ICRC | Integrated Care Resource Center

New MLTSS Assessment and Care Planning Quality Measures: Implementation Issues for States and Integrated Care Plans

March 26, 2019

12:00-1:00 Eastern

The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services' Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica Policy Research and the Center for Health Care Strategies.

Introductions and Speakers

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MLTSS Quality Measures: Context for States

- Developed and tested by Mathematica and NCQA under a CMS contract to fill the gap in LTSS measures that are specified for health plan reporting.
- First nationally standardized MLTSS measures that will allow states to compare plan performance in these areas within a state, and across states.
- CMS does not require states to use these measures; it is optional. If states want to use these measures, they can require (via their contracts with MLTSS plans and/or D-SNPs) that plans report them to the state.
- Four of the measures are also included in HEDIS starting in 2019; starting in 2020, NCQA will begin publishing plan ratings on these measures.

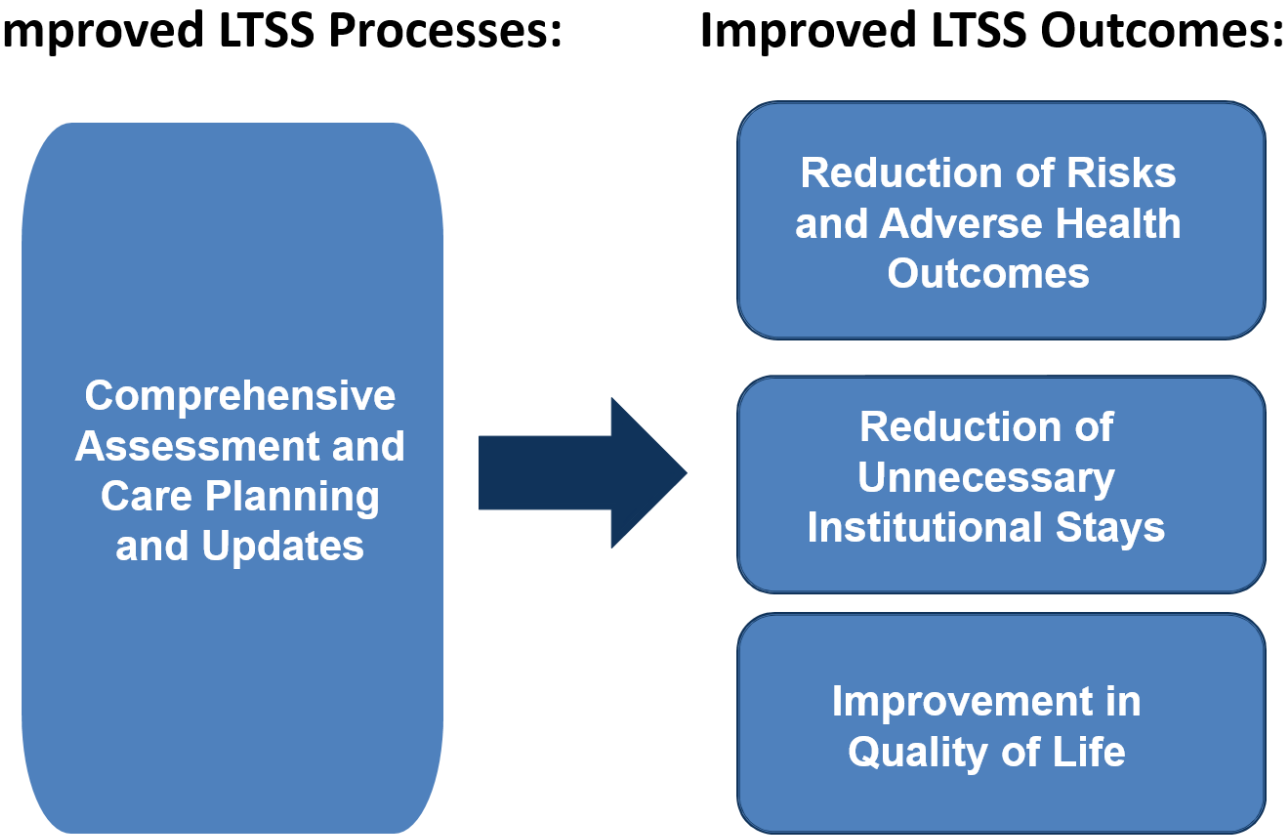
Agenda

- Describe new measures to compare the quality of member assessment and care planning conducted by MLTSS plans
- Understand differences between MLTSS quality measures and related measures for Medicare Advantage (MA) plans and Medicare-Medicaid Plan (MMPs)
- Examine data collection and validation challenges faced by health plans, and present strategies to overcome them
- Discuss considerations for states deciding whether and how to use these measures

