

# INNOVATIVE APPROACHES FOR MEASURING OUTCOMES FOR HCBS PARTICIPANTS

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TUESDAY, AUGUST 30<sup>TH</sup>

10:15-11:30

# SESSION OVERVIEW AND GOALS

## **Navigant – Setting the Stage (Why, What and How of measuring quality)**

### ***Tamyra Porter, Facilitator & James Bulot, Quality Overview***

- Discussion on Quality and Leading Thoughts on Measures for HCBS Programs and Populations
- Challenges with Data

## **JEN Associates – Using Claims and Encounter Data**

### ***Dee O’Conner***

- Which measures can we calculate using claims?
- Strategies to more effectively align incentives

## **Alabama Medicaid – Starting from Ground Zero**

### ***Drew Nelson***

- ICNs & Role of Quality Assurance Committee
- Adult Core Measures

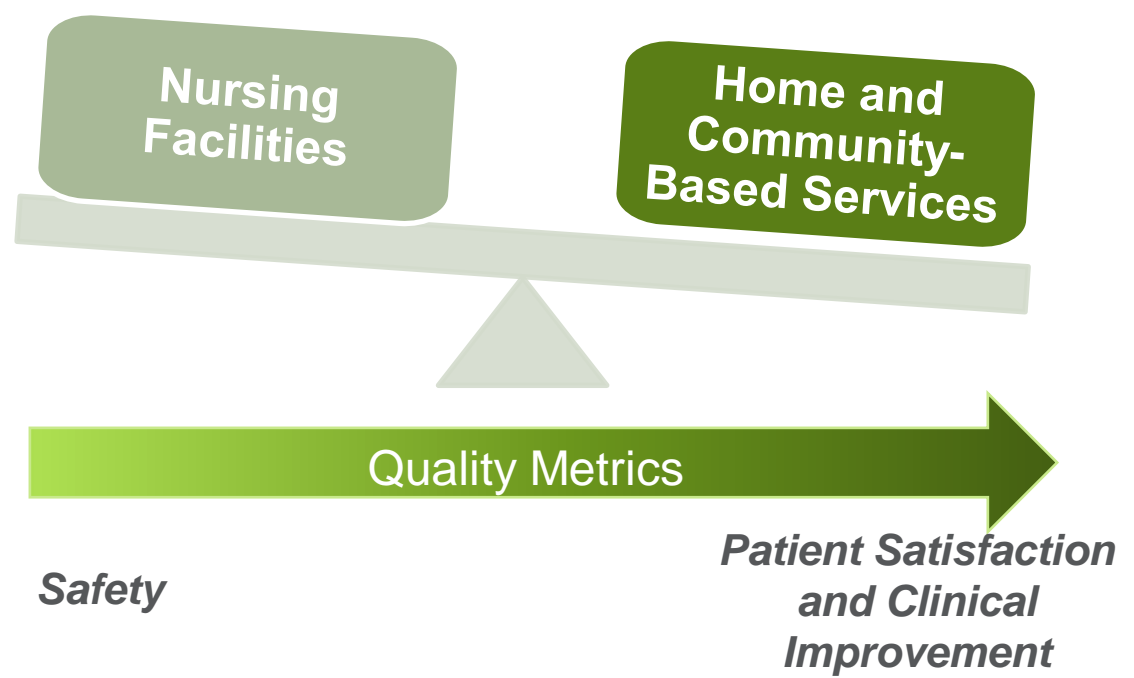
## **Connecticut – Lessons Learned and Best Practices**

### ***Kathy Bruni***

- Experience of care survey implementation

# REBALANCING EFFORTS REQUIRE A BROADER QUALITY FOCUS

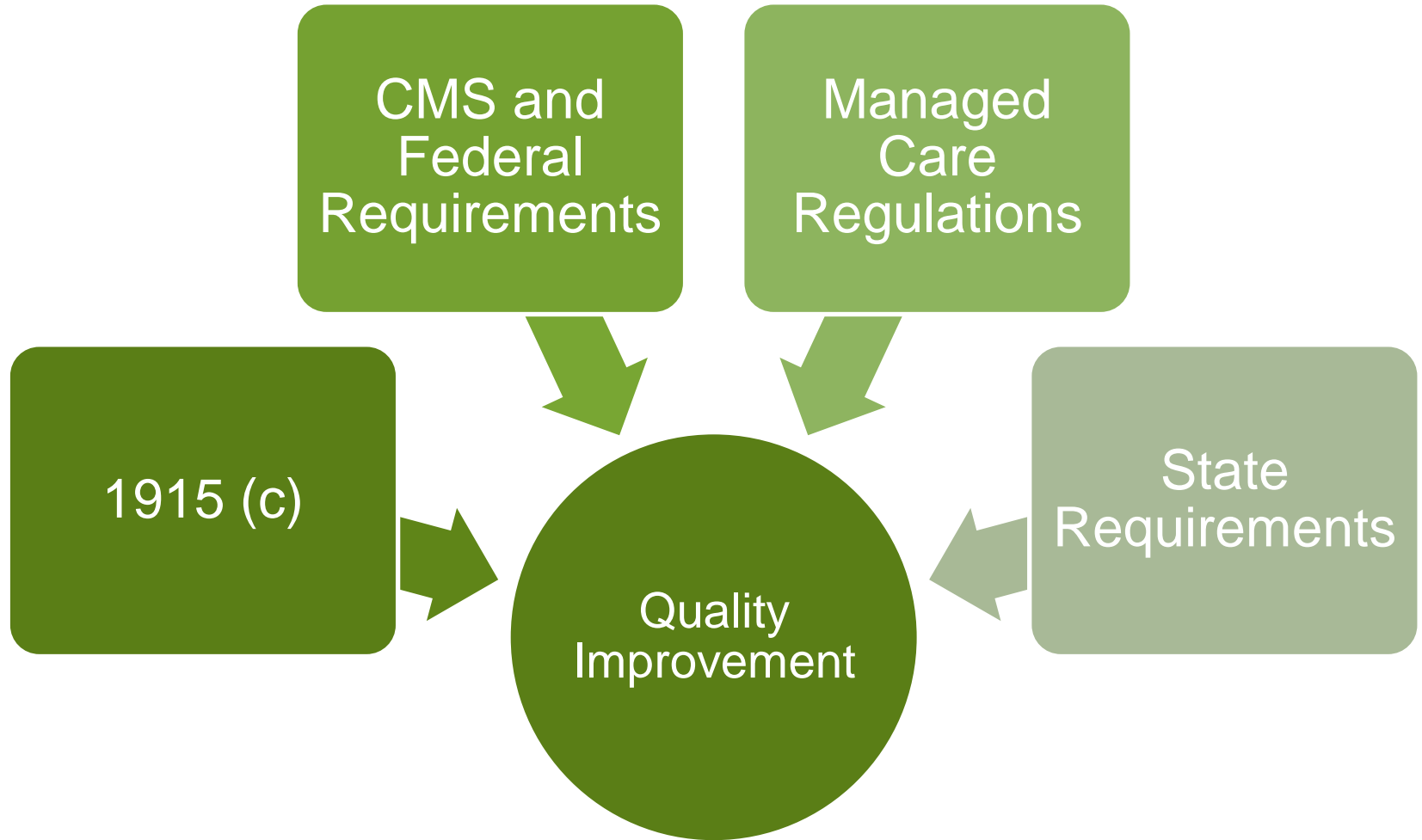
- Prior to rebalancing of the long-term care system, quality focused on nursing home safety and waiver assurances
- HCBS patients have same level of care needs as those previously in nursing homes
- As we shift more services, we will need to expand quality indicators to focus on areas such as:
  - Patient satisfaction
  - Clinical improvement
  - Access



# THE TRIPLE AIM AND GOALS OF CMS

Triple Aim	Goals
Better Care	<ul style="list-style-type: none"><li>• Patient Safety</li><li>• Quality</li><li>• Patient Experience</li></ul>
More Efficient Care (Reduce Per Capita Cost Through Improvements in Care)	<ul style="list-style-type: none"><li>• Reduce unnecessary and unjustified medical cost</li><li>• Reduce administrative cost thru process simplification</li></ul>
Improve Population Health	<ul style="list-style-type: none"><li>• Decrease health disparities</li><li>• Improve chronic care management and outcomes</li><li>• Improve community status</li></ul>

