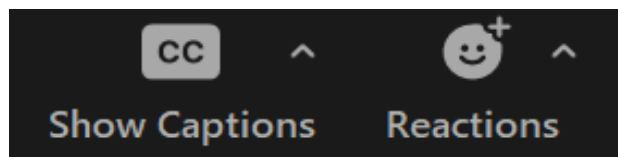# Logistics

To ask a question or share a comment, use the Q&A icon at the bottom of your screen.
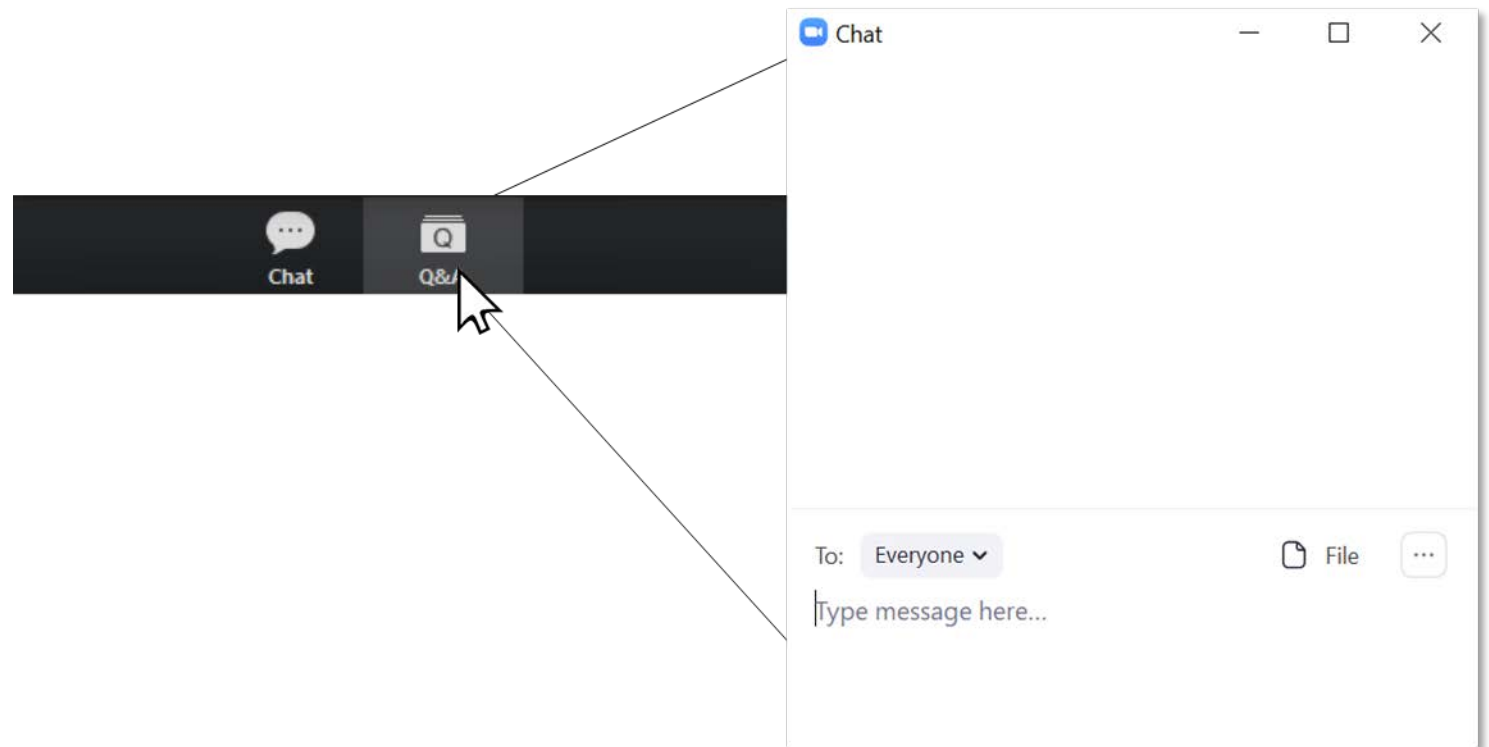
To enable closed captioning, click on the "Show Captions" icon in the Zoom toolbar at the bottom of your screen.

# ICRC's Quality Oversight and Improvement Series (1/2)

**ICRC**

This webinar is part of a series of ICRC resources for states on how they can oversee and improve the quality of care delivered to dually eligible individuals enrolled in Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). Introductory resources in this series include:

- Tips for States on Incorporating D-SNPs into Medicaid Quality Improvement Activities
- Improving Quality and Performance in Dual Eligible Special Need Plans (D-SNPs): Monitoring and Oversight Tips for States

# ICRC's Quality Oversight and Improvement Series (2/2)

**ICRC**

The introductory resources provide foundational information for states, such as:

- Oversight of the quality of care provided by coordination only D-SNPs vs. D-SNPs that cover at least some Medicaid benefits beyond Medicare cost sharing, such as LTSS and behavioral health services.

- The quality improvement lifecycle, including how to incorporate D-SNPs into Medicaid quality improvement activities.

- The Medicare resources that states can use to monitor D-SNPs, including the levels (i.e., plan, contract, sponsor) at which they provide information.

- The advantages of using the D-SNP only contract option to facilitate use of Medicare resources to oversee D-SNPs.

This webinar builds on these introductory materials and provides tips on how to oversee and improve the quality of LTSS and behavioral health services for dually eligible D-SNP enrollees.

# Agenda

- Welcome and introductions
- Importance of improving the quality of LTSS and behavioral health services for dually eligible individuals
- Quality improvement lifecycle
- Key steps in improving LTSS for D-SNP enrollees
- Key steps in improving behavioral health services for D-SNP enrollees
- Questions and answers

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# Importance of Improving the Quality of LTSS and Behavioral Health Services for Dually Eligible Individuals

# LTSS Needs and Coverage for Dually Eligible Individuals

- More than 40 percent of dually eligible individuals use LTSS, and dually eligible individuals are nearly four times more likely to need institutional LTSS than people who are only enrolled in Medicaid.

- While Medicare is the primary payer for skilled nursing facility services, Medicaid is the sole payer for institutional LTSS and home and community-based services (HCBS).