Importance and Definitions of the MLTSS Assessment and Care Planning Quality Measures

Debra J. Lipson, Senior Fellow
Mathematica Policy Research

Assessment and Care Planning Are Key to Improving LTSS Outcomes



State MLTSS Contract Requirements Related to Assessment and Care Plans

- State contracts with MLTSS plans generally require them to conduct assessments and create care plans:
  - For new enrollees, within a specified timeframe after enrollment
  - For continuing enrollees, updated annually
- However, state contracts do not always specify the content of the assessments or care plans, hindering states' ability to determine if they are done well
- State-specific measures do not allow for cross-state comparisons

Measure #1: LTSS Comprehensive Assessment and Update

The percentage of MLTSS plan members, 18 years of age and older, who have documentation of an in-home, **comprehensive assessment covering core elements**, within 90 days of enrollment or annually.

Rate 1: Nine Core elements

Rate 2: Nine Core elements + at least 12 supplemental elements

Nine Core Elements of Comprehensive Assessment

- Activities of daily living (ADLs)
- Cognitive function
- Living arrangement
- Current medications
- Mental health status
- Availability of friend/family caregiver support
- Acute and chronic conditions
- Home safety risk
- Current provider

FAQs: LTSS Comprehensive Assessment and Update

Does the assessment have to take place in the home?

Yes. A face-to-face discussion in the member's home is required for the measure unless certain exceptions are met.

What if a member refuses an assessment?

Plans must document any member refusals. Documented refusals will be excluded from the denominator.

What if a member could not be reached?

Members who cannot be reached after three documented attempts to be contacted will be excluded from the denominator.

Measure #2: LTSS Comprehensive Care Plan and Update

The percentage of MLTSS plan members, 18 years of age and older, who have documentation of a **comprehensive LTSS care plan, covering core elements**, within 120 days of enrollment or annually with documentation of caregiver involvement and beneficiary consent.

Rate 1: Nine Core elements

Rate 2: Nine Core elements + at least 4 supplemental elements

Nine Core Elements of Comprehensive Care Plan

- Member's goal(s)
- Plan for medical needs
- Plan for functional needs
- Plan for cognitive needs
- List of all LTSS needs
- Follow-up & communication
- Emergency need plan
- Caregiver involvement
- Member agreement to plan

FAQs: LTSS Comprehensive Care Plan and Update

Does the comprehensive care plan have to be completed in the home?

No, but it must be done face-to-face (with certain exceptions).

Is documentation of "no change" in status acceptable?

No. Documentation of "no change" in the care plan is not acceptable for inclusion in the numerator.

What if there are multiple care plans during the measurement period?

Required elements will be extracted from the most recently updated care plan.

What if a member refuses a care plan?

Plans must document any member refusals. Documented refusals will be excluded from the denominator.

What if a member could not be reached?

Members who cannot be reached after three documented attempts to be contacted will be excluded from the denominator.

Measure #3: LTSS Shared Care Plan with Primary Care Practitioner

The percentage of MLTSS plan members, 18 years of age and older, with a comprehensive care plan that was transmitted to their primary care practitioner (PCP) or other documented medical care practitioner identified by the plan member within 30 days of its development.

Evidence of a Transmitted Care Plan

- Who the plan was submitted to
- A copy of the transmitted care plan or plan sections
- Date of transmittal
- The entire care plan does not need to be transmitted – only the most relevant parts

FAQs: LTSS Shared Care Plan with Primary Care Practitioner

Does the care plan need to meet the criteria of a comprehensive care plan outlined in LTSS Comprehensive Care Plan and Update?

Yes.

Why is the care plan shared with a primary care practitioner (PCP)?

The care plan is shared with a PCP to promote coordination of medical and LTSS services. If the member identifies someone other than a PCP as their primary contact for medical care, that practitioner can be substituted.

