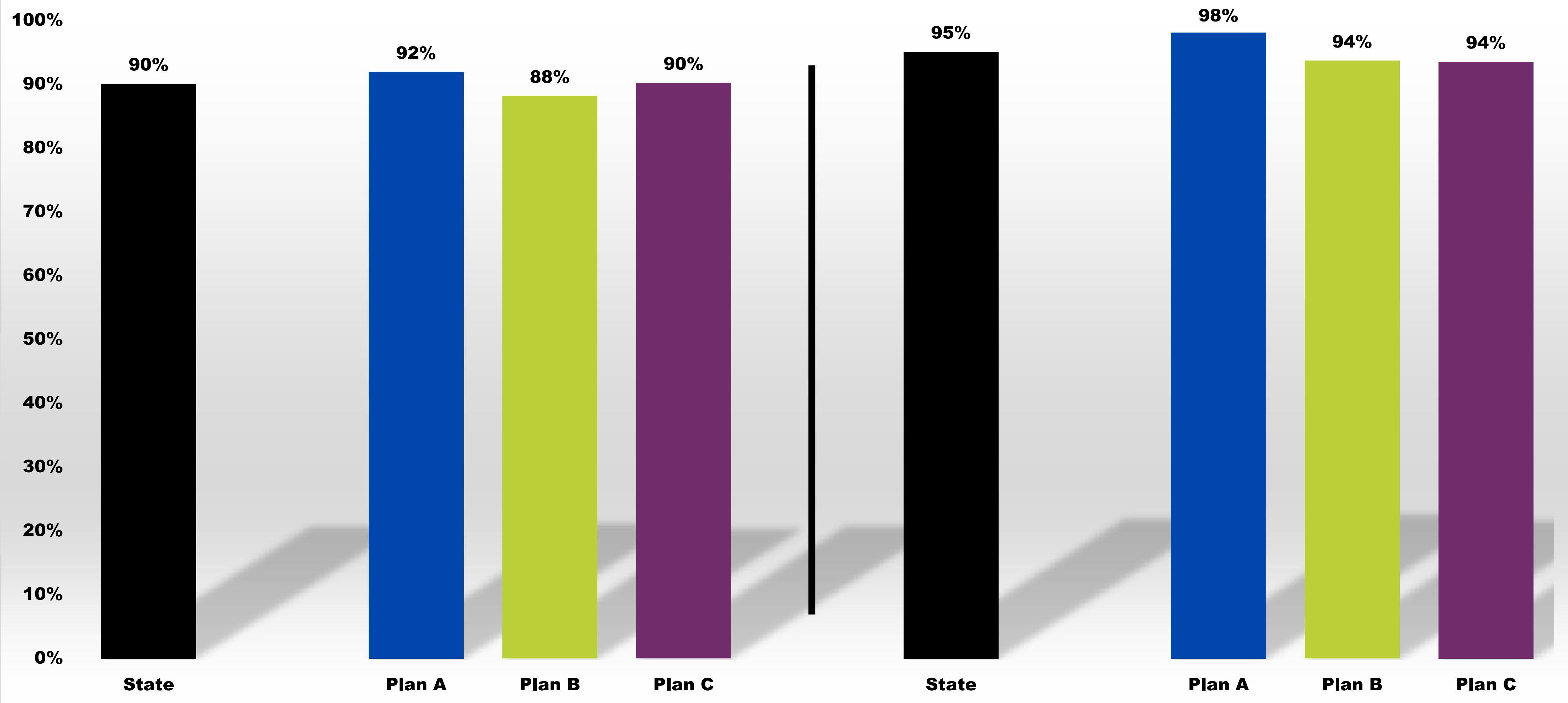