# WHY WE MEASURE QUALITY



# RECENT FEDERAL REQUIREMENTS

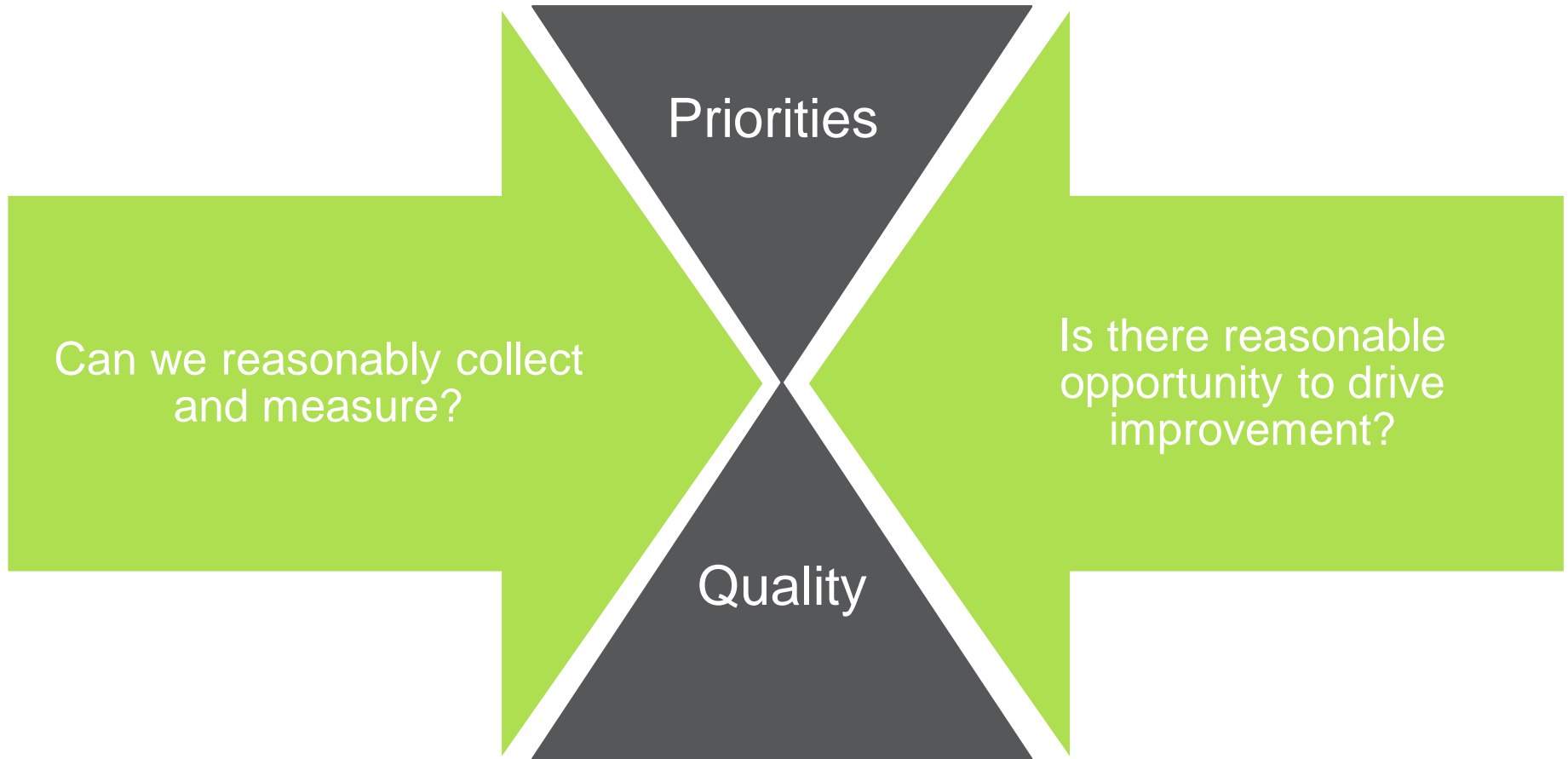
External Quality Review (2013)	<ul style="list-style-type: none"><li>• Incorporate LTSS within EQRO reviews for managed LTSS</li></ul>
HCBS Settings Rule (2014)	<ul style="list-style-type: none"><li>• Implement HCBS quality improvement strategy</li></ul>
Medicaid and CHIP Managed Care Rule (2016)	<ul style="list-style-type: none"><li>• Identify standard performance measures</li><li>• Review impact and effectiveness of quality assessment and performance improvement strategy</li><li>• Submit report to CMS</li><li>• <u>Align ???</u> with Medicare rules/quality reporting</li></ul>

# CMS QUALITY STRATEGY GOALS

The vision of the CMS Quality Strategy is to optimize health outcomes by improving quality and transforming the health care system. The CMS Quality Strategy goals reflect the six priorities set out in the National Quality Strategy:

Priority	Quality Measures
1	Make care safer by reducing harm caused in the delivery of care.
2	Strengthen person and family engagement as partners in their care.
3	Promote effective communication and coordination of care across the continuum.
4	Promote effective prevention and treatment of chronic disease.
5	Work with communities to promote best practices of healthy living.
6	Make care affordable.

# WHAT DO WE MEASURE?





# COMMON PAY-FOR-PERFORMANCE QUALITY MEASURES IN MLTSS

Level of Care Assessment Prior to Enrollment

Reporting of Critical Incidents within Timeframe

Plan of Care Established within 30 of Enrollment

Plans of Care Aligned with Member's needs based on Choice

Compliance with Contractual Provider Network Standards

Follow up with MH Professional when Hospitalized for Mental Illness

Complaint/Appeal/Grievance Reviews Completed in Timely Manner

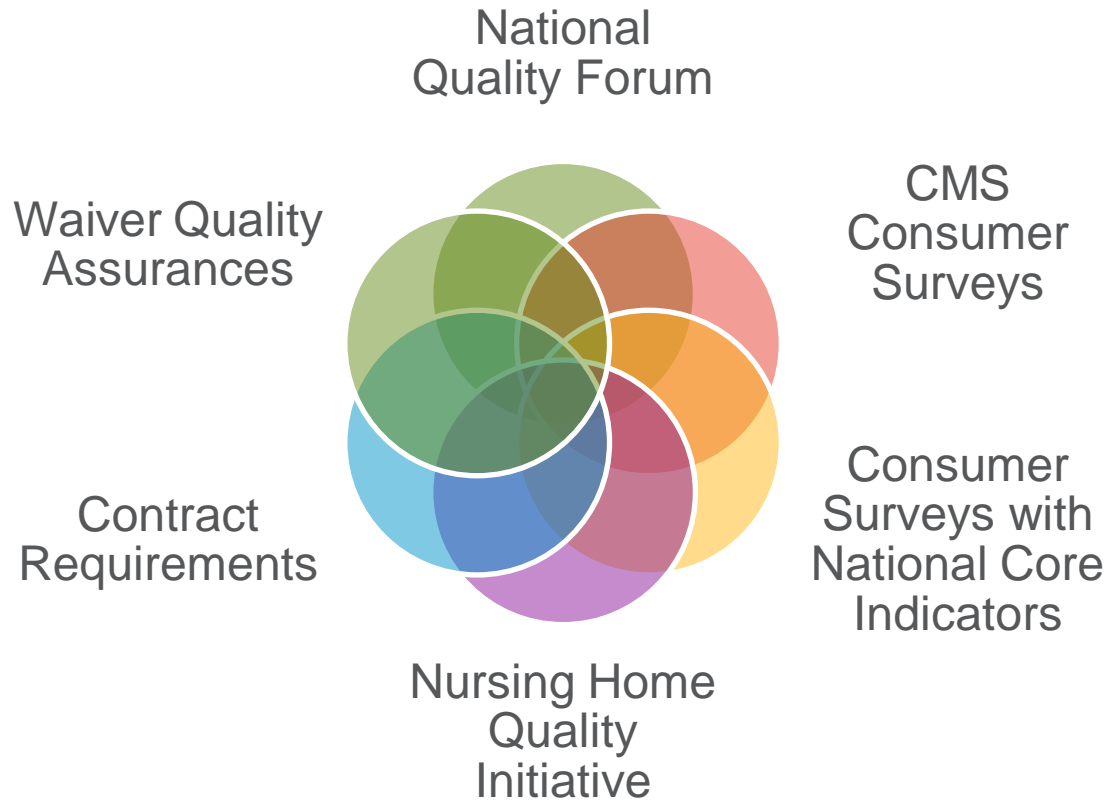
# of MLTSS Members Moving from Nursing Facilities to Community