How does sharing LTSS care plans with PCPs promote coordinated care?

Even if MLTSS plans do not provide or cover primary care for the member, sharing LTSS care plans with PCPs makes it possible to coordinate medical services and LTSS.

Measure #4: LTSS Reassessment/Care Plan Update After Inpatient Discharge

The percentage of inpatient discharges of MLTSS plan members, 18 years of age and older, resulting in updates to the assessment and care plan within 30 days of discharge.

Rate 1: Reassessment after inpatient discharge

Rate 2: Reassessment and care plan update after inpatient discharge

Elements

- Nine Core Elements of Comprehensive Assessment
- Nine Core Elements of Comprehensive Care Plan

FAQs: LTSS Reassessment/Care Plan Update After Inpatient Discharge

Does this include planned hospital admissions?

No, planned admissions are excluded, and identified using Value Sets for specific diagnosis, procedure, and type of bill codes.

Does the re-assessment need to meet certain criteria?

Yes, the re-assessment must include nine specified core elements and be done face-to-face (with certain exceptions).

Does the care plan update need to meet certain criteria?

Yes, the care plan must include nine specified core elements and be done face-to-face (with certain exceptions).

What if the MLTSS plan member does not receive medical benefits through the MLTSS plan?

Discharges for members who do not receive plan MLTSS benefits are excluded from the measure.

Measure #5: Falls Risk Reduction

Part 1: Falls Screening

The percentage of MLTSS plan members, 18 years of age and older, who have documentation of screening for history of falls and/or problems with balance or gait.

Part 2: Falls Risk Assessment and Plan of Care

The percentage of MLTSS plan members 18 years of age and older with a documented *history* of falls (at least two falls or one fall with injury in the past year), who have documentation of: (1) a falls risk assessment; and (2) plan of care to prevent future falls.

Rate 1: Falls Risk Screening	History of falls or balance/gait assessment
Rate 2: Risk Assessment and Plan of Care for Falls	Balance/gait assessment AND one other assessment Exercise therapy or referral to exercise

FAQs: Falls Risk Reduction

What is the difference between a screening (Part 1) and a risk assessment (Part 2)?

Part 1, falls screening evaluates whether a MLTSS plan member has had a history of falls and/or problems with balance or gait.

Part 2, falls risk assessment includes a balance/gait assessment AND one other assessment component, and should only be performed for members with a documented history of at least 2 falls or one fall with injury in the past year.

Is a specific screening tool required for this measure?

No. Examples of validated screening tools that can be used include the Morse Fall Scale and timed Get-Up-And-Go test.

Are there any exclusions from the measure denominators?

Yes, for Part 1 (screening for a history of falls), exclude plan members who are not ambulatory. For Part 2, Rates 1 & 2 (assessment and plan of care), exclude members who refused an assessment and/or a plan of care, and report the number who refused either one with the measure rates.

HEDIS Status

- **Four (of five) assessment and care planning measures are now included in HEDIS 2019**
  - http://store.ncqa.org/index.php/catalog/product/view/id/3419/s/hedis-2019-technical-specifications-for-ltss-organizations-epub/
  - For questions about HEDIS measures, contact NCQA at: https://my.ncqa.org/
- **The measures in HEDIS 2019 are for measurement year 2018**
  - Reporting the measures for years prior to 2018 is not recommended
- **First year (2018) HEDIS reported measures are for display and analysis, not reporting**
  - NCQA will compare plan scores, identify anomalies and examine potential reasons for inconsistencies
  - NCQA may revise or clarify measure specifications to help plans report measures accurately
- **Plan-level LTSS falls risk reduction (5th) measure will be submitted to NQF as part of measure maintenance for the related physician-level measure (NQF #0101) in late 2019**

Additional Resources

- Technical specifications and additional information about MLTSS in general can be found at:

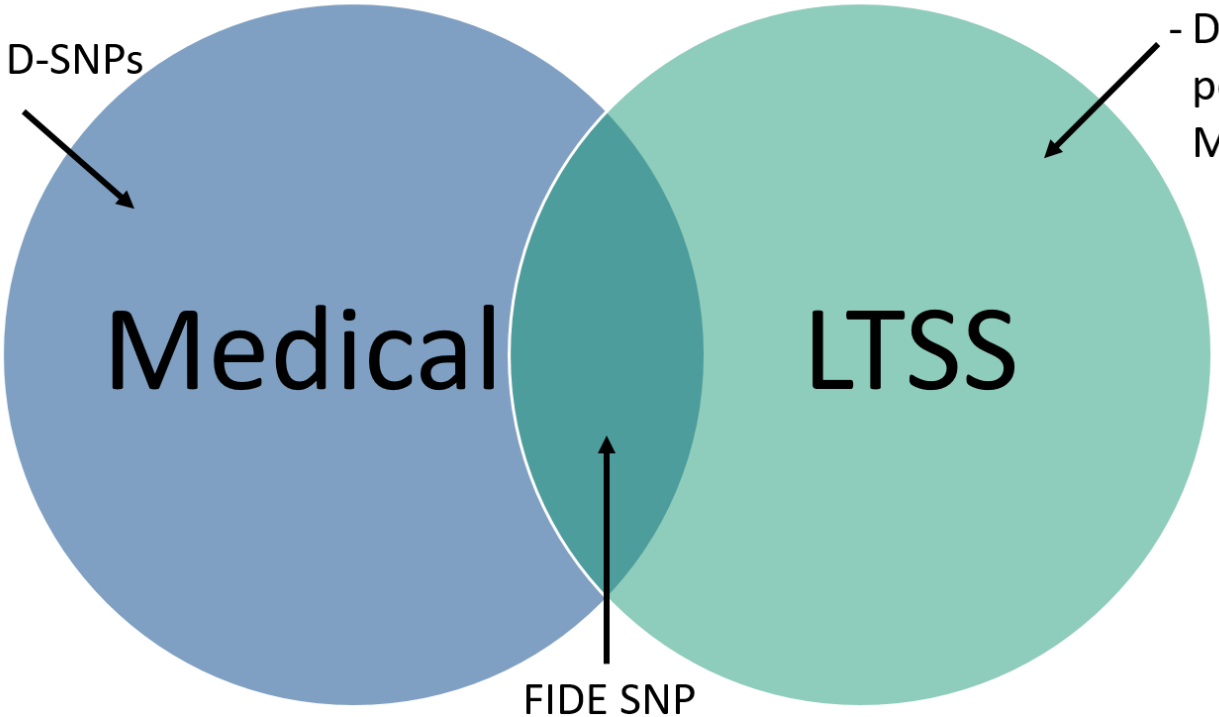
  https://www.medicaid.gov/medicaid/managed-care/ltss/index.html

- Need help? States and their health plan contractors may send questions to: MLTSSMeasures@cms.hhs.gov

Comparing Related Measures for Medicare Advantage and Integrated Medicare-Medicaid Plans

Erin Giovannetti, Senior Research Scientist
National Committee for Quality Assurance (NCQA)

Eligible Population Based on Benefits



MA plans
Non-integrated D-SNPs

- MLTSS standalone
- Dual eligible population in MLTSS plans

FIDE SNP
MMP
Aligned SNP/MLTSS
Some MLTSS plans for Medicaid only
PACE

Assessment – What, Who, Where, How Often, Exclusions

MA/SNP/MMP	MLTSS	MMP
• SNP Care Management: Members whose plan did an assessment of their health needs and risks with in 90 days of enrollment and annually • Care for Older Adults - Functional Status Assessment • Care for Older Adults - Pain Assessment • Care for Older Adults - Medication Review	• Members who have documentation of an in-home, comprehensive assessment covering core/supplemental elements, within 90 days of enrollment and updated annually	• 2.1 Members with an assessment completed within 90 days of enrollment • 2.2 Members with an assessment completed • 2.3 Members with an annual reassessment

Care Plan – What, Who, Where, How Often, Exclusions

MA/SNP/MMP	MLTSS	MMP
• Care for Older Adults - Advance Care Plan	• Members who have documentation of a comprehensive LTSS care plan, covering core/supplemental elements, within 120 days of enrollment, and updated annually • Members with a care plan that was transmitted to their primary care practitioner (PCP) or other documented medical care practitioner within 30 days of its development	• 3.2 Members with (an initial) care plan completed within 90 days of enrollment

