Logistics

• All lines will be muted
• Use the chat box on your screen to ask a question or leave a comment
  – Note: chat box will not be seen in “full screen” mode
• Slides and a transcript will be posted online within a few weeks of the webinar
• Please complete the post-webinar survey at the conclusion of the webinar. We value your feedback!
Welcome & Overview

- Keith Branham
  - Research Analyst, Medicaid IAP Data Analytics Team, Data and Systems Group, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services
Agenda for Today’s Webinar

• Introduction
• Overview of the Medicaid Innovation Accelerator Program
• Leveraging Data Analytics for Long-Term Services and Supports (LTSS) Programs and Populations
• State Examples of LTSS Analytic Approaches
  – Massachusetts: Quality Measurement and Value-Based Payment
  – Virginia: Commonwealth Coordinated Care Plus
Today’s Speakers

• Beth Lewis
  – Senior Research Leader, IBM Watson Health

• Jill Morrow-Gorton
  – Acting Chief Medical Officer and Director of the Office of Clinical Affairs, MassHealth

• Jeanette Trestrail
  – Program Manager, Data, Encounter and Compliance, Integrated Care Division, Virginia Department of Medical Assistance Services
Medicaid Innovation Accelerator Program (IAP)
In this interactive webinar, participants will learn about:

- setting objectives to gather LTSS analytics
- challenges with LTSS data/data analytics
- state approaches to LTSS analytics
- lessons learned and looking ahead
Applying Data Analytics to Long-Term Services and Supports Programs

Beth Lewis, Senior Research Leader, IBM Watson Health
What is LTSS?

- LTSS refers to the long-term services and supports provided to Medicaid beneficiaries based on level of need.
- LTSS services are provided in both institutional and non-institutional settings:
  - Nursing facilities, long-term care hospitals, and intermediate care facilities for individuals with developmental disabilities.
  - Home and community-based services (HCBS) such as personal care attendants, homemaker or chore services, or home-delivered meals.
- LTSS services are paid under both fee-for-service (FFS) as well as managed care delivery systems.
Why is Data Analytics Important to LTSS?

• States can use data analytics to:
  – Measure program performance
  – Track and identify trends in expenditures
  – Share program information with interested stakeholders
  – Improve transparency
Challenges and Data Limitations

• **LTSS data can be difficult to collect**
  – Record reviews can be labor-intensive, especially if data is not collected electronically, as it is often the case in LTSS.
  – States juggle staff time, expertise and resources

• **LTSS populations vary across a range of factors**
  – Data needs will vary across populations

• **LTSS analytics are less developed than other health care analytics**
  – Predictive analytics is not yet in-place for LTSS
  – In general, states report more on the Medicaid population at-large or on health care metrics than on LTSS specifically
Approaches to Data Analytics Being Pursued by States

- States are pursuing varied goals:
  - Using analytics to monitor performance of managed care organizations (MCO) during the transition from fee-for-service (FFS) to managed care
  - Using data analytics to prepare public-facing dashboards or legislative reports to tell the story of the program
  - Using data to compare performance in order to apply value-based payment (VBP) incentives
State Considerations for Enhancing Data Analytics

- Complete data documentation
- Connect metrics with the identified goals of the program
- If delivering managed long-term services and supports (MLTSS), communicate expectations, and requirements for data collection to MCOs
Key Takeaways/Considerations for States

• Start small
• Plan to devote adequate time and resources
• Messages should be carefully crafted for reports and dashboards
• Find good partners to benefit from other states’ lessons learned
• Constant evolution of data and analytic capacity
Massachusetts LTSS: Quality Measurement and Value-Based Payments

Jill Morrow-Gorton MD MBA, Acting Chief Medical Officer and Director of the Office of Clinical Affairs, MassHealth
Objectives

• Share the process that Massachusetts used to develop strategies for quality metrics and value-based payments for LTSS
• Highlight the role of IAP in their work
• Discuss lessons learned
• Outline next steps in implementation
Steps in Process