MLTSS/HCBS Member Hospital Readmissions within 30 Days

Reporting Critical Incidence within Required Timeframe

Emergency Room Utilization by MLTSS HCBS Members

# VARIOUS NATIONAL EFFORTS TO DEFINE QUALITY METRICS



# NATIONAL QUALITY FORUM FRAMEWORK FOR HCBS

Choice and  
Control

Human/Legal  
Rights

Community  
Inclusion

Holistic Health  
and Functioning

Workforce

Caregiver  
Support

Person Centered  
Service Planning/  
Coordination

Service Delivery  
& Effectiveness

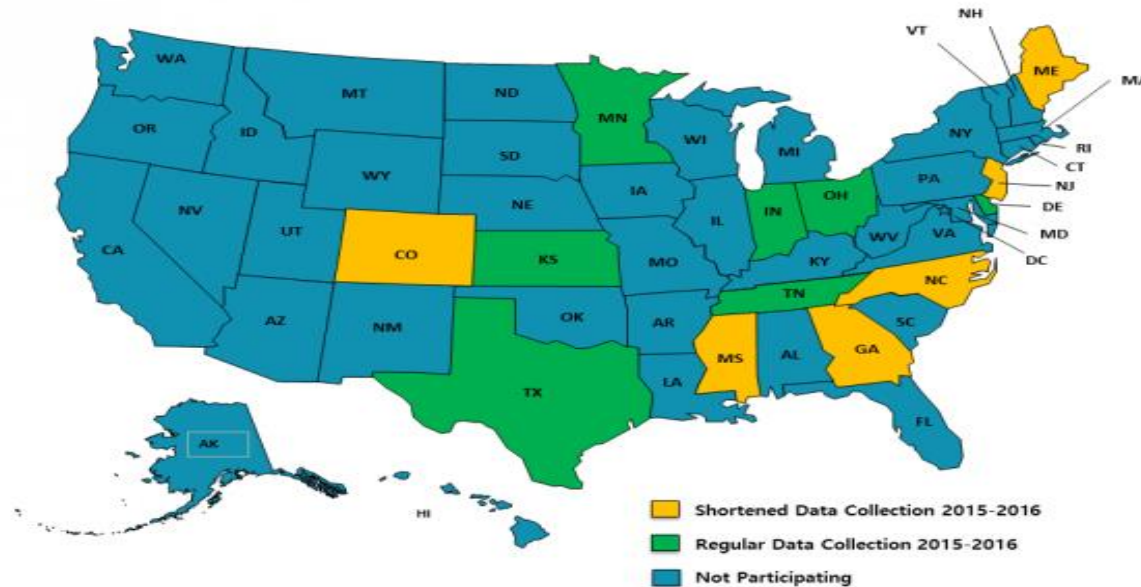
Equity

System  
Performance &  
Accountability

Consumer  
Leadership in  
System  
Development

# NATIONAL CORE INDICATORS-AGING AND DISABILITIES (NCI-AD)

- Goal is to collect and maintain valid and reliable data that give states a broad view of how publicly-funded services impact the quality of life and outcomes of service recipients
- Collaborative effort between NASUAD and Human Services Research Institute
- NCI-AD officially launched on June 1, 2015 with 13 participating states
  - Six states agreed to an expedited data collection cycle



# NCI-AD MEASURE DOMAINS

Demographic Characteristics of Respondents	Wellness
Community Participation	Medications
Choice and Decision Making	Rights and Respect
Relationships	Self-Direction of Care
Satisfaction	Work
Service Coordination	Everyday Living
Care Coordination	Affordability
Access	Planning for Future
Safety	Control
Health Care	

# NURSING HOME QUALITY INITIATIVE (NQHI)

Type	Quality Measures (Percent of)
Long Stay	<p>Percentage of residents whose need for help with activities of daily living has increased</p> <p>Percentage of residents whose ability to move independently worsened*</p> <p>Percentage of high risk residents with pressure ulcers (sores)</p> <p>Percentage of residents who have/had a catheter inserted and left in their bladder</p> <p>Percentage of residents who were physically restrained</p> <p>Percentage of residents with a urinary tract infection</p> <p>Percentage of residents who self-report moderate to severe pain</p> <p>Percentage of residents experiencing one or more falls with major injury</p> <p>Percentage of residents who received an antipsychotic medication</p>

# CONTINUOUS QUALITY IMPROVEMENT

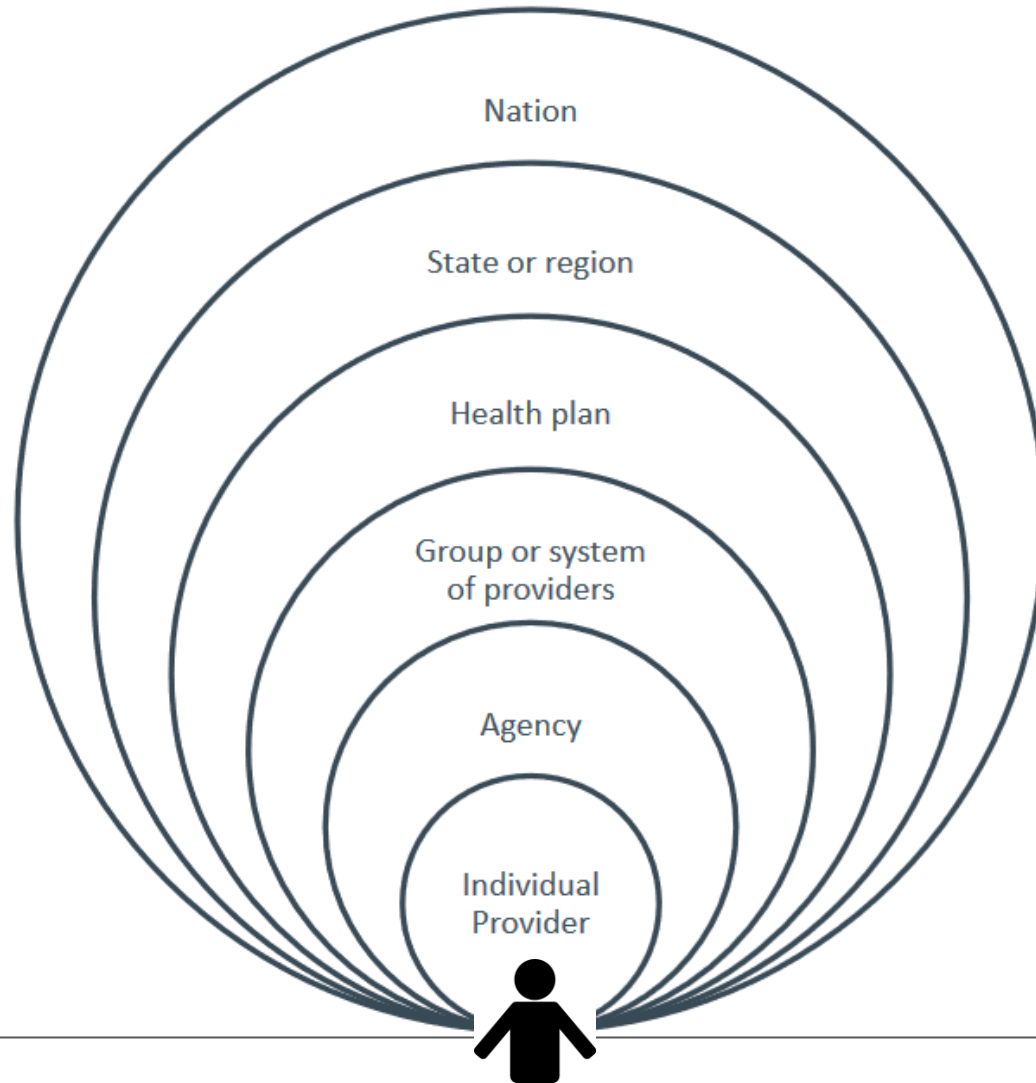
Medicaid HCBS programs should:

- Embrace continuous quality improvement approach
- Nurture a culture of quality improvement

States will need design and implement quality improvement strategies for measurement and quality improvement.