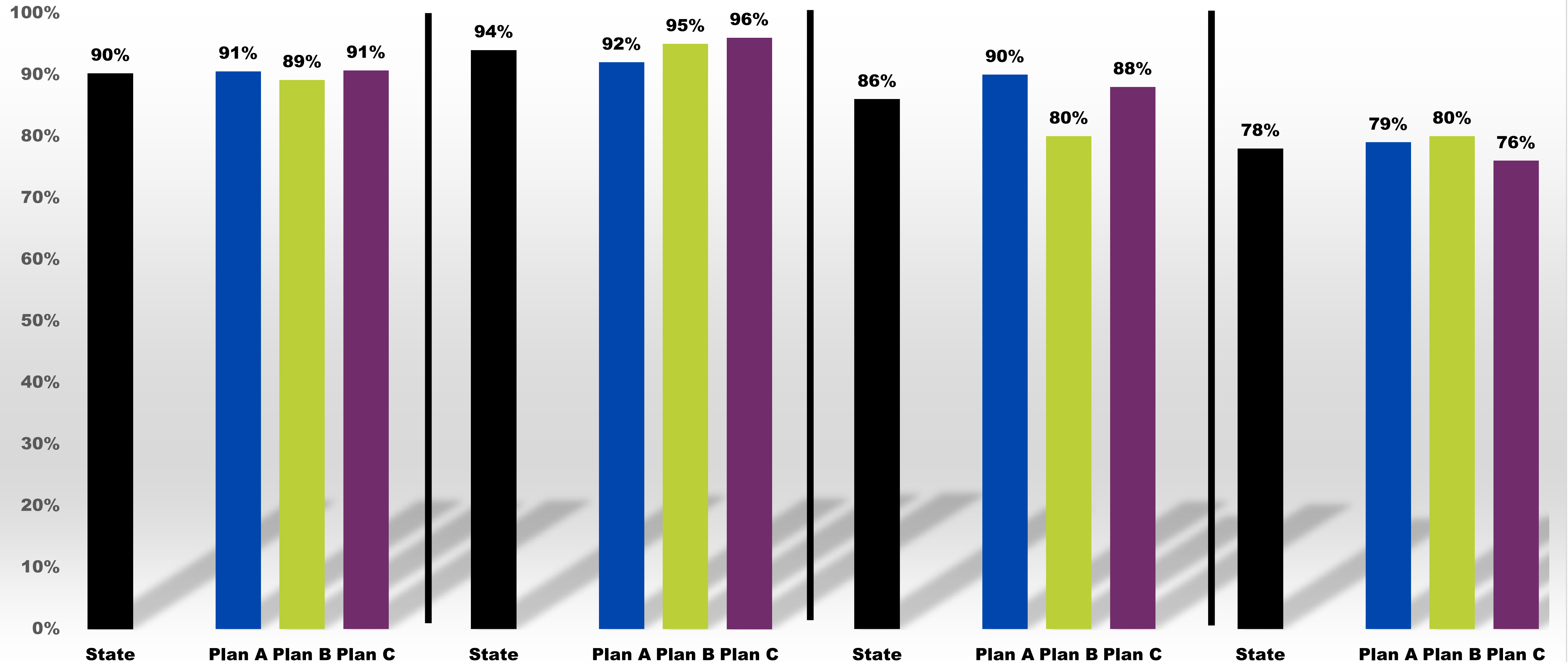
HCBS CAHPS Survey CY 2020