  - To learn more about Medicaid and Medicare coverage of LTSS, see the following ICRC resources:
    - Medicare and Medicaid Nursing Facility Benefits: The Basics and Options for Improved Coordination and Quality
    - Medicare 101: An Introduction to Medicare Benefits and the Roles of Medicare and Medicaid in Serving Dually Eligible Individuals

Sources: MedPAC-MACPAC. "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." January 2024. Available at: https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/.
MedPAC. "Health Care Spending and the Medicare Program Databook." July 2024. Available at: https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf.

# Behavioral Health Needs and Coverage for Dually Eligible Individuals

- Half of full-benefit dually eligible individuals report having a mental health condition, compared to 29 percent of Medicaid enrollees.

- Medicaid covers behavioral health services that fall within mandatory Medicaid benefit categories, and states can cover additional services through state plans or waivers.

- In recent years, Medicare has expanded coverage for behavioral health services, such as expanded substance use disorder (SUD) services.
    - To learn more about Medicaid and Medicare coverage of behavioral health services, see the following ICRC resources:
        - Working with Medicare Webinar: Coordination of Medicare and Medicaid Behavioral Health Benefits
        - Tips for States on Incorporating D-SNPs into Medicaid Quality Improvement Activities

Sources: Kaiser Family Foundation (KFF). "A Profile on Medicare-Medicaid Enrollees (Dual Eligibles)." January 2023. Figure 3. Available at: https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/.

Kaiser Family Foundation (KFF). "Demographics and Health Insurance Coverage of Nonelderly Adults With Mental Illness and Substance Use Disorders in 2020." June 2022. Available at: https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/.

# Refresher on the Quality Improvement Lifecycle

# Step 1: Identify Quality Improvement Opportunities

- Use data to identify opportunities for quality improvement:
  - Gather Medicaid and Medicare quality measure results. Example measure sources include:
    - Healthcare Effectiveness Data and Information Set (HEDIS) measures.
    - Special Needs Plan (SNP) HEDIS measures.
    - Medicaid Adult Core Set measures.
    - Measures developed by states.
      - States that are interested in using their own measures or measures developed by other states will need to consider existing infrastructure, systems for data sharing, and capacity for developing and maintaining measure specifications.
    - Measures developed by others, such as research entities.
  - Compare plan data to data from other plans, state or national performance, and/or specific benchmarks or targets.

Although dually eligible individuals are exempt from mandatory Adult Core Set reporting through 2026, CMS expects to phase them in. Therefore, states may wish to consider how they might use Adult Core Set measures in their quality improvement activities for dually eligible individuals. More information on mandatory Core Set reporting is available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/faq-mandatory-reporting-042024.pdf.  More information on how to access and use Medicare quality measures is available at: https://integratedcareresourcecenter.com/resources-by-topic/oversight-and-monitoring-dual-eligible-special-needs-plans.

# Step 2: Set Measurable Goals and Objectives

- After identifying quality improvement opportunities, states should develop measurable goals and objectives and incorporate them into their Medicaid managed care quality strategies.

- For example, a state might set a goal to improve coordination during care transitions, with an objective to increase follow-up rates after discharge from hospitals for dually eligible enrollees with behavioral health needs.

Goals are high-level managed care performance aims that provide direction for the state.

Objectives are measurable steps toward meeting the state's goals and typically include quality measures.

More information about state Medicaid quality strategies and developing goals and objectives is available in the CMS Medicaid and CHIP Managed Care Quality Strategy Toolkit at https://www.medicaid.gov/sites/default/files/2021-12/managed-care-quality-strategy-toolkit.pdf.

# Step 3: Implement Quality Improvement Tools

- States should then use quality improvement tools to drive performance improvement. Medicaid and Medicare quality improvement tools include:
  - Quality Assessment and Performance Improvement (QAPI) programs, including Performance Improvement Projects (PIPs);
  - Medicare Advantage Quality Improvement programs;
  - Medicare Advantage Chronic Care Improvement Programs (CCIPs); and
  - D-SNP Models of Care (MOCs).

# Step 4: Evaluate Progress

- States should periodically evaluate statewide and plan-level progress toward quality improvement goals and objectives. Example Medicaid and Medicare evaluation tools that states can implement, review, and or/customize include:
  - Medicaid managed care External Quality Review (EQR);
  - Medicaid managed care quality strategy evaluations;
  - Medicare Advantage CCIP evaluations; and
  - D-SNP MOC evaluations.

# Leveraging D-SNP contracts in the Quality Improvement Lifecycle

- Within the state Medicaid agency contract (SMAC), states can require D-SNPs to submit quality measure data and results to the state, implement quality improvement tools, and undergo evaluation. Sample contract language is available in the following ICRC resources:
  - Tips for States on Incorporating D-SNPs into Medicaid Quality Improvement Activities
  - Improving Quality and Performance in Dual Eligible Special Need Plans (D-SNPs): Monitoring and Oversight Tips for States
  - Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans

# D-SNP Only Contracts

- Some Medicare resources (such as Medicare Advantage HEDIS measures) are only available at the Medicare Advantage contract level. Because Medicare Advantage contracts can include multiple plans operating across states, this dilutes states' ability to leverage these resources for monitoring individual D-SNPs.

- States can require D-SNPs that operate with exclusively aligned enrollment to establish (and operate within) contracts with CMS that only include one or more D-SNPs within a state. These are referred to as **D-SNP-only contracts.**

  - This flexibility enables **reporting of contract-level resources specific to the D-SNPs within a particular state** rather than for all Medicare Advantage plans included in a contract.

  - For more information about D-SNP only contracts, see:
    - This ICRC March 2024 webinar: https://integratedcareresourcecenter.com/resource/d-snp-only-contracts-benefits-and-key-steps-states
    - This CMS guidance: https://www.cms.gov/files/document/stateoppsintegratedcareprogs.pdf

# Improving the Quality of LTSS for D-SNP Enrollees

# Step 1: Identify LTSS Quality Improvement Opportunities (1/2)

- States can use a variety of measure sets to identify LTSS quality improvement opportunities, such as:
  - Home and Community Based Services (HCBS) Consumer Assessment of Healthcare Provider and Systems (CAHPS) Survey
    - The HCBS CAHPS survey captures adults' experience with LTSS, including managed LTSS.
    - HCBS CAHPS measures include composite measures (such as "staff listen and communicate well"), unmet need single item measures (for example, "staff were not available to help with medications"), physical safety measures, a global ratings measure (such as "rating of case manager"), and recommendation measures (for example, "recommended homemaker").
  - Medicaid LTSS Quality Measure Set
    - These measures cover topics such as (1) screening, risk assessment, and plan of care to prevent future falls, (2) admission to a facility from the community, (3) minimizing facility length of stay, and (4) successful transition after long-term facility stay measures.