# CONTINUOUS QUALITY IMPROVEMENT



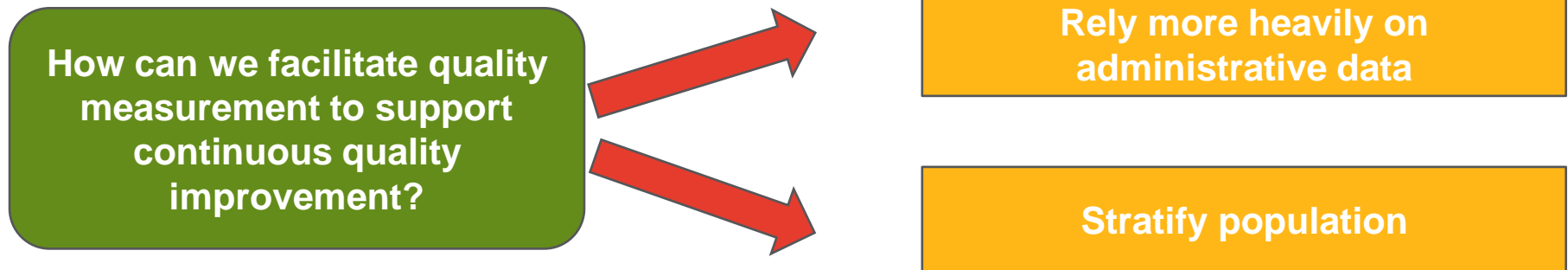


# CHALLENGES AND BARRIERS

- Lack of standardization
- Institutional bias and focus on quality
- Limited access to comprehensive data
- Misalignment of measures and reporting
- Administrative burden

# CHALLENGES AND BARRIERS (CONT.)

Limited “outcomes” measures since defining the outcome is challenging



# CONTACT INFORMATION

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# Using health claims to monitor quality across HCBS waivers



Dee O'Connor, PhD  
VP for Strategic Planning  
JEN Associates, Inc.  
August 30, 2016

# What this segment will cover

- Why use claims data?
- What quality measures are in claims data?
- What are limitations of using claims data?
- Examples: HCBS waiver monitoring using claims data
- Frailty-based risk adjustment
- New potential consolidated measure: **Healthy Days at Home**
- Questions / Discussion

# Why use claims data?

- Data available for all Medicaid enrollees (waiver & non-waiver)
- Consistent measures across waivers
- Can be risk adjusted based on level of need

# What quality metrics are in claims?

## Preventive/wellness services

- General practitioner visits
- Medical screening
- Follow-up after hospital
- Monitoring for chronic conditions, e.g.
  - Diabetes
  - Congestive heart failure
  - Depression/mental illness
- Well child visits

## Hospitalization rates

- All-cause admission rates
- Emergency dept. visits
- Potentially avoidable admits, e.g.,
  - asthma/COPD
  - diabetes,
  - hypertension,
  - pressure ulcers,
  - UTIs
- Re-hospitalizations within 7 and 30 days

# Ways of adjusting claims analysis

- Frequency of service use  
(e.g. care management, medication adherence)
- Acuity (HCC, case mix scores)
- Frailty scoring (chronic conditions, ADLs/IADLs, specialized risk algorithms)



# Limitations of using claims data

- Primary focus is medical services
- Most services are outside scope of waiver
- Billing lags delay reporting
- Medicare & Medicaid data needed for dually eligible enrollees
- Significant resources needed for analysis

# Claims-based HCBS waiver monitoring (illustrations from a single state)

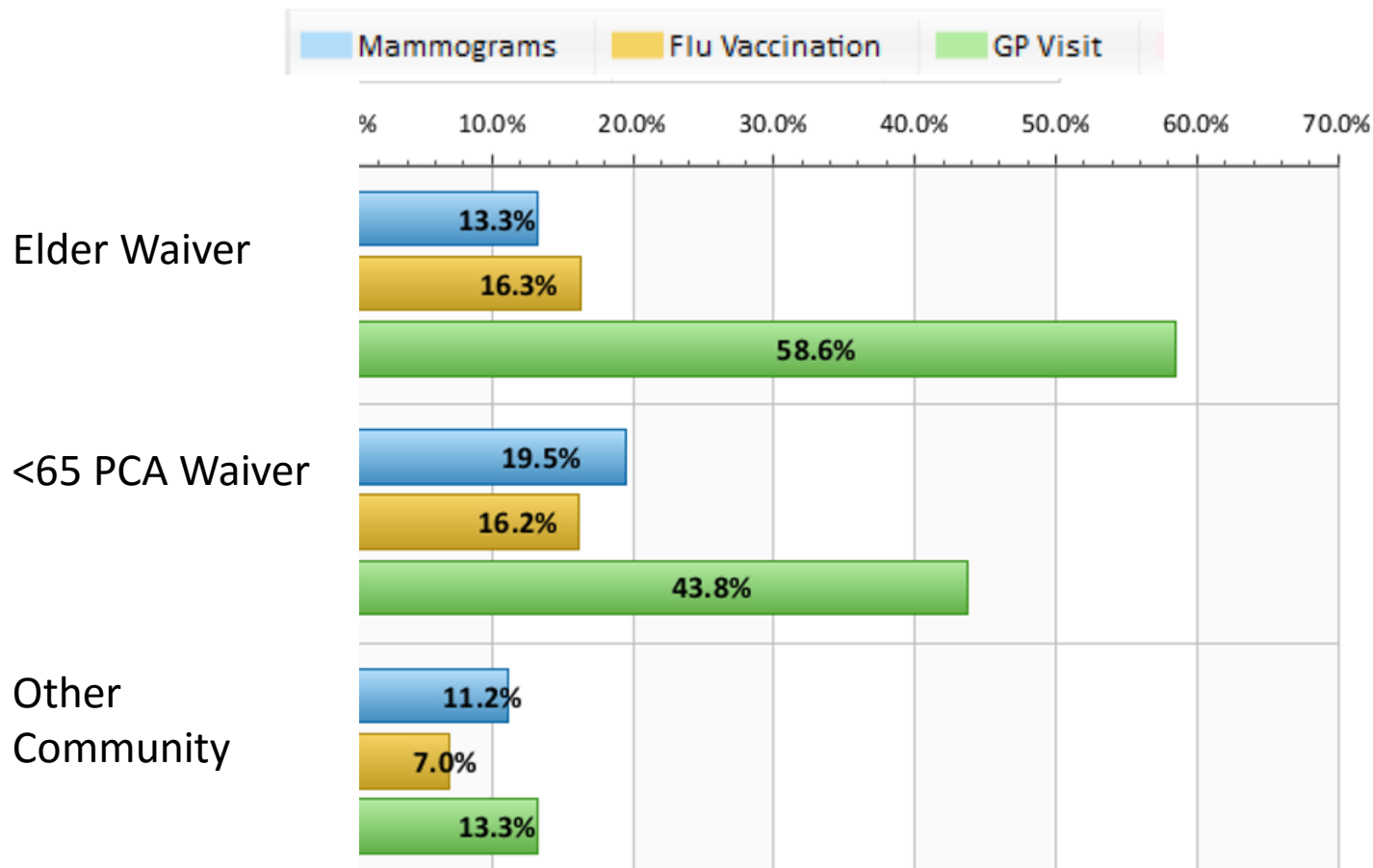
- Health-related preventive services
- Hospital admissions and emergency department visits per person
- Potentially avoidable hospitalizations
- Disease-specific monitoring—e.g. diabetes

## Note:

These charts are for illustration only. The Waiver groups are limited to those who only qualify for Medicaid due to the HCBS financial rules.