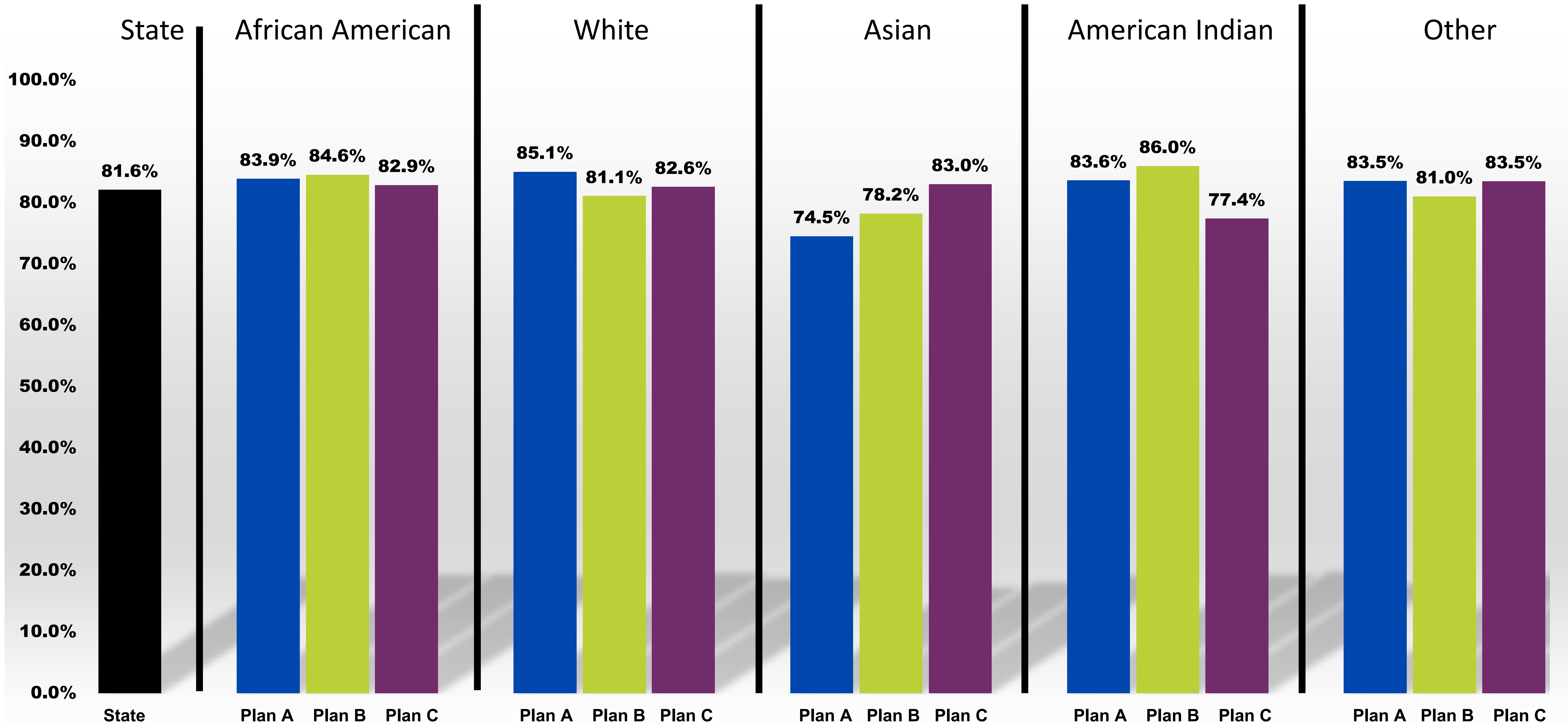
HCBS CAPHS Data – Service Coordinator and Service Choice