# Step 1: Identify LTSS Quality Improvement Opportunities (2/2)

ICRC

- States can use their SMACs to require D-SNPs to submit LTSS measure results and data. For example:

---

**Indiana SMAC Quality Measure Reporting Language**

In Section 5 of Exhibit 1A of Indiana's SMAC, the state specifies that D-SNPs must submit to the state *"Currently reported quality assessment data and deliverables consistent with those described in Chapter 5 of the Medicare Managed Care Manual, Section 30... to be received within thirty (30) business days of submission or receipt—which includes but is not limited to:*

- *Audited summary-level and patient-level [HEDIS] data the MAO is required to submit to National Committee for Quality Assurance (NCQA) and CMS respectively;*
- *The final NCQA HEDIS Compliance Audit Report provided to the MAO by the NCQA licensed audit firm;*
- *NCQA HEDIS Measures broken out from aggregated Star Ratings for Indiana population and A&D Waiver subpopulation:*
  - a) *Measure: C06 – Care for Older Adults – Medication Review*
  - b) *Transitions of Care (TRC)*
  - c) *Plan All-Cause Readmissions (PCR)*
- *All Medicare Health Outcomes Survey (HOS) data feedback reports provided to the MAO by CMS; and*
- *Any reports or materials pertaining to annual MAO participation in the Medicare Advantage and Prescription Drug Plan (MA & PDP) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey."*

Source: Indiana 2024 SMAC, Amendment #2. Available at: https://www.in.gov/medicaid/partners/files/CY2024INSMACAmendment.pdf.

# Example LTSS Measures

| **Managed LTSS Comprehensive Assessment and Update** | **Managed LTSS Comprehensive Person-Centered Plan and Update** | **Managed LTSS Screening, Risk Assessment, and Plan of Care to Prevent Future Falls** | **Managed LTSS Shared Person-Centered Plan with Primary Care Provider** |
|---|---|---|---|
| • Assesses the percent of LTSS enrollees with a documented comprehensive assessment<br>• Included in the Medicaid LTSS quality measure set | • Assesses the percent of LTSS enrollees with a documented person-centered plan<br>• Included in the Medicaid LTSS quality measure set | • Assesses the percent of LTSS enrollees with documented screening for a history of falls, problems with balance or gait, or both<br>• Included in the Medicaid LTSS quality measure set | • Assesses the percent of LTSS enrollees with a person-centered plan transmitted to their primary care provider (or other documented medical provider) identified by the enrollee within 30 days of its development<br>• Included in the Medicaid LTSS quality measure set |

For a comprehensive list of LTSS measures, see Appendix A.

More information on the Medicaid LTSS Quality Measure Set reporting is available at: https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-tech-specs-res-manual.pdf?t=1738031986.

# Using LTSS Quality Measure Results to Determine Quality Improvement Priorities

- After gathering LTSS measure results, states can (1) compare plan performance with other plans, statewide performance, and/or national performance, and (2) compare state performance to other states and national performance. For example:

| Measure Name | D-SNP A Rate | D-SNP B Rate | Statewide Rate | HEDIS Overall Rate (2022) |
|---|---|---|---|---|
| *Hospitalization Following Discharge From a Skilled Nursing Facility (within 30 days)* | 15% | 20% | 17% | 13% |

More information on *Hospitalization Following Discharge From a Skilled Nursing Facility* is available at
https://www.ncqa.org/hedis/measures/hospitalization-following-discharge-from-a-skilled-nursing-facility/.

# Step 2: Develop LTSS Goals and Objectives

- Develop measurable goals and objectives. Example goals include:
  - Improve HCBS care for LTSS enrollees.
  - Reduce fall risk for nursing facility residents.
  - Increase coordination between LTSS providers and primary care providers.

- Pair the goals with an objective, measure, and performance target.
  - Measures could be drawn from the Medicaid LTSS Quality Measure Set, HCBS CAHPS, state measures, and/or other measure sets.

# Example LTSS Goal and Objective

**Measure used to identify an LTSS quality improvement opportunity:** *Hospitalization Following Discharge From a Skilled Nursing Facility (SNF)*

| Goal |
| --- |
| Improve access to HCBS coordination after hospitalization for people with recent SNF stays. |
| **Objective** |
| Increase the percentage of recently hospitalized enrollees who receive follow-up outreach from an LTSS coordinator within 60 days of hospitalization. |
| **Measure to Monitor Progress** |
| Percent of enrollees who received follow-up outreach within 60 days of hospitalization. |

**States can apply this and similar goals and objectives to D-SNPs that are directly capitated to cover Medicaid LTSS benefits or D-SNPs' affiliated Medicaid managed care plans.**

# State Goal and Objective Example: District of Columbia

## Example goal

- Improve population health.

## Example objectives

- Increase the percent of LTSS enrollees who receive an LTSS comprehensive assessment and update.
- Increase the percent of LTSS enrollees who receive an LTSS comprehensive care plan and update.
- Increase the percent of LTSS enrollees who receive an LTSS reassessment/care plan update after discharge.
- The average HEDIS rates for the following social need screening and intervention measures will improve by 3 percent: Food screening, food intervention, housing screening, housing intervention, transportation screening, and transportation intervention.

## Example measure to monitor progress

- LTSS enrollees with a documented comprehensive assessment, annually or within 90 days of enrollment.

Source: Government of the District of Columbia, Department of Health Care Finance. "Medicaid Managed Care Quality Strategy." Available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/CURRENT_%202024-2027%20DC%20Medicaid%20Managed%20Care%20Quality%20Strategy.pdf.