# Health-Related Preventive Services

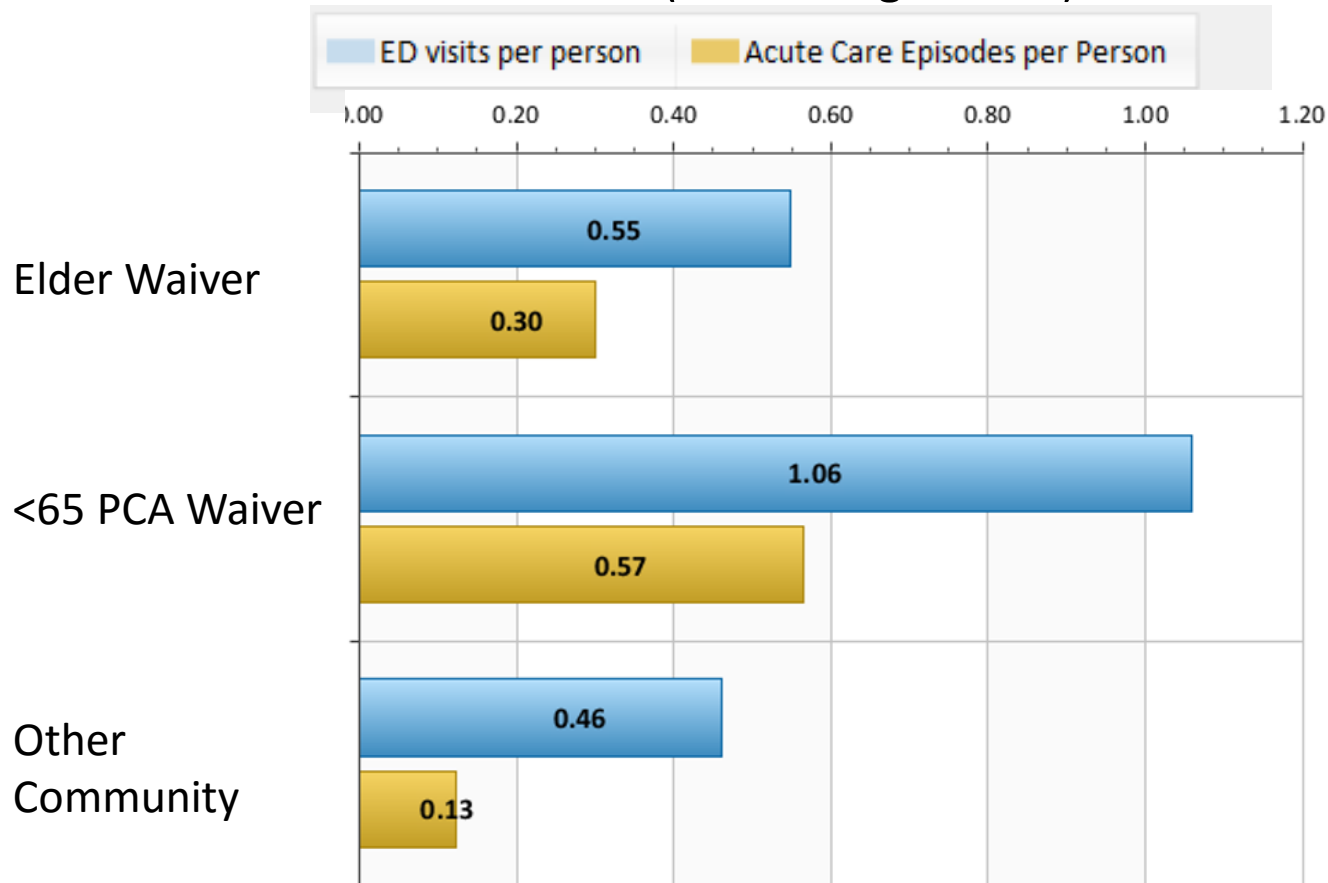
(2015--single state)



Waiver enrollees had better rates of preventive services than the other community population

# Hospital admissions and ED Visits

(2015--single state)

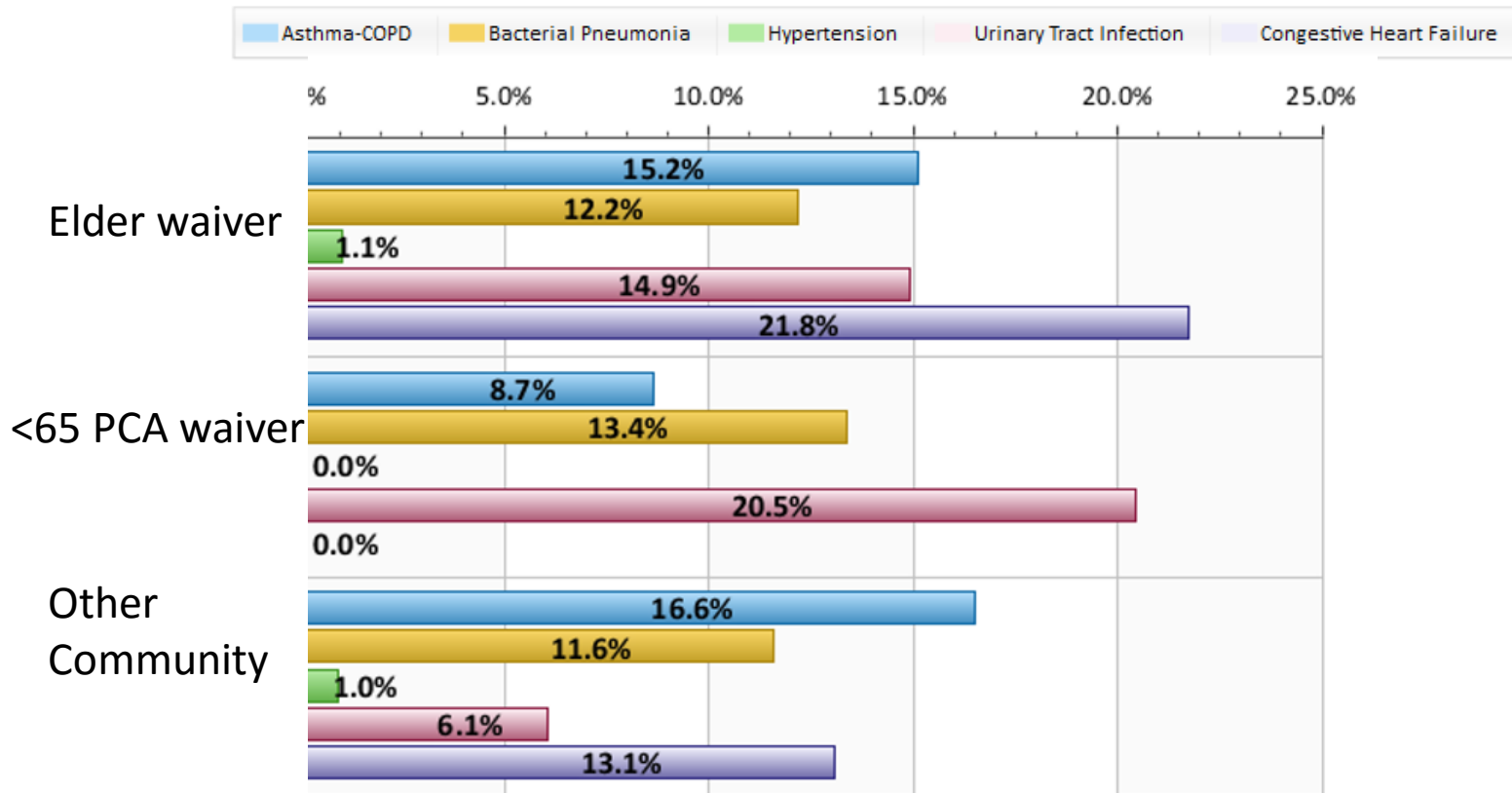


Both waiver groups had higher rates of ED visits and hospital admits compared with other community enrollees.

PCA waiver enrollees had almost twice the rate of elder waiver enrollees.