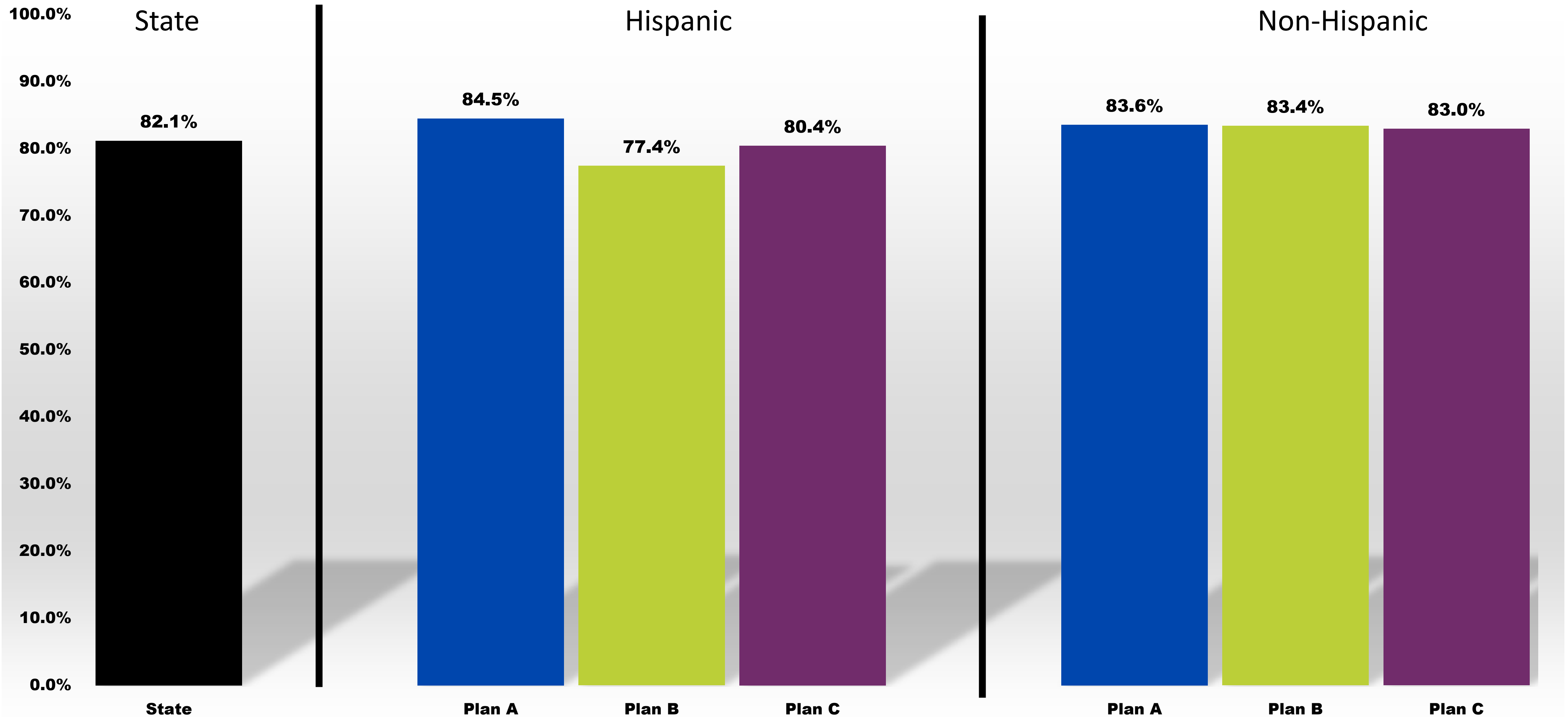
HCBS CAHPS – Participant Experience



HCBS CAPHS Data – Participant Overall Satisfaction by Race



HCBS CAPHS Data – Participant Overall Satisfaction by Ethnicity



Challenges

- LTSS HEDIS® measures
  - First year MCOs reported to NCQA
  - Difficulty capturing all data elements in assessment and update
  - Difficulty capturing all data elements in care plan and update
  - Challenges with sending care plans to PCP
  - Difficulty in notification of inpatient discharge
  - MCOs making internal care management information system changes and leveraging external health information exchange
- HCBS-CAHPS survey
  - Adequate sampling across multiple zones
  - Telephonic versus in-person interviews- Covid-19 challenges

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Future Directions

- Continue with LTSS HEDIS® measures and HCBS-CAHPS survey
- Evaluate results by region, race, and ethnicity
- Continue Health Plan CAHPS survey
- Consider additional CMS LTSS measures
- Calculate quality measures for physical and behavioral health services that combine Medicare and Medicaid data.

Laura E. Chaise
Vice President

Long Term Services and Supports and Medicare-Medicaid Plans
Centene

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Centene Overview

WHO WE ARE

Centene provides access to high-quality healthcare, innovative programs and a wide range of health solutions that help families and individuals get well, stay well, and be well.

PURPOSE Transforming the health of the community, one person at a time

71,800	#42	#7
EMPLOYEES	FORTUNE 500® (2020)	FORTUNE® Change the World (2019)

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BRAND PILLARS

Focus on the Individual Whole Health Active Local Involvement

WHAT WE DO

50 states

with government-sponsored healthcare programs

Centene successfully provides **high quality, whole health solutions for our diverse membership** by recognizing the significance of the many different cultures our members represent and by forming partnerships in communities that bridge social, ethnic and economic gaps.