• Outline the development of a quality measure set for LTSS FFS providers
• Evaluate the viability of quality measures based on data stability
• Benchmark data
• Frame the financial simulation model process for value-based payments
• Apply provider scorecard concept to quality measures using benchmarks and simulations
• Employ value-based payments based on scorecards
## Office of LTSS (OLTSS) System Organization

<table>
<thead>
<tr>
<th>Community Based Programs 28%</th>
<th>Home Based Programs 13%</th>
<th>Institutional Programs 29%</th>
<th>Coordinated Care 30%</th>
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<tbody>
<tr>
<td>667 Providers</td>
<td>1643 Providers</td>
<td>493 Providers</td>
<td>14 Providers</td>
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<td>86,836 members</td>
<td>111,070 members</td>
<td>46,917 members</td>
<td>67,613 members</td>
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### SERVICES

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<tr>
<th>Personal Care</th>
<th>Oxygen and Respiratory</th>
<th>Nursing Facilities</th>
<th>Senior Care Options</th>
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<td>Day Habilitation</td>
<td>Hospice</td>
<td>Chronic Disease and Rehabilitation Hospitals</td>
<td>Program of All-inclusive Care for the Elderly (PACE)</td>
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<tr>
<th>Adult Day Health</th>
<th>Orthotics</th>
<th>Rest Homes</th>
<th>Prosthetics</th>
<th>Home Health, Shift Nursing and Therapies</th>
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<tbody>
<tr>
<td>Adult Foster Care</td>
<td>Orthotics</td>
<td>Rest Homes</td>
<td>Prosthetics</td>
<td>Home Health, Shift Nursing and Therapies</td>
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<thead>
<tr>
<th>Group Adult Foster Care</th>
<th>Home Health, Shift Nursing and Therapies</th>
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<tr>
<th>Early Intervention</th>
<th>Community Case Management</th>
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<th>Targeted Case Management</th>
<th>Durable Medical Equipment</th>
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Quality Measure Set Identification

• Quality goals to create a core set of measures that are aligned with and apply across:
  – A range of LTSS services
  – Broad cross-disability populations
  – Multiple payment types (FFS, Senior Care Options (SCO), Program of All-Inclusive Care for the Elderly (PACE), etc.)
  – MassHealth’s payment reform initiatives (Accountable Care Organizations (ACOs))

• CMS IAP Incentivizing Quality and Outcomes (IQO)
  – Technical assistance and support
  – National groups and resources (NQF, AHRQ, NASUAD, and others)
  – States (NJ, WA, TN)
# Potential Massachusetts Scorecard

## Performance Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>What are they?</th>
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<tbody>
<tr>
<td><strong>30 Day All Cause Hospital Readmission - NQF</strong></td>
<td>Readmission rate for members who were hospitalized and experienced an unplanned readmission for any cause within 30 days of discharge</td>
</tr>
<tr>
<td><strong>Potentially Preventable ED Visits - NYU</strong></td>
<td>Uses an algorithm to categorize whether an ED visit could have been prevented. Eligible ED visits fit into 1 of 3 categories: non-emergent, emergent primary care treatable, and emergent ED care needed, but could have been prevented with timely ambulatory care</td>
</tr>
<tr>
<td><strong>Hospital Admission for Ambulatory Care Sensitive Conditions - AHRQ</strong></td>
<td>Identify whether members have been hospitalized due to conditions for which good outpatient care could potentially prevent the need for hospitalization, or for which early intervention could prevent complications or more severe disease</td>
</tr>
<tr>
<td><strong>Community Tenure</strong></td>
<td>Measure the time spent in the community between hospital or other facility admissions as a measure of clinical and quality of life improvement and risk reduction</td>
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</tbody>
</table>
Data Stability and Benchmarks

• **Impacts on Data Stability**
  – Rare events such as readmissions
  – Half of providers serve <80 members