# Potentially Avoidable Hospitalizations

## % of population (2015--single state)

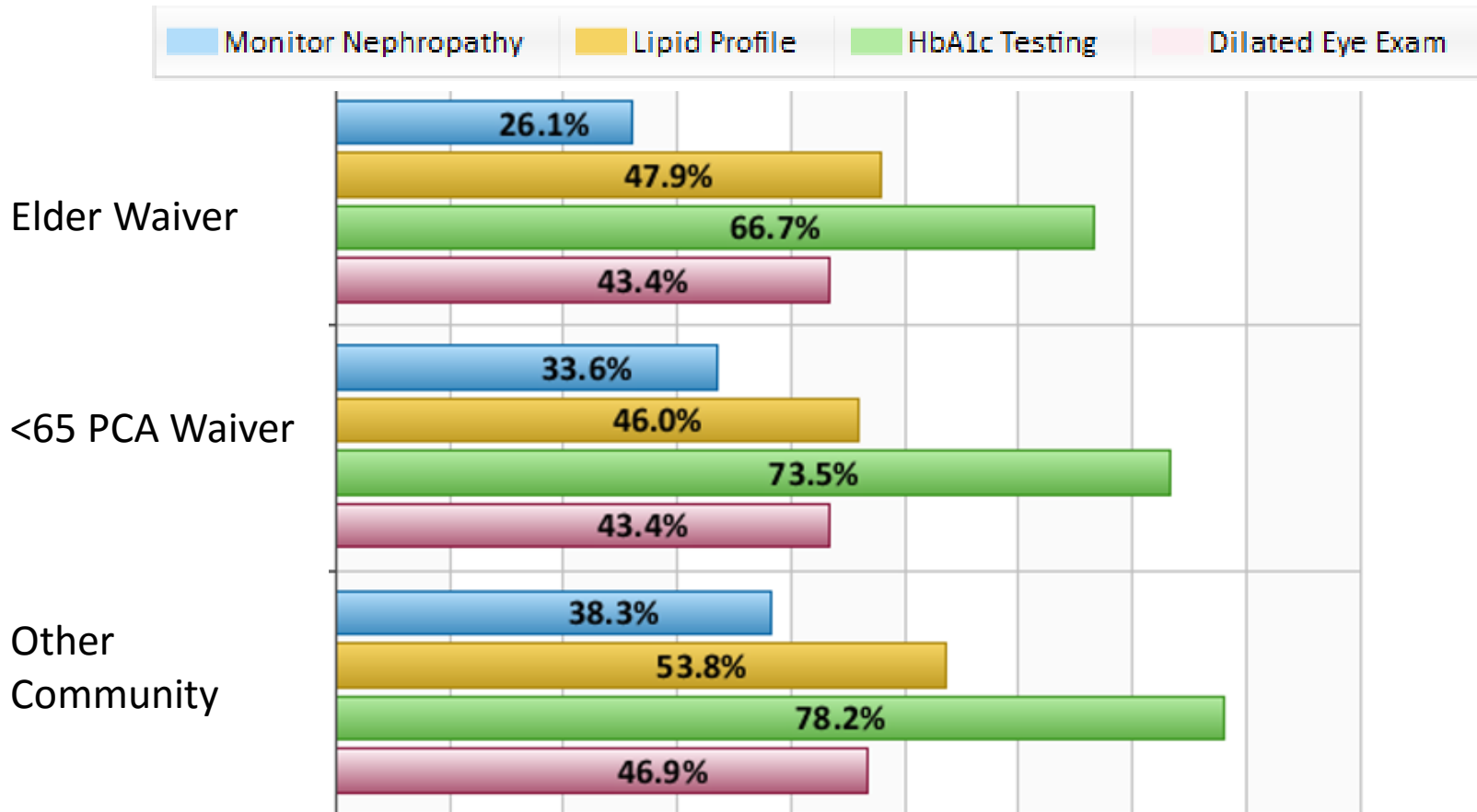


Both waivers had lower admits for Asthma/COPD than other community.

Elder waiver enrollees had highest rates of CHF admits.

PCA waiver enrollees had highest rates for bacterial pneumonia and UTIs.

# Diabetes—% of persons with diabetes meeting HEDIS benchmarks (2015--single state)



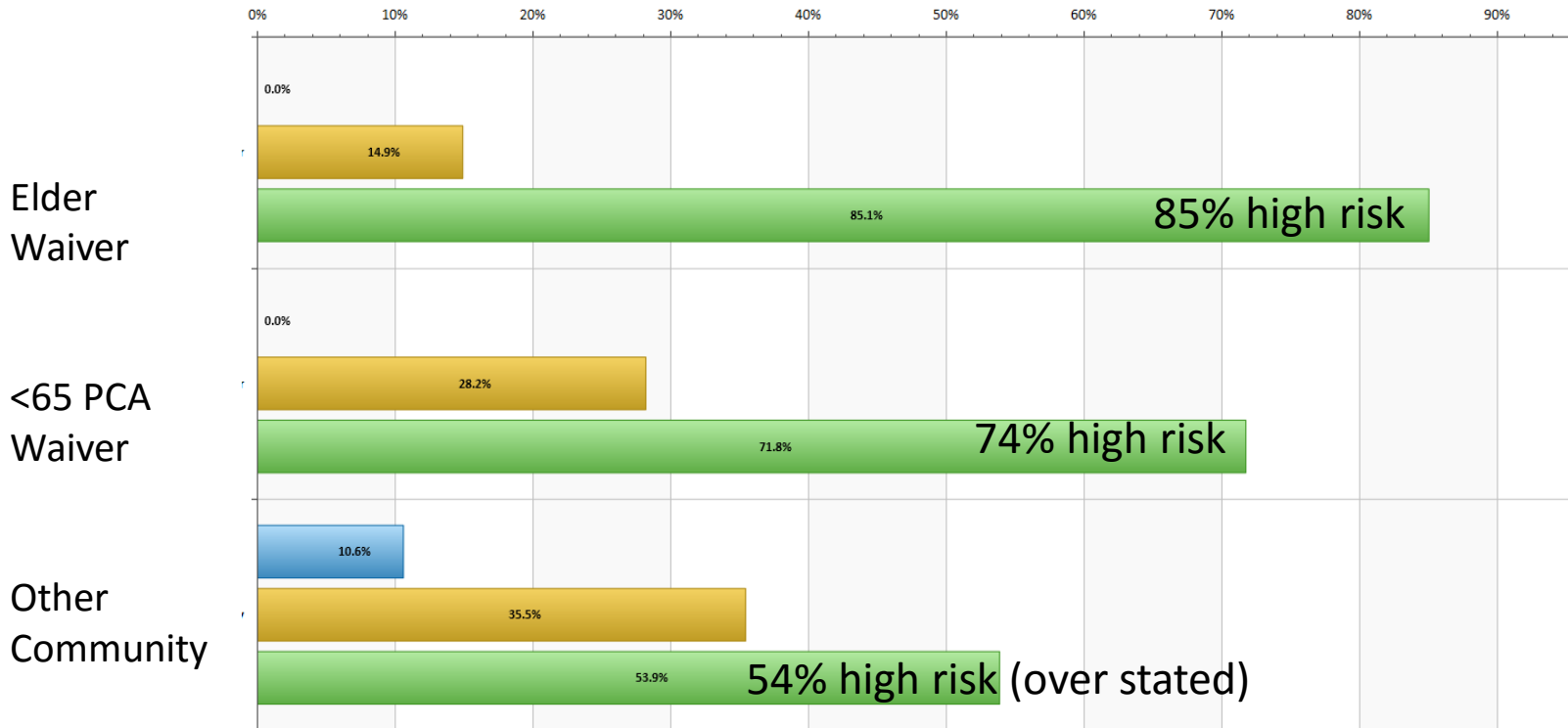
The other community population had the highest rate of diabetes monitoring  
Elders with diabetes had the most room for improvement

# Risk adjusting based on frailty

- Typical risk adjustment approaches are medically focused (HCC, CDPS, Charlson)
- ADL & IADL needs are a key risk indicator for waiver enrollees (but are only assessed for those with service needs)
- The JEN Frailty Index uses claims to risk-adjust based on impairment-related diagnoses

# Community Population by Frailty

(illustration, 2015--single state)

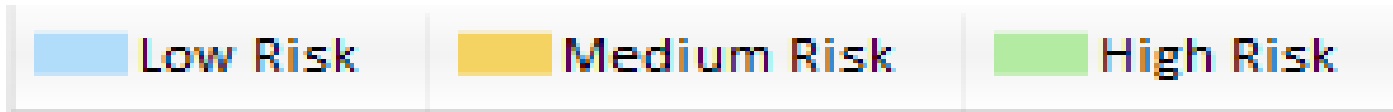


Note: The Other Community group overstates risk because waiver eligibility status only reflects those who qualify for Medicaid due to HCBS waiver financial rules.