Coordination across Transfers – Shared Accountability

MA/SNP/MMP	MLTSS	MMP
• Transition of Care ▪ Notification of admission ▪ Receipt of Discharge Information ▪ Patient Engagement After Discharge ▪ Medication Reconciliation	• The percentage of inpatient discharges of MLTSS plan members resulting in updates to the assessment and care plan within 30 days of discharge. *Only for integrated plans	• *Members discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary care provider or other health care professional designated for follow-up care. (Retired)*

Fall Prevention

MA/SNP/MMP	MLTSS	MMP
• Falls Risk Management: Collected through Health Outcomes Survey ▪ Did your provider ask about falls? ▪ Did your provider recommend exercise to prevent falls or problems with balance?	• Screening to identify individuals at risk of falls • Assessment of specific fall risks among individuals at risk for falls • Plan of care to prevent future falls that includes exercise	

CMS MLTSS vs. HEDIS

- Measures specifications are completely harmonized*
- HEDIS measures are also specified for Community Based Organizations
- HEDIS measures will be audited for reporting in 2020

**Slight difference in timing of updates may cause small differences*

Aiming for Alignment – What Can States and Health Plans Do?

- Examine assessment and care plan standardized tools and aim for tools which meet measurement criteria
- Adopt and promote standard data elements for documenting assessment and care plan components electronically
- Adopt and promote real-time sharing of information between health plans, facilities and clinicians

Help CMS and NCQA to Better Align

- CMS MLTSS Measures Technical Assistance
  MLTSSMeasures@cms.hhs.gov
- NCQA State Quality Solutions
  publicpolicy@ncqa.org
- HEDIS Allowable Adjustments
  https://my.ncqa.org
- NCQA LTSS Learning Collaborative
  ltsslearningcollaborative@ncqa.org

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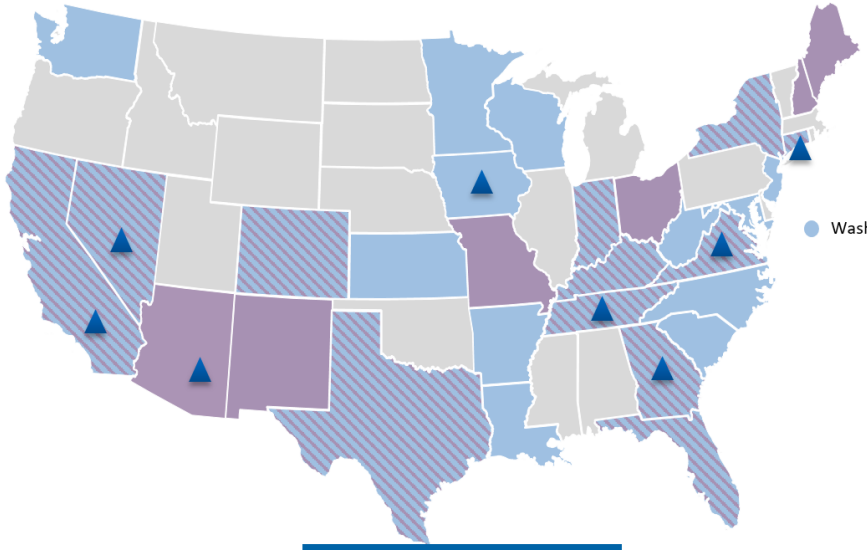
Health Plan Use of MLTSS Measures: Data Collection, Measure Validation and Quality Improvement Issues

March 26, 2019

Government Business Division



$48.3B
OPERATING REVENUE

9.6M
MEDICAL MEMBERS

Four lines of business

Medicaid	Medicare	CareMore
(24 states + DC)	(21 states)	(8 states)

Federal Government Solutions

- Federal Employee Program (FEP)
- National Government Services (CMS Medicare Administrative Contractor)
- WellPoint Military Care

*CareMore Health Plan membership is included with Medicare / functional management of the program is within DBG.