• **Benchmarking**
  – Evaluated different ways to calculate
  – Graphed the data
  – Set the benchmark
  – Varied by provider type and measure
    • Small providers
    • Small numbers of events
    • Distribution of measure
Benchmarking Model

average = 34%
median = 32%

90th %ile = 18%
10th %ile = 45%

benchmark = 12%
Benchmarking Model

Readmission rates from Adult day

90th %ile = 0%
average = 27%
median = 21%
10th %ile = 42%

benchmark = 0%

Source data: Optum ***does not match Cognos***
## Benchmarking and MA Scorecard

**Provider Name:** ABC Agency, Inc.

**Provider Type:** Adult Foster Care

**Provider ID:** 5555555-55

**Total number of members served:** 83

**Total number of duals served:** 27

**Total number of non-duals served:** 56

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<thead>
<tr>
<th>Metric</th>
<th>Provider FFS Results</th>
<th>All Provider Mean</th>
<th>Benchmark 50% Percentile</th>
<th>Above or Below Benchmark</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>Preventable ED Visits Per 1,000 Members</td>
<td>125</td>
<td>299</td>
<td>296</td>
<td>Below</td>
<td></td>
</tr>
<tr>
<td>30 Day All Cause Readmission Rate</td>
<td>15%</td>
<td>8%</td>
<td>14%</td>
<td>Above</td>
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</tr>
<tr>
<td>Inpatient Admissions for Ambulatory Care Sensitive Conditions Per 1,000 Members</td>
<td>13</td>
<td>44</td>
<td>35.4</td>
<td>Below</td>
<td></td>
</tr>
<tr>
<td>Community Tenure</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>At</td>
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</table>
## Financial Simulation

<table>
<thead>
<tr>
<th>Simulation Metric</th>
<th>Provider A</th>
<th>Provider B</th>
<th>Provider C</th>
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</thead>
<tbody>
<tr>
<td>Number of measures</td>
<td>3</td>
<td>4</td>
<td>4</td>
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<tr>
<td>Weighted points</td>
<td>8 (12)</td>
<td>3 (12)</td>
<td>10 (12)</td>
</tr>
<tr>
<td>Percentage of maximum weights</td>
<td>67%</td>
<td>25%</td>
<td>83%</td>
</tr>
<tr>
<td>Program expenditures</td>
<td>$1,750,591</td>
<td>$1,750,591</td>
<td>$1,750,591</td>
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<tr>
<td>Withhold 1%</td>
<td>$17,506</td>
<td>$17,506</td>
<td>$17,506</td>
</tr>
<tr>
<td>$ Withheld</td>
<td>$5,777</td>
<td>$13,129</td>
<td>$2,976</td>
</tr>
<tr>
<td>% Expenditure</td>
<td>0.33%</td>
<td>0.75%</td>
<td>0.17%</td>
</tr>
<tr>
<td>Withhold 5%</td>
<td>$87,530</td>
<td>$87,530</td>
<td>$87,530</td>
</tr>
<tr>
<td>$ Withheld</td>
<td>$28,885</td>
<td>$65,647</td>
<td>$14,880</td>
</tr>
<tr>
<td>% Expenditure</td>
<td>1.6%</td>
<td>3.75%</td>
<td>0.85%</td>
</tr>
</tbody>
</table>
Next Steps

• Re-engage stakeholders to:
  – Show measure results and scorecard
  – Illustrate the VBP model and how could be used
  – Get feedback

• Implementation of VBP
  – Set benchmarks
  – Determine magnitude of the amount of the % withhold
  – Identify exclusions based on # people served or # events

• Pursue provider population risk-adjustment
• Measure set with administrative data and meaningful for LTSS providers
• Built a basic, flexible, and modifiable VBP financial model using points and weights
• Provider scorecard strategy shows provider in comparison to all providers
Lessons Learned

• Lack of well validated measures for many LTSS/HCBS services (e.g. shared living, adult day programs)

• Small providers and small numbers of events (e.g. readmissions) makes data less stable
Lessons Learned, continued

• The diversity and specific characteristics of LTSS programs, providers, and beneficiary populations require careful consideration in quality measurement.