24.6 million Managed Care Members

~400 Product / Market Solutions

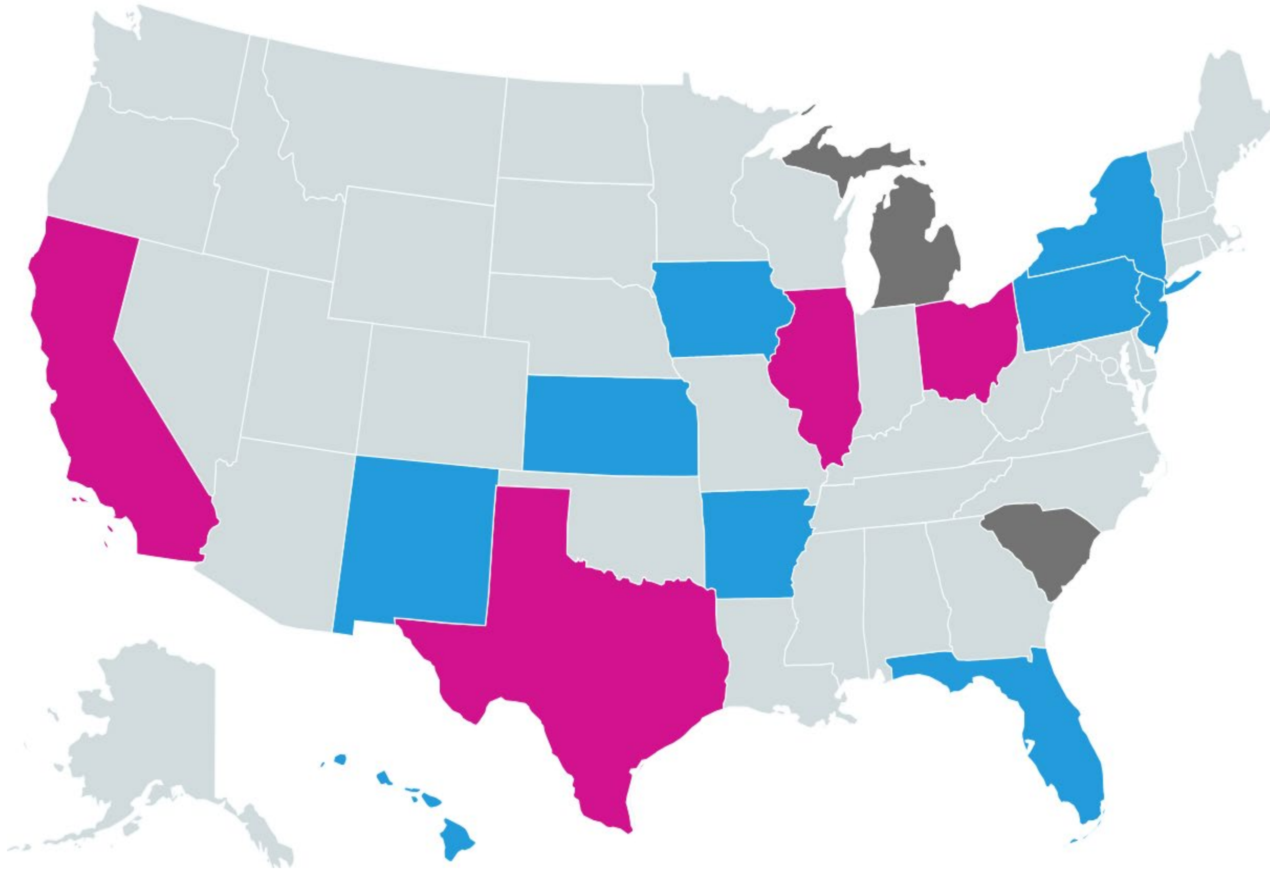
3 International Markets

$109.0B – 111.4B 2020 Projected Revenue*

**As of June 30, 2020.*

Centene is a national leader in LTSS

National footprint for Long-Term Services and Supports & Medicare-Medicaid Plans



414,000 members across 15 states, largest Managed LTSS & MMP membership in the country

Experience serving all populations: Duals & Non-Duals; Older Adults, Persons with Physical Disabilities, IDD, HIV/AIDS, Brain Injury, SPMI

Color Key: LTSS, LTSS & MMP, MMP

Plan considerations for national quality measurement

- Consumer and care manager impact
- Continuity with existing state measures and assessment/survey tools
- Alignment with other national quality programs (NCQA LTSS Distinction, LTSS HEDIS measures)
- Foundation for provider performance initiatives and value-based models
- Parity across plans and states (including Managed Care & FFS systems)
- Operational effort to report
- Data exchange challenges

Panel Discussion

Panel questions

/ **Why did you decide to invest in developing, reporting and using these measures?**

/ **What are the biggest challenges with collecting data or validating these measures?**

- How have you resolved them?
- What would help to overcome these challenges?

Panel questions

- **How are you using the results and what has been your experience so far?**
  - Quality monitoring?
  - Quality improvement?
  - Pay for performance/value-based payment?
  - Public reporting?
  - Program evaluation?
  - Other?

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Panel questions

- **Should CMS encourage or require states to collect data for these two sets of measures and report them to CMS?**
  - Pros
  - Cons
  - Concerns about public reporting
- **What comes next? Critical HCBS measure gaps?**
- **Most important driver of improved HCBS quality?**

Comments or Questions?

Mathematica