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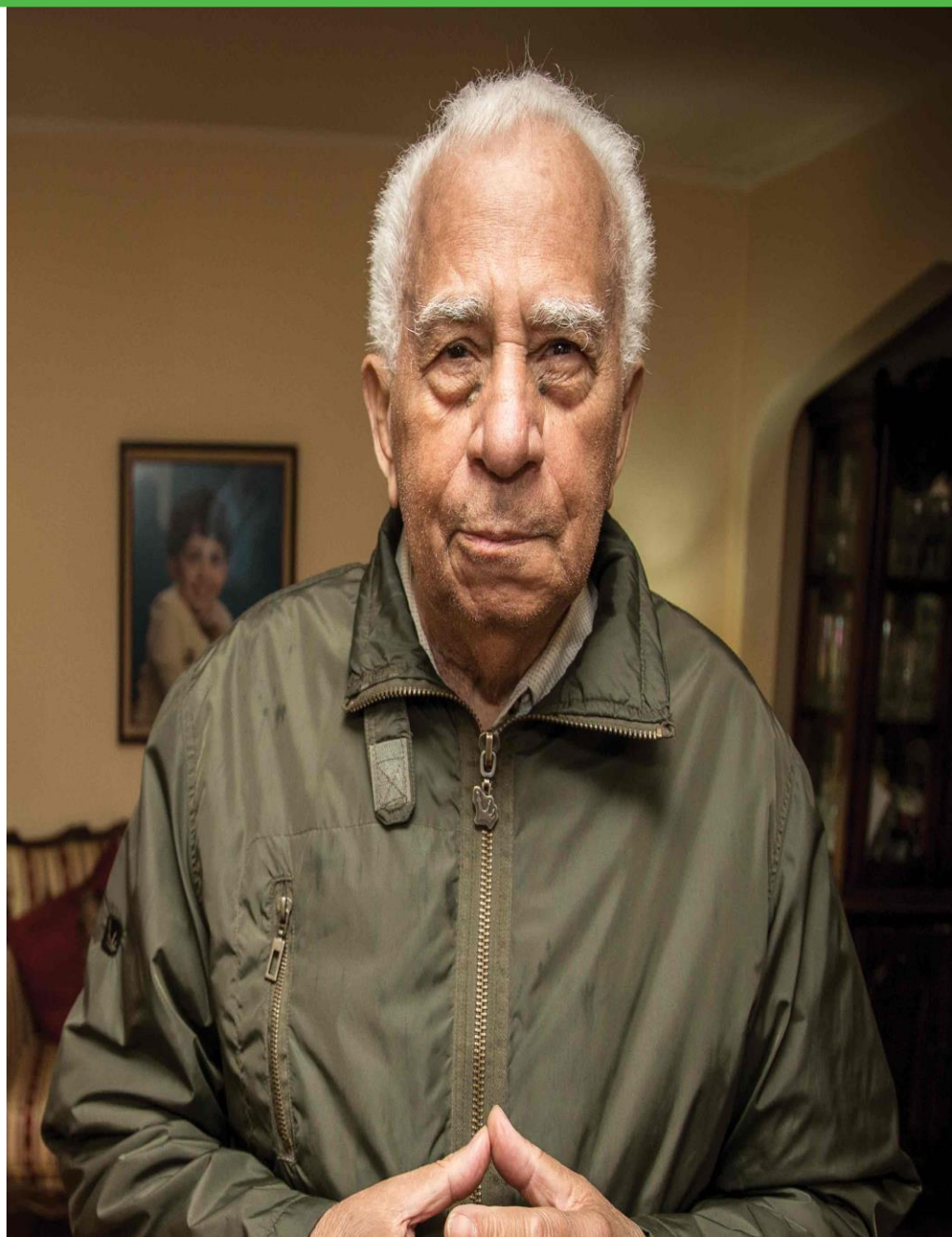
2007 Initial launch TANF, ABD/SSI and Medicare
- Medicaid membership ~360K
- Statewide, 95 counties

2010 LTSS (CHOICES) program launched
- CHOICES membership ~8000
- 90+% are dual eligible

2016 Participated as a beta test health plan for measurement development

2017 Early adopter and one of the 1st health plans in the nation to be awarded LTSS distinction by NCQA

2018 Renewal of LTSS distinction; next survey 2021



Lessons Learned: Data Collection Challenges

Data Collection Challenges	• Additional data capture fields were needed • Lack of uniform data location • Provider Engagement and understanding of the program is limited • Enrollment process and eligibility is shared with State partner
Solutions	• Leverage specific “note types”, pull-down lists, check list functionality • Establish an ongoing feedback loop to correct data errors and omissions in near “real-time” • Participate in NCQA Learning Collaboratives or volunteer to test measures • Involve all stakeholders (IT, analytics, operations and quality) • Create a “cross-walk” of data element location, system and data dictionary