• Data use agreements, data analysis, and building the model take a long time and require program-analytics partnership.
Data Analytics in LTSS: Commonwealth of Virginia

Jeanette Trestrail, Encounters and Compliance Manager, Department of Medical Assistance Services (DMAS)
“Most of the world will make decisions by either guessing or using their gut. They will be either lucky or wrong.” – Suhail Doshi, chief executive officer, Mixpanel.

“The goal is to turn data into information and information into insight.” – Carly Fiorina, former chief executive officer, Hewlett Packard.
Objectives

- Present the Commonwealth Coordinated Care Plus (CCC Plus) Program
- Define encounters and types
- Introduce the Encounter Processing Solution (EPS)
- Measuring Payment Timeliness
- Measuring Reasonableness
- Focus on Diagnosis
- Display Expenditures by Service
Commonwealth Coordinated Care Plus

- Participation is mandatory for eligible members 238,000
- 6 MCOs Across 6 Regions
- All members receive care coordination
- MLTSS (facility and community based)
- Includes dual and non-dual individuals
- Promotes innovation and value-based payment strategies
- Primary focus is to improve quality, access and efficiency
## Enrollment by Benefit Plans

<table>
<thead>
<tr>
<th>Benefit By Plan</th>
<th>Count of Recip.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-LTSS</td>
<td>46,562</td>
</tr>
<tr>
<td>CCC Plus Waiver w/o PDN</td>
<td>35,477</td>
</tr>
<tr>
<td>DD Waiver</td>
<td>21,114</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>12,733</td>
</tr>
<tr>
<td>CCC Plus Waiver with PDN</td>
<td>4,457</td>
</tr>
</tbody>
</table>

**Benefit By Plan Distribution**

- **AETNA**:
  - Non-LTSS: 27,331
  - CCC Plus Waiver w/o PDN: 12,733
  - Nursing Facility: 1,979
  - CCC Plus Waiver with PDN: 4,457

- **ANHELM**:
  - Non-LTSS: 18,361
  - CCC Plus Waiver w/o PDN: 2,538
  - Nursing Facility: 1,143
  - CCC Plus Waiver with PDN: 2,538

- **MAGELLAN**:
  - Non-LTSS: 29,381
  - CCC Plus Waiver w/o PDN: 5,400
  - Nursing Facility: 2,299
  - CCC Plus Waiver with PDN: 5,400

- **OPTIMA**:
  - Non-LTSS: 21,114
  - CCC Plus Waiver w/o PDN: 3,351
  - Nursing Facility: 1,225
  - CCC Plus Waiver with PDN: 3,351

- **UNITED**:
  - Non-LTSS: 21,114
  - CCC Plus Waiver w/o PDN: 6,157
  - Nursing Facility: 2,299
  - CCC Plus Waiver with PDN: 6,157

- **VA Premier**:
  - Non-LTSS: 21,114
  - CCC Plus Waiver w/o PDN: 6,157
  - Nursing Facility: 2,299
  - CCC Plus Waiver with PDN: 6,157
Encounter Types

- Professional (837P)
  - Professional health care providers
  - Waiver Providers
  - Clinics
  - Transportation

- Institutional (837I)
  - Hospitals and urgent care facilities
  - Nursing Facilities

- Dental (837D)

- Pharmacy (NCPDP)

- Non-Emergency Medical Transportation (NEMT)
Encounter Processing Solution (EPS) Overview

- CMS certified system that applies DMAS’ business requirements via a series of data validation edits
- Interfaces with other data systems that track such data as, but not limited to:
  - Member demographics, eligibility, and enrollment
  - Provider demographics, taxonomy, and enrollment
  - Medicaid Pharmacy Benefit Manager (PBM) contractor for collection of pharmacy rebates