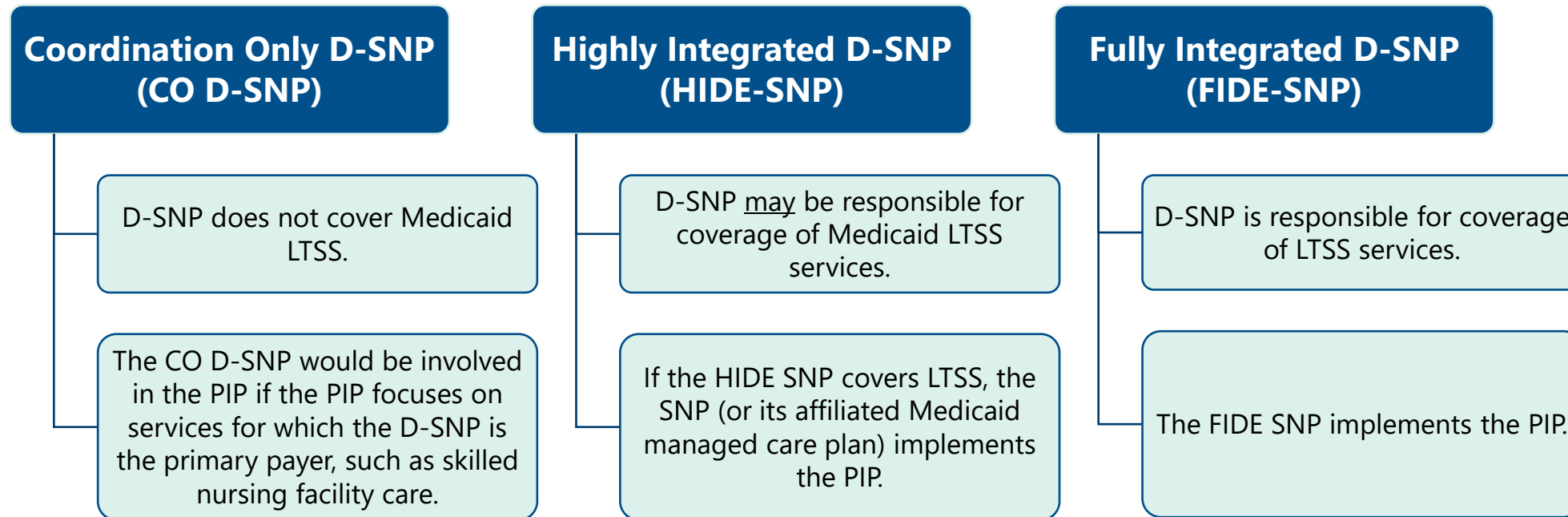# Step 3: Implement Quality Improvement Tools to Improve LTSS Quality

**ICRC**

| Goal |
|------|
| Reduce avoidable emergency department (ED) utilization. |
| **Objective** |
| Decrease the rate of avoidable ED use for LTSS enrollees who had three or more ED visits in a quarter. |
| **Measure to Monitor Progress** |
| Percent of LTSS enrollees with three or more ED visits per quarter. |

| Topic |
|-------|
| Reducing avoidable ED use among LTSS enrollees. |
| **Aim** |
| To reduce avoidable ED use among LTSS enrollees who had three or more ED visits in a quarter. |
| **Interventions** |
| • Educational outreach for LTSS enrollees to (1) reduce avoidable ED use and (2) increase use of ED alternatives.<br>• Program to facilitate increased coordination between primary care and HCBS providers aimed at reducing avoidable ED use. |
| **Performance Measure** |
| The percent of LTSS enrollees with three or more ED visits in a quarter. |

# Customizing D-SNP Involvement in Medicaid Quality Improvement Tools

**ICRC**

- States can customize their D-SNPs' involvement in Medicaid quality improvement tools (such as Medicaid PIPs) based on the D-SNP's level of integration. For example:

| **Coordination Only D-SNP (CO D-SNP)** | **Highly Integrated D-SNP (HIDE-SNP)** | **Fully Integrated D-SNP (FIDE-SNP)** |
|---|---|---|
| D-SNP does not cover Medicaid LTSS. | D-SNP <u>may</u> be responsible for coverage of Medicaid LTSS services. | D-SNP is responsible for coverage of LTSS services. |
| The CO D-SNP would be involved in the PIP if the PIP focuses on services for which the D-SNP is the primary payer, such as skilled nursing facility care. | If the HIDE SNP covers LTSS, the SNP (or its affiliated Medicaid managed care plan) implements the PIP. | The FIDE SNP implements the PIP. |

For more information on incorporating D-SNPs into Medicaid quality improvement tools, see ICRC's fall 2023 tip sheet and webinar on D-SNP monitoring and oversight:

- https://www.integratedcareresourcecenter.com/index.php/resource/tips-states-incorporating-d-snps-medicaid-quality-improvement-activities
- https://www.integratedcareresourcecenter.com/index.php/resource/improving-quality-and-performance-dual-eligible-special-need-plans-d-snps-monitoring-and

# State Quality Improvement Tool Example: District of Columbia

**ICRC**

| PIP topic | Fall Risk Management |
|---|---|
| Aims | • To decrease the number of falls in enrollees 65 years of age and older during the measurement year by utilizing member education on fall prevention.<br>• To decrease the number of falls for enrollees 18 years of age and older with a history of falls during the measurement year by implementing comprehensive assessments and fall risk management plans. |
| Interventions | • Discussing fall risk.<br>• Managing fall risk.<br>• Falls screening and risk assessment.<br>• Plan of care. |
| Performance Measures | • *Fall Risk Management.*<br>• *Managed LTSS Screening, Risk Assessment, and Plan of Care to Prevent Future Falls.* |

Source: Example based on District of Columbia PIP, Department of Health Care Finance, Office of Medicaid. "District of Columbia Medicaid Managed Care Programs, 2023 Annual Technical Report" Available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/2023%20District%20of%20Columbia%20Annual%20Technical%20Report%20%28ATR%29.pdf.

# Leveraging Medicare Quality Improvement Tools for LTSS Quality Improvement

- States can require D-SNPs to focus their Medicare quality improvement tools (such as their CCIPs) on improving performance on the state's quality improvement priorities. For example:

| CCIP Topic | Minimizing facility length of stay for enrollees with LTSS needs |
|---|---|
| Targeted chronic conditions | • Dementia<br>• Spinal cord or traumatic brain injury |
| Interventions | • Enrollee/family support to minimize avoidable institutionalization after inpatient hospital discharge<br>• Enrollee/family education on HCBS options for people with dementia<br>• Coordination with inpatient and long-term care providers to minimize avoidable institutionalization and promote community transitions for long-term care residents |
| Performance Measures | • *Managed LTSS Minimizing Facility Length of Stay* |

More information on Medicare CCIPs is available at: https://www.cms.gov/medicare/advantage-quality-improvement-program/chronic-care.