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Lessons Learned: Validation Challenges

State or EQRO Validation Challenges	• Knowledge of the measure is limited • New data source: Data is 100% from Case Management documentation systems vs claims • Limited internal knowledge within LTSS Teams of HEDIS and the audit/validation rigor needed • Varying degrees of quality assurance processes and structures (i.e. Understanding of sampling methodology) • Current HEDIS Certified Vendors do not have the measure developed or a defined audit process to validate their rates, even if they can produce
Solutions	• Leverage existing audit programs, such as HEDIS and Performance Improvement Validation tools • Leverage current case management audit processes and expand to cover LTSS HEDIS data capture oversight • Initiate discussions between your EQRO and State partner to establish a working set of knowledge and common understanding • Participate in NCQA Learning Collaboratives or volunteer to test measures • Leverage national tools and educational resource, such as National Association of Healthcare Quality or your EQRO

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Quality Improvement: Use Cases

Workload Reduction

- Performance improvement projects
- LTSS distinction-report metrics “in-lieu” of standard documentation-proposed

Robust Analysis

- Comparison within large multi-state health plans
- Comparison to peers
- Consistent tracking of core metrics
- Don’t be afraid of quality improvement!

Business Growth

- Strengthen RFP submissions
- Strengthen public policy input

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State Considerations in Deciding Whether and How to Use the MLTSS Assessment and Care Planning Measures

Debra J. Lipson, Senior Fellow
Mathematica Policy Research

States Operate Many MLTSS Programs with Different Health Plan Types

Number of States in 2018	MLTSS programs by health plan types
7	MLTSS "stand-alone" programs – cover institutional and HCBS benefits only – for dually eligible or non-dually eligible individuals
20	Comprehensive MCO (medical) plus LTSS benefits (for non-dually eligible)
15	Aligned Dual Eligible Special Needs Plans (D-SNPs) and MLTSS plans: beneficiaries enrolled in Medicare and Medicaid plans operated by the same parent company
10	Fully Integrated Dual Eligible (FIDE) SNPs
9	Medicare-Medicaid Plans (MMPs): capitated model demonstrations
31	Programs of All-Inclusive Care for the Elderly (PACE)

State MLTSS Program Designs Vary

- The five MLTSS assessment and care planning measures can be used **for all types** of MLTSS health plans, except PACE*
- But, certain state MLTSS program design features can influence the relevance and use of the MLTSS assessment and care planning measures:
  - Which types of beneficiaries are eligible to participate
  - Which types of benefits are covered
  - Extent of integration with Medicare managed care, for example, MMP, D-SNP, FIDE SNP, which may affect the burden of adding more performance measures to those they already report to Medicare

* *PACE plans must report a separate set of measures*

What Different MLTSS Program Eligibility Rules Mean for Measure Use

- MLTSS assessment and care planning measures are intended for enrollees who need **any type or amount of LTSS**
  - Individuals who meet nursing home level of care criteria
  - Individuals who need LTSS, including those who need a small amount of help with ADLs, even if they do not meet nursing facility LOC criteria
- So, MLTSS assessment and care planning measures may not be appropriate for enrollees who **do not [yet] need any LTSS**
  - For example, in plans that enroll all dually eligible beneficiaries, including those who do not need LTSS, the measures may be applicable only to those who do need LTSS

What Different Types of Covered Benefits Mean for Measure Use

- For each measure, states and plans should include only the Medicaid enrollees eligible to receive the services assessed
  - Four measures – comprehensive assessment, comprehensive care plan and shared care plan, and falls risk reduction – apply to members eligible to receive LTSS benefits (HCBS and institutional services)
  - States may consider excluding dually eligible enrollees in D-SNPs and MMPs not eligible to receive LTSS benefits from these 4 measures
- One measure – Reassessment/Care Plan Update After Inpatient Discharge – requires enrollees to be eligible for both LTSS and medical care benefits through the plan
  - Plans must have access to hospital admission and discharge data, either from claims paid, or from other sources

About ICRC

- Established by CMS to advance integrated care models for dually eligible beneficiaries
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send other ICRC questions to: integratedcareresourcecenter@chcs.org