EPS | Data Validation | Reports
Encounter Data Use

- Service utilization & trends
- Determine & monitor costs
- Measure timeframes
- Confirm provider networks
- Rate setting

Clean Encounter Data
Critical Claim and Encounter Dates

**Provider**
- Date(s) of Service
- Submitted claim date to health plan (not on the encounter)

**MCO**
- Date of Receipt (DREC) = Date that the Payer received the transaction from the provider
- Date of Adjudication (DADJ) = Date that the Payer adjudicated the transaction
- Date of Payment (DPYM) = Payment cycle date in which the transaction is processed
- Payment Status (PYMS) = Payment status will reflect whether the Payer’s adjudication process considers the claim to be paid or denied

**DMAS**
- Encounter submittal date
- “Passed” encounter processed date
Measuring Encounter Timeliness

The amount of time it takes to complete the following:

- Healthcare provider to submit claim to health plan
- Health plan to pay the claim
- Health plan to submit the encounter to DMAS
<table>
<thead>
<tr>
<th>Year-Month</th>
<th>Days</th>
<th>Claims Processed</th>
<th>Days</th>
<th>Claims Processed</th>
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<td>52</td>
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<td>2019-02</td>
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<td>2019-03</td>
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</tbody>
</table>
HOSPITAL INPATIENT CLAIMS TIME FROM PAID DATE TO EPS SUBMISSION DATE BY MONTH

2018-09: 59 (Health Plan) - 39 (DMAS) - 48 - 14 (Paid) - 27 (Total)
2018-10: 37 - 27 - 36 - 12 - 13 - 66
2018-11: 24 - 28 - 4 - 15 - 11 - 46
2018-12: 21 - 24 - 3 - 9 - 9 - 39
2019-01: 22 - 21 - 1 - 12 - 7 - 26
2019-02: 20 - 16 - 0 - 10 - 6 - 23
2019-03: 15 - 13 - 0 - 11 - 5 - 38
Nursing Facility (NF) Measure

- Considerations
  - Determine how many distinct NF members enrolled with each plan
    - Individuals with a benefit plan indicating NF
  - Count the number of distinct NF encounters by plan
  - Assume that each NF submits a monthly claim per member
  - Allow for discharges, benefit plan changes and hospitalizations

- We can determine if the health plans are submitting encounters within the range expected based on enrollment
# Nursing Facility (NF) Encounters

## Enrollment – Number of Distinct Members with NF Exception Indicator

<table>
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</thead>
<tbody>
<tr>
<td>Health Plan A</td>
<td>2,192</td>
<td>2,195</td>
<td>2,192</td>
<td>2,200</td>
<td>2,251</td>
<td>2,261</td>
<td>2,251</td>
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<tr>
<td>Health Plan B</td>
<td>2,865</td>
<td>2,839</td>
<td>2,825</td>
<td>2,816</td>
<td>2,803</td>
<td>2,820</td>
<td>2,771</td>
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<tr>
<td>Health Plan C</td>
<td>3,178</td>
<td>3,125</td>
<td>3,096</td>
<td>3,062</td>
<td>3,040</td>
<td>3,056</td>
<td>3,020</td>
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<tr>
<td>TOTAL</td>
<td>8,235</td>
<td>8,159</td>
<td>8,113</td>
<td>8,078</td>
<td>8,094</td>
<td>8,137</td>
<td>8,042</td>
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</table>