# Step 4: Evaluate Progress

- After using quality improvement tools to improve performance, states should evaluate statewide progress toward goals and objectives. For example:

| Measure Name | Statewide Baseline Rate | Current Statewide Rate | Statewide Objective |
|---|---|---|---|
| *Fall Risk Management* | 70% | 80% | 95% |

- States can also evaluate plan progress toward meeting their goals and objectives. For example:

| Discussing Fall Risk | Plan Baseline Rate | Plan Current Rate | Plan Objective |
|---|---|---|---|
| D-SNP A | 68% | 75% | 85% |
| D-SNP B | 70% | 80% | 85% |

# Example EQR Evaluation of an LTSS PIP

ICRC

| Topic |
|---|
| Access to an LTSS coordinator. |
| **Aim** |
| To increase the percent of enrollees with LTSS needs who receive outreach from an LTSS coordinator within 90 days of enrollment. |
| **Interventions** |
| • Collaboration between primary care providers and LTSS providers.<br>• Member support including outreach from an LTSS coordinator post enrollee admission. |
| **Performance Measure** |
| LTSS coordinator outreach within 90 days of enrollment. |

| Measure Name | Plan Rate (Baseline) | Plan Rate (Year 1) |
|---|---|---|
| LTSS coordinator outreach within 90 days of enrollment. | 79% | 83% |

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# Improving the Quality of Behavioral Health Services for D-SNP Enrollees

# Step 1: Identify Behavioral Health Quality Improvement Opportunities

- States can use a variety of measure sets to identify behavioral health quality improvement opportunities, such as:
  - Medicaid Adult Core Set measures
    - These measures cover topics such as antidepressant medication management, engagement in SUD treatment, outpatient follow-up after hospitalization and emergency department visits, and diabetes care and screening for individuals with mental illness.
  - SNP HEDIS measures
    - D-SNPs are required to report SNP HEDIS measures to CMS. SNP HEDIS behavioral health measures cover topics such as antidepressant medication management and follow up after hospitalization for mental illness.
- Like with LTSS quality measurement, states can require D-SNPs to submit quality measure data and results via the SMAC.
- For a comprehensive list of measures, see Appendix A.

More information on Medicaid Adult Core Set measures is available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

More information on SNP HEDIS measure reporting is available at: https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/data-information-set.

# Example Behavioral Health Quality Measures

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| Antidepressant Medication Management | Follow-Up After Hospitalization for Mental Illness | Follow-Up After Emergency Department Visit for Substance Use | Initiation and Engagement of Substance Use Disorder Treatment |
|---|---|---|---|
| • Assesses medication compliance for individuals newly prescribed antidepressant medication<br>• Included in the Adult Core Set, SNP HEDIS, and HEDIS measure sets<br>• D-SNPs report this measure to CMS | • Assesses the rate of follow-up care with a mental health provider following a hospitalization for mental illness or intentional self-harm<br>• Included in the Adult Core Set, SNP HEDIS, and HEDIS measure sets<br>• D-SNPs report this measure to CMS | • Assesses the rate of follow-up care after an emergency department visit with a primary diagnosis of SUD or drug overdose<br>• Included in the Adult Core Set and HEDIS measure sets | • Assesses if an individual diagnosed with SUD receives treatment within 14 days of diagnosis<br>• Included in the Adult Core Set and HEDIS measure sets |

For a comprehensive list of behavioral health measures, see Appendix A.
More information on Adult Core Set reporting is available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set-reporting-resources/index.html.
More information on SNP HEDIS reporting is available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/snp-hedis-public-use-files.
More information on Medicare Advantage HEDIS reporting is available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-hedis-public-use-files/ma-hedis-public-use-files-0.

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# Using Behavioral Health Quality Measure Results to Determine QI Priorities

ICRC

- After gathering behavioral health measure results, states can (1) compare plan performance with other plans, statewide performance, and/or national performance, and (2) compare state performance to other states and national performance. For example:

| Measure Name | D-SNP A Rate | D-SNP B Rate | Statewide Rate | SNP HEDIS Overall D-SNP Rate (MY 2022) |
|---|---|---|---|---|
| *Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (within 30 days).* | 29% | 34% | 35% | 49% |

Source: National Committee for Quality Assurance, "Final Medicare Special Needs Plans HEDIS® Performance Results: Measurement Years 2017–2022." Available at https://www.cms.gov/files/document/snp-hedis-2017-2022-report.pdf.

More information on *Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (within 30 days)* is available at https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/.

# Step 2: Develop Behavioral Health Goals and Objectives

- Develop measurable goals and objectives. Example goals include:
  - Reduce opioid abuse.
  - Improve medication adherence for individuals with serious mental illness.
  - Improve management of co-morbid physical health conditions for individuals with serious mental illness.
  - Improve care coordination between physical and behavioral health care.

- Pair the goals with an objective, a measure, and a performance target.
  - Measures could include behavioral health quality measures from the SNP HEDIS, Adult Core Set, or other measure sets that contain behavioral health measures.

- The Substance Abuse and Mental Health Services Administration's (SAMHSA) 2023–2026 strategic plan provides additional examples of behavioral health goals and objectives.

For a comprehensive list of behavioral health measures, see Appendix A.

# Example Behavioral Health Goal and Objective

**Measure used to identify a behavioral health quality improvement opportunity:**
*Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (within 30 days)*

→

| Goal |
|---|
| Improve access to outpatient mental health care. |
| **Objective** |
| Increase the follow-up after hospitalization for mental illness within 30 days rate by five percent within three years. |
| **Measure to Monitor Progress** |
| *Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (within 30 days)* |

**States can apply this and similar goals and objectives to D-SNPs that are directly capitated to cover Medicaid behavioral health benefits or D-SNPs' affiliated Medicaid managed care plans.**

# State Goal and Objective Example: District of Columbia

## Example goal

- Improve management of chronic conditions.

## Example objectives

- The average HEDIS rate for follow-up after an ED visit for mental illness within seven days will increase by three percentage points.
- The average HEDIS rate for follow-up after an ED visit for mental illness within 30 days will increase by three percentage points.