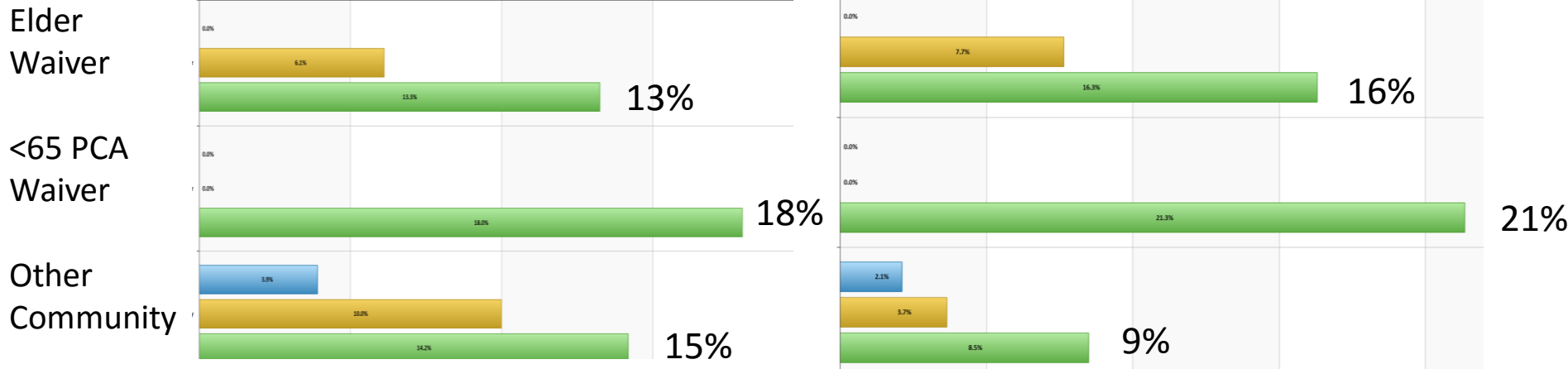
# Risk-adjusted Hospitalization Rates

(illustration, 2015--single state)



Bacterial Pneumonia

Urinary Tract Infection



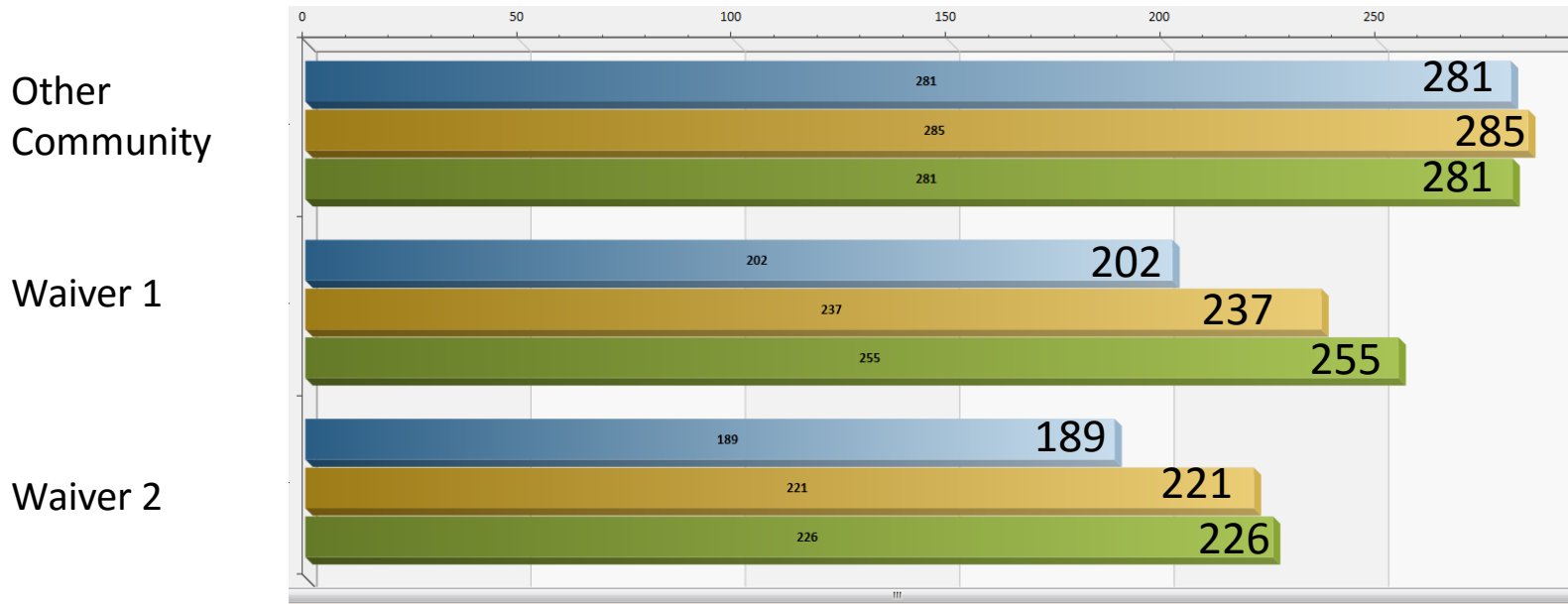
Note: Other community group overstates risk because waiver eligibility status only reflects those who qualify for Medicaid due to HCBS waiver.

# Healthy Days at Home

- Goal: find a common metric that can be applied to all waivers
- Metric should be consistent with the goals of keeping people **healthy and at home**
- Potential for measurability across all waivers (as well as other community populations)
- HD@H =  
Total days – (hospital + NF days) – (unhealthy days at home)

# Healthy Days at Home

(for example only)



Although the sample shows that waiver participants may have fewer Healthy Days at Home, the waivers show more progress from years 1-3.

# Creating Comparison Populations

- Potential sources for comparison
  - Non-waiver population with similar characteristics
  - Waiver population in another region or state
  - Medicare 5% sample
- Match 1:1 or 1:10 (depending on population size)
- Direct matching (e.g. age, gender, race)
- Propensity matching (e.g., chronic conditions, mental health/substance use, service use)

# Summary

- Claims data can supplement other measures of quality for HCBS waivers
- Claims provide opportunity for comparison across waivers and non-waiver populations
- Claims can reveal opportunities for improved coordination between waiver staff and other health providers
- Non-claim based measures are at least as important and potentially more important for measuring effectiveness of HCBS.

# For more information, please contact:

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SEE THE DATA  SHAPE THE FUTURE  
jen.com

# Alabama ICN Program

Drew Nelson, MPH  
Epidemiologist

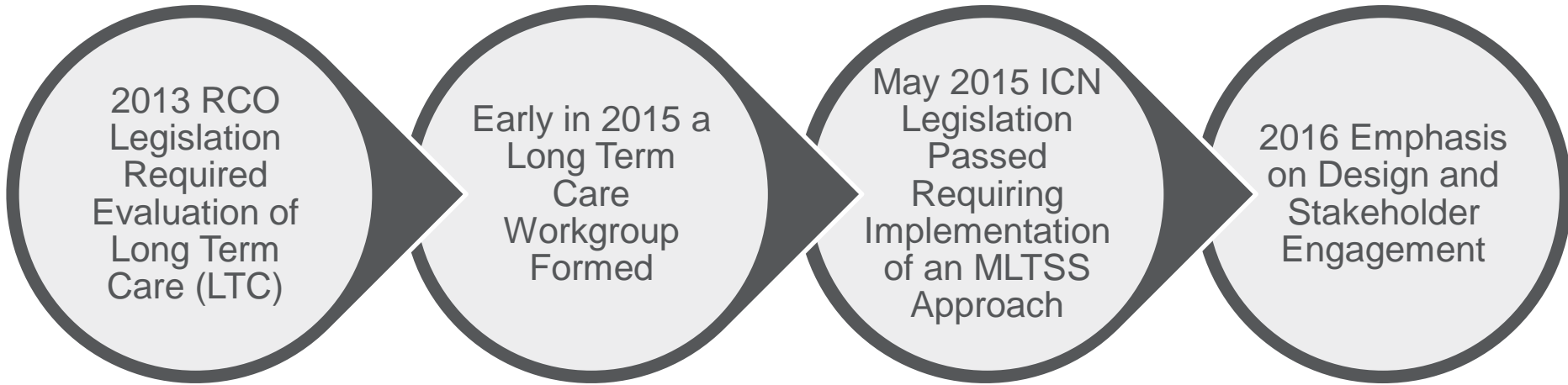
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# ICN PROGRAM OVERVIEW