## EPS Encounter – Number of Distinct Members by Service Month

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</thead>
<tbody>
<tr>
<td>Health Plan A</td>
<td>2,027</td>
<td>2,028</td>
<td>2,045</td>
<td>2,043</td>
<td>2,077</td>
<td>2,044</td>
<td>2,153</td>
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<tr>
<td>Health Plan B</td>
<td>2,605</td>
<td>2,586</td>
<td>2,605</td>
<td>2,586</td>
<td>2,536</td>
<td>2,496</td>
<td>2,510</td>
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<tr>
<td>Health Plan C</td>
<td>2,812</td>
<td>2,757</td>
<td>2,873</td>
<td>2,817</td>
<td>2,797</td>
<td>2,763</td>
<td>2,735</td>
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<tr>
<td>TOTAL</td>
<td>7,444</td>
<td>7,371</td>
<td>7,523</td>
<td>7,446</td>
<td>7,410</td>
<td>7,303</td>
<td>7,398</td>
</tr>
</tbody>
</table>
Data Reasonableness

NF MMIS Member Count vs EPS Distinct Members by Service Month %

2/2019

- 98%
- 96%
- 94%
- 92%
- 90%
- 88%
- 86%
- 84%


- Health Plan A
- Health Plan B
- Health Plan C

Difficulty with encounters passing
Claims System Issue
Comparison of Specific Diagnosis

• Determined the population to be studied
  – CCC Plus Waiver individuals with a diagnosis of either diabetes or hypertension
  – Utilized enrollment data to gather members
• Defined the procedure codes to be included
• Developed a program to collect all members and procedure codes matching the requirements
Membership limited to individuals utilizing CCC Plus Waiver services and have a diagnosis of diabetes or hypertension

<table>
<thead>
<tr>
<th>CCC Plus Waiver</th>
<th>2017</th>
<th>2018</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percent received any ambulatory or preventive care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All members</td>
<td>27.6%</td>
<td>82.2%</td>
<td>54.6%</td>
</tr>
<tr>
<td>Member with any diagnosis of diabetes</td>
<td>1.4%</td>
<td>12.0%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Member with any diagnosis of hypertension</td>
<td>2.0%</td>
<td>16.1%</td>
<td>14.1%</td>
</tr>
<tr>
<td><strong>Percent with preventive or new patient service</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>All members</td>
<td>6.5%</td>
<td>28.2%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Member with any diagnosis of diabetes</td>
<td>0.2%</td>
<td>1.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Member with any diagnosis of hypertension</td>
<td>0.3%</td>
<td>1.7%</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>Percent that had breast cancer screenings (women ages 40 and over)</strong></td>
<td>0.2%</td>
<td>4.7%</td>
<td>4.5%</td>
</tr>
<tr>
<td><strong>Percent with colon cancer screenings (ages 50 and over)</strong></td>
<td>0.2%</td>
<td>3.1%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>
Expenditures

• Defined the procedure codes to be included
• Determined the timeframe
• Decide which date field to use for the report
  – Dates of service
  – Health plan received date
  – Remittance date
• Developed a program to collect procedure codes matching the requirements
Selected Services Spend Over Time

<table>
<thead>
<tr>
<th></th>
<th>FY16</th>
<th>FY17</th>
<th>FY18</th>
<th>FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive In Home</td>
<td>$26.11</td>
<td>$46.22</td>
<td>$41.72</td>
<td>$51.37</td>
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<tr>
<td>ADHC</td>
<td>$47.78</td>
<td>$74.26</td>
<td>$84.29</td>
<td>$106.57</td>
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<tr>
<td>Respite</td>
<td>$24.64</td>
<td>$47.69</td>
<td>$45.99</td>
<td>$45.06</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>$25.58</td>
<td>$46.27</td>
<td>$57.49</td>
<td>$68.59</td>
</tr>
</tbody>
</table>
Discussion & Questions
Today’s Takeaways

• States should start small and plan to devote adequate staff, time, and resources to pursue meaningful analytics.

• States should be prepared to be agile since metrics are updated often.

• The diversity and specific characteristics of LTSS programs and beneficiary populations require careful consideration in quality measurement.
Thank You!

Thank you for joining today’s webinar!
Please take a moment to complete the post-webinar survey.

We appreciate your feedback!

For more information & resources, please visit Medicaid.gov