## Example measure to monitor progress

- Adult Core Set measure: *Follow-Up After ED Visit for Mental Illness.*

Source: Example based on District of Columbia Quality Strategy goal and objectives. Government of the District of Columbia, Department of Health Care Finance. "Medicaid Managed Care Quality Strategy." Available at https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/CURRENT_%202024-2027%20DC%20Medicaid%20Managed%20Care%20Quality%20Strategy.pdf.

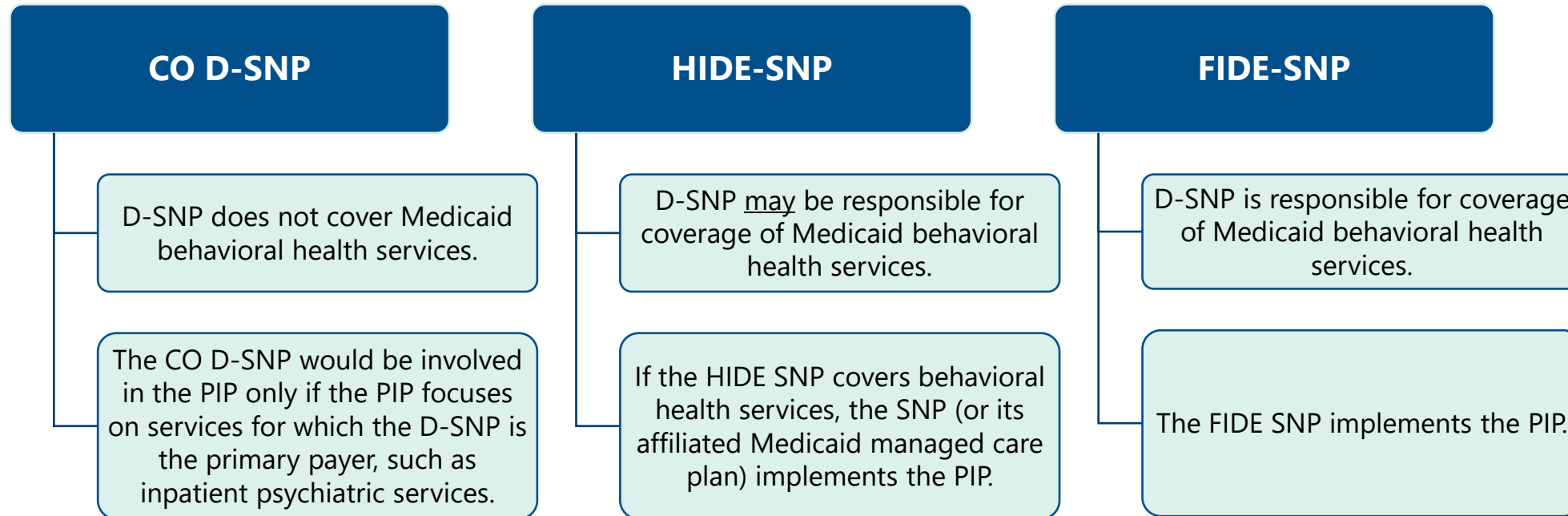# Step 3: Implement Quality Improvement Tools to Improve Behavioral Health Quality

**ICRC**

| Goal |
|---|
| Improve access to outpatient mental health care. |
| **Objective** |
| Increase the follow-up after hospitalization for mental illness within 30 days rate by five percent within three years. |
| **Measure to Monitor Progress** |
| *Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (within 30 days)* |

| Topic |
|---|
| Care coordination following inpatient behavioral health discharge. |
| **Aim** |
| To increase the rate of follow-up after hospitalization for mental illness and use of outpatient behavioral health services. |
| **Interventions** |
| • Targeted enrollee outreach to encourage engagement with follow-up and outpatient services.<br>• Program to support collaboration between inpatient and outpatient facilities. |
| **Performance Measure** |
| *Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (within 30 days).* |

# Customizing D-SNP Involvement in Medicaid Quality Improvement Tools

- States can customize their D-SNPs' involvement in behavioral health Medicaid quality improvement tools (such as Medicaid PIPs) based on the D-SNP's level of integration. For example:

| CO D-SNP | HIDE-SNP | FIDE-SNP |
|---|---|---|
| D-SNP does not cover Medicaid behavioral health services. | D-SNP <u>may</u> be responsible for coverage of Medicaid behavioral health services. | D-SNP is responsible for coverage of Medicaid behavioral health services. |
| The CO D-SNP would be involved in the PIP only if the PIP focuses on services for which the D-SNP is the primary payer, such as inpatient psychiatric services. | If the HIDE SNP covers behavioral health services, the SNP (or its affiliated Medicaid managed care plan) implements the PIP. | The FIDE SNP implements the PIP. |

For more information on incorporating D-SNPs into Medicaid quality improvement tools, see ICRC's fall 2023 tip sheet and webinar on D-SNP monitoring and oversight:
- https://www.integratedcareresourcecenter.com/index.php/resource/tips-states-incorporating-d-snps-medicaid-quality-improvement-activities
- https://www.integratedcareresourcecenter.com/index.php/resource/improving-quality-and-performance-dual-eligible-special-need-plans-d-snps-monitoring-and

# State Quality Improvement Tool Example: Massachusetts

**ICRC**

| PIP topic | Care coordination and planning following a behavioral health hospital discharge within seven days |
|---|---|
| Aim | • To increase the number of follow-up appointments within seven days of discharge following a behavioral health inpatient discharge.<br>• By ensuring members are seen within seven days following a hospital discharge, members will be equipped with resources and tactics to avoid future unnecessary hospitalizations by utilizing Cityblock Health services available to them. |
| Interventions | • Member support post hospitalization.<br>• Collaboration with inpatient and acute care facilities.<br>• Care navigator program at the UMass Memorial Health. |
| Performance Measure | • *Follow-up After Hospitalization for Mental Illness.* |

# Leveraging Medicare QI Tools for Behavioral Health Quality Improvement

- States can require D-SNPs to focus their Medicare quality improvement tools (such as their CCIPs) on improving performance on the state's quality improvement priorities. For example:

| CCIP Topic | Improving follow-up after hospitalization for members with major depression or schizophrenia |
|---|---|
| Targeted chronic conditions | • Major Depression <br> • Schizophrenia |
| Interventions | • Member support post hospitalization to increase follow-up and reduce risk of readmissions <br> • Collaboration with inpatient and outpatient facilities to increase follow-up and reduce risk of readmissions <br> • Care navigator program at hospitals |
| Performance Measure | • *Follow-up After Hospitalization for Mental Illness* |

More information on Medicare CCIPs is available at: https://www.cms.gov/medicare/advantage-quality-improvement-program/chronic-care.