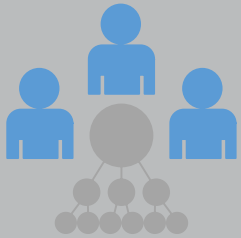




## ICN PROGRAM OVERVIEW (CONT.)



Shifts the financial risk from taxpayers to private investors through risk-based contracting for coverage for certain elderly and disabled populations



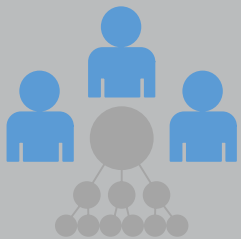
Establishes Integrated Care Networks (ICNs) led by Governing and Advisory boards



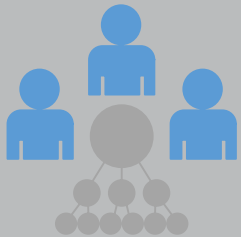
Gives Medicaid the authority and flexibility to set standards and oversee implementation



## LEGISLATION AND QUALITY



The Medicaid Agency shall create a quality assurance committee appointed by the Medicaid Commissioner to review the care rendered through the integrated care network. The members of the committee shall serve two-year terms. The Medicaid Agency shall promulgate a rule establishing the membership and criteria to serve on the quality assurance committee.



Establish by rule the quality standards and minimum service delivery network requirements for an integrated care network to provide care to Medicaid beneficiaries.

Establish by rule and implement quality assurance provisions for an integrated care network



## LEGISLATION AND QUALITY

- The Medicaid Agency shall continuously evaluate the outcome and quality measures adopted by the committee pursuant to this section.
- The Medicaid Agency shall utilize available data systems for reporting outcome and quality measures adopted by the committee and take actions to eliminate any redundant reporting or reporting of limited value.
- The Medicaid Agency shall publish the information collected under this section at aggregate levels that do not disclose information otherwise protected by law. The information published shall report all of the following: (1) Quality measures. (2) Costs. (3) Outcomes.



## LESSONS LEARNED FROM OTHER REFORMS

- The Medicaid Agency utilized a CMS Adult Core Measures grant developed a Quality Analytics unit giving the State experience in reporting on quality measures and access to technical assistance from CMS.
- Know the environment and the availability and types of data in your system.
  - Collaborations with other state agencies is critical.
- Don't be afraid to push the limits in driving the conversation in moving to value-based purchasing and more robust quality reporting.
- Work with leadership to ensure they are bought into data-driven decision-making and evaluation.

# USE OF THE EXPERIENCE OF CARE SURVEY IN WAIVER QUALITY MANAGEMENT

- Kathy Bruni, MPA,  
LCSW
- CT Department of  
Social Services
- Director of  
Community Options  
Unit

# CT WAIVER STRUCTURE

**11 Medicaid waivers**

**7 Operated directly by Medicaid agency**

**3 Operated by the DD agency**

**1 operated by Mental Health Agency**

**Two HCBS State Plan Options**

- 1915i effective 2012
- 1915k effective 2015

# PERFORMANCE MEASURES IN WAIVERS

Inconsistent approach across waivers

“Reinventing the wheel”

Performance measures in Waivers varied

Evidence collection for CMS always challenging

Goal is a consistent approach to reward quality and facilitate reporting





# WAIVER CASE MANAGEMENT STRUCTURE

For Elder, Disabled and Brain Injury Waivers, case management is a contracted service with contractors in 5 different regions in the state

Quality varied among these providers

Difficult to compare one provider with another

EoC offers that opportunity



# 2013 CASE MANAGEMENT CONTRACT

Added performance bonus incentives to the contracts in 2013

Pool is divided by the number of performance standards

Pool total available is \$500,000

4 Performance incentives tied to EoC in the contracts

- Access to Care

- Having Choice and Control over assistance received

- Being treated with respect and dignity

- Feeling included in the community



# EOC COMPOSITES

Composites have changed since contracts were written

Decisions yet to be made regarding new composites and incentive payments

State will decide whether to use individual questions or groups of questions that comprise the composite


Focus likely to be on experiences with staff, case managers, personal safety and respect and choosing services

Use Round 2 to establish baseline and reward those who improve



# ROUND 1 DATA

## Composite Measures Modified to:


- Getting Needed Services From Staff
  - How Well Staff Communicate and Treat You
  - Care Management
  - Choosing Your Services
  - Transportation
  - Personal Safety
  - Community Inclusion and Empowerment
- 

# AREAS OF CONCERN

Mental Health Waiver below national average in the following:

- Staff come to work on time
- Someone tells you if staff can't come
- Staff Treat you the way you want them to

Acquired Brain Injury Waivers below national average in the following:

- Staff are nice and polite
  - Staff treat you the way you want them to
  - Person centered service plan included all of the things that are important
  - Choosing your services
- 

# AREAS OF CONCERN

Elder Waiver findings below national average in the following areas:

- Transportation
- Personal Safety
- Staff Come to Work on time
- Someone Tells you if Staff Cannot Come
- Can Do Things in The Community

# CONNECTICUT STRENGTHS

Elder Waiver responses exceeded the national average in the following areas:

- Getting needed care
- Staff come to work on time
- Someone tells you if a staff member can't come
- Staff are respectful and treat the participant the way they expect to be treated
- Person Centered Service Plan reflects what is important
- Can get together with family/friends
- Takes part in deciding what to do with their time

# CONNECTICUT STRENGTHS

Acquired Brain Injury Waivers exceeded the national average in the following areas:

- Transportation
- Politeness of Homemaker staff
- Taking part in deciding what to do with their time



# NEXT STEPS

Round 2 Data will set baseline for performance measures and drive unit QA activities

QA Team will utilize survey data to identify need for remediation activities

Areas of Remediation could be:

- Related to direct service providers
- Care Management contractors
- Training on Person Centered Planning and Client Choice of Providers
- Evaluation of Our Transportation Systems

# OTHER QA/QI DATA SOURCES

For the Elder Waiver the primary goal is to prevent or delay unnecessary institutionalization of frail elders.

How do we know how well we are doing with that?

How do we know if programmatic changes have the desired impact?




# COLLABORATION WITH UNIVERSITY OF CT CENTER ON AGING

In 2010, utilizing funds under the Money Follows the person Demonstration the research set out to answer the question: What are the unmet needs and associated service gaps for individuals who transition to nursing homes?

Study had 3 components:

- 1) review of CHCPE administrative data for a retrospective cohort of CHCPE clients,
- 2) review of care manager notes for a 15% subsample of the retrospective cohort, and
- 3) focus groups with access agency care managers to address broader aspects of systems gaps leading to nursing home admission.

# STUDY RECOMMENDATIONS

1. Add PCA services
  2. Expand Adult Day Programs and Adult Family Living
  3. Flexible Home Care Provider
  4. Mental Health and Substance Abuse Services and Training
  5. Transportation
  6. Care Manager Training
  7. Coordination With Hospital and Nursing Home Discharge Planning
- 

# WHAT CHANGES WERE MADE

7/1/2010- PCA service including live in was added

4/1/13 –Amendment added Adult Family Living

7/1/15 – Care Transitions, Bill Payer, Chronic Disease Self Management and Recovery Assistant Services were added to the program

We continually evaluate the effectiveness of the services including our survey data, info from providers, family members and waiver participants



# DISCONTINUANCE DATA

Percent of program discharges that were discharges due to nursing home placement:

SFY 2012- 45.14%

SFY 2013 - 41.19%

SFY 2014 - 41.26%

SFY 2015 - 39.13%

SFY 2016 -37.73%



# QUESTIONS???

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