# Step 4: Evaluate Progress Towards Behavioral Health Goals and Objectives

- After implementing quality improvement tools to improve performance on their behavioral health quality improvement opportunities, states should evaluate statewide progress towards meeting their goals and objectives. For example:

| Measure Name | Statewide Baseline Rate | Current Statewide Rate | Statewide Objective |
|---|---|---|---|
| *Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (within 30 days)* | 29% | 34% | 36% |

- States can also evaluate plan progress toward meeting their goals and objectives. For example:

| Plan Name | Plan Baseline Rate | Plan Current Rate | Plan Objective |
|---|---|---|---|
| D-SNP A | 29% | 36% | 34% |
| D-SNP B | 30% | 32% | 34% |

# Example EQR Evaluation of Massachusetts' Behavioral Health PIP

**ICRC**

| PIP Topic |
|---|
| Care coordination and planning following a behavioral health hospital discharge within seven days |
| **Aim** |
| To increase the number of follow-up appointments within seven days of discharge following a behavioral health inpatient discharge. |
| **Interventions** |
| • Member support post hospitalization.<br>• Collaboration with inpatient and acute care facilities.<br>• Care navigator program at UMass Memorial Health. |
| **Performance Measure** |
| *Follow-Up After Hospitalization for Mental Illness: Age 18 and Older.* |

| Measure Name | Plan Rate (Baseline) | Plan Rate (Year 1) |
|---|---|---|
| *Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (within 30 days)* | 49% | 54% |

Source: Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. "External Quality Review One Care Plans Annual Technical Report, Calendar Year 2023." Available at https://www.mass.gov/doc/masshealth-one-care-eqr-technical-report-2023-0/download.

# Questions?

# Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.
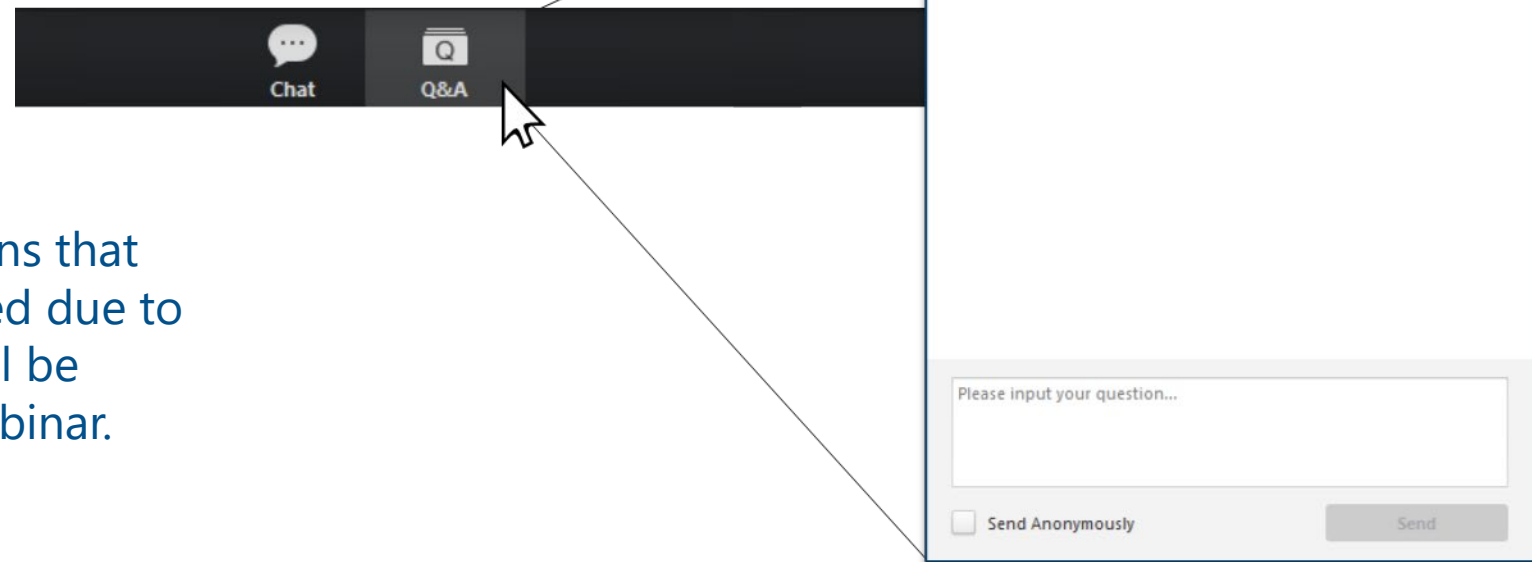
Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.

# About ICRC

- Established by CMS to advance integrated care models for dually eligible individuals.

- ICRC provides technical assistance (TA) to states, coordinated by Mathematica 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@mathematica-mpr.com.

# Appendix A: Behavioral Health and LTSS Quality Measures

# Behavioral Health Measures and Surveys (1/3)

| Measure | Measure Sets |
|---|---|
| Adherence to Antipsychotic Medications for Individuals With Schizophrenia | HEDIS Measures |
| Antidepressant Medication Management | Adult Core Set<br>HEDIS Measures<br>SNP HEDIS |
| CAHPS Outpatient Mental Health Survey | CAHPS |
| Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia | HEDIS Measures |
| Concurrent Use of Opioids and Benzodiazepines | Adult Core Set |
| Depression Remission or Response for Adolescents and Adults | HEDIS Measures |
| Depression Screening and Follow-Up for Adolescents and Adults | HEDIS Measures |
| Diabetes Care for People with Serious Mental Illness: Glycemic status (>9.0%) | Adult Core Set |
| Diabetes Monitoring for People with Diabetes and Schizophrenia | HEDIS Measures |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications | Adult Core Set<br>HEDIS Measures |

The CAHPS Outpatient Mental Health Survey focus on experiences with treatment and counseling services, including getting help between appointments and potential barriers to care. States can use results assess patient experience.

# Behavioral Health Measures and Surveys (2/3)

| Measure | Measure Sets |
|---|---|
| Diagnosed Mental Health Disorders | HEDIS Measures |
| Diagnosed Substance Use Disorders | HEDIS Measures |
| Follow-Up After Emergency Department Visit for Mental Illness | Adult Core Set<br>HEDIS Measures |
| Follow-Up After Emergency Department Visit for Substance Use: | Adult Core Set<br>HEDIS Measures |
| Follow-Up After High-Intensity Care for Substance Use Disorder | HEDIS Measures |
| Follow-Up After Hospitalization for Mental Illness | Adult Core Set<br>HEDIS Measures<br>SNP HEDIS |
| Medicare Health Outcomes Survey | Medicare Health Outcomes Survey |
| Initiation and Engagement of Substance Use Disorder Treatment | Adult Core Set<br>HEDIS Measures |
| Medical Assistance with Smoking and Tobacco Use Cessation | Adult Core Set<br>CAHPS |

The Medicare Health Outcomes Survey includes the measure *Improving or Maintaining Mental Health*.

# Behavioral Health Measures and Surveys (3/3)

| Measure | Measure Sets |
|---|---|
| Mental Health Utilization | HEDIS Measures |
| Pharmacotherapy for Opioid Use Disorder | HEDIS Measures |
| Postpartum Depression Screening and Follow-up | Adult Core Set HEDIS Measures |
| Prenatal Depression Screening and Follow-up | HEDIS Measures |
| Risk of Continued Opioid Use | HEDIS Measures |
| Screening for Depression and Follow-Up Plan: Age 18 and Older | Adult Core Set HEDIS Measures |
| Unhealthy Alcohol Use Screening and Follow-Up | HEDIS Measures |
| Use of Opioids from Multiple Providers | HEDIS Measures |
| Use of Opioids at High Dosage | HEDIS Measures |
| Use of Opioids at High Dosage in Persons Without Cancer | Adult Core Set |
| Use of Pharmacotherapy for Opioid Use Disorder | Adult Core Set |
| Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults | HEDIS Measures |

# LTSS Measures and Surveys (1/2)

| Measure | Measure Sets |
|---|---|
| CAHPS Home and Community-Based Services Survey | CAHPS |
| CAHPS Home Health Care Survey | CAHPS |
| CAHPS Hospice Survey | CAHPS |
| CAHPS Nursing Home Discharged Resident Survey | CAHPS |
| CAHPS Nursing Home Long-Stay Resident Survey | CAHPS |
| Fall Risk Management | HEDIS Measures |
| Medicare Health Outcomes Survey | Medicare Health Outcomes Survey |
| Hospitalization Following Discharge From a Skilled Nursing Facility | HEDIS Measures |
| Long-Term Services and Supports Comprehensive Care Plan and Update | Adult Core Set |
| Managed Long-Term Services and Supports Admission to a Facility from the Community | Medicaid LTSS Quality Measures |

# LTSS Measures and Surveys (2/2)

| Measure | Measure Sets |
|---|---|
| Managed Long-Term Services and Supports Comprehensive Assessment and Update | Medicaid LTSS Quality Measures |
| Managed Long-Term Services and Supports Comprehensive Person-Centered Plan and Update | Medicaid LTSS Quality Measures |
| Managed Long-Term Services and Supports Minimizing Facility Length of Stay | Medicaid LTSS Quality Measures |
| Managed Long-Term Services and Supports Reassessment and Person-Centered Plan Update after Inpatient Discharge | Medicaid LTSS Quality Measures |
| Managed Long-Term Services and Supports Screening, Risk Assessment, and Plan of Care to Prevent Future Falls | Medicaid LTSS Quality Measures |
| Managed Long-Term Services and Supports Shared Person-Centered Plan with Primary Care Provider | Medicaid LTSS Quality Measures |
| Managed Long-Term Services and Supports Successful Transition after Long Term Facility Stay | Medicaid LTSS Quality Measures |
| National Core Indicators Survey | Adult Core Set |

# Measure Sets for LTSS and Behavioral Health Quality Improvement (1/2)

- More information on the **Adult Core Set** is available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

- More information about **CAHPS Patient Experience surveys** is available at:
  - CAHPS Home and Community-Based Services Survey: https://www.ahrq.gov/cahps/surveys-guidance/hcbs/index.html.
  - CAHPS Home Health Care Survey: https://www.ahrq.gov/cahps/surveys-guidance/home/index.html.
  - CAHPS Hospice Survey: https://www.ahrq.gov/cahps/surveys-guidance/hospice/index.html.
  - CAHPS Mental Health Survey: https://www.ahrq.gov/cahps/surveys-guidance/mental-health/index.html.
  - CAHPS Nursing Home Surveys: https://www.ahrq.gov/cahps/surveys-guidance/nh/index.html.

- More information on the **HEDIS measures** is available at: https://www.ncqa.org/hedis/measures/.

- More information about **HEDIS measures that Medicare Advantage plan report** is available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-hedis-public-use-files/ma-hedis-public-use-files-0.

# Measure Sets for LTSS and Behavioral Health Quality Improvement (2/2)

- More information about the **SNP HEDIS measures** is available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/snp-hedis-public-use-files.

- More information about the **Medicare Health Outcomes Survey** is available at: https://www.cms.gov/data-research/research/health-outcomes-survey.

- More information about the **Medicaid LTSS Quality Measures** is available at: https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-quality/long-term-services-supports-quality-measures/index.html.

- More information about **National Core Indicators - Aging and Disabilities** is available at: https://nci-ad.org/.

# Appendix B: Related ICRC Resources

# Related ICRC Resources (1/2)

- [Tips for States on Incorporating D-SNPs into Medicaid Quality Improvement Activities](#) (ICRC tip sheet, October 2023)

- [Improving Quality and Performance in Dual Eligible Special Need Plans (D-SNPs): Monitoring and Oversight Tips for States](#) (ICRC webinar, November 2023)

- [Working with Medicare Webinar: Coordination of Medicare and Medicaid Behavioral Health Benefits](#) (ICRC webinar, April 2024)

- [Medicare 101: An Introduction to Medicare Benefits and the Roles of Medicare and Medicaid in Serving Dually Eligible Individuals](#) (ICRC webinar, March 2022)

- [Medicare and Medicaid Nursing Facility Benefits: The Basics and Options for Improved Coordination and Quality](#) (ICRC webinar, July 2021)

# Related ICRC Resources (2/2)

- Oversight and Monitoring of Dual Eligible Special Needs Plans (ICRC collection of resources)

- Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans (ICRC sample language, February 2024)