NEW YORK STATE | Department of Health | Medicaid Redesign Team

Managed Long Term Care

Clinical Advisory Group Meeting 2

Meeting Date: December 18th

December 2015

Tentative Meeting Schedule & Agenda

Depending on the number of issues address during each meeting, the meeting agenda for each CAG meeting will consist of the following:

Meeting 1

- Clinical Advisory Group- Roles and Responsibilities
- Introduction to Value Based Payment
- Value Based Payment in Managed Long Term Care
- The Opportunities of Empowering Providers

Meeting 2

- Reviewing key themes of first meeting
- Impressions of Data Available for Value-Based Contracting
- Quality Measures

Meeting 3

- Recap of Second Meeting
- Streamlining Regulatory & Assessment opportunities
- Deeper dive into Quality Measures

Content

Introductions & Tentative Meeting Schedule and Agenda

Part I:

A. Review of Key Themes
    i. MLTC Population
    ii. VBP Overview
    iii. Medicare Alignment
    iv. Independence at Home Demonstration Overview

Part II:

A. Impressions of Data Available for Value-Based Contracting
B. Introduction to Quality Measures

Part I

A. Recap of First Meeting

MLTC and VBP

Managed Long Term Care

- Last time we discussed Value Based Payment in Managed Long Term Care and understanding the population.
  - MLTC delivers long-term services to the chronically ill or disabled.
  - Dual-Eligible members represent the majority of both Spend and Member Volume

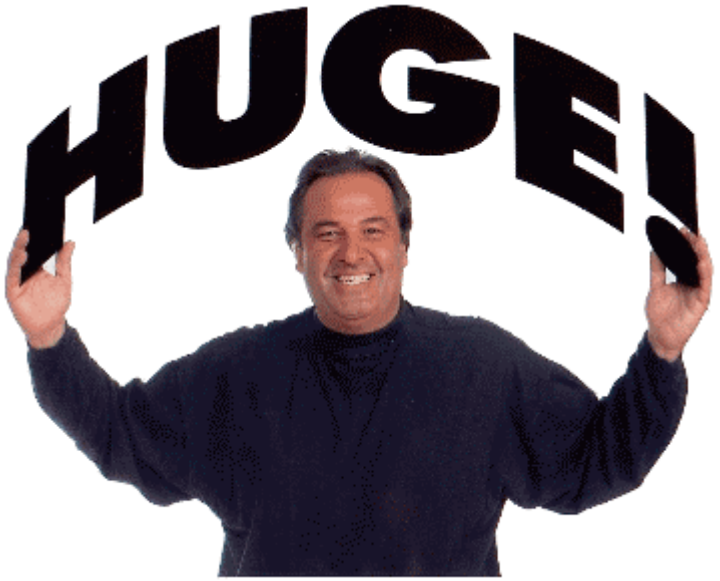
Value Based Payment (VBP)

- Reward value instead of volume
- Different levels of VBP: variation in risk-sharing for the provider
- Challenge: lowering total costs PMPY by
  - 1) finding where there are efficiencies to be gained in the system is and
  - 2) improving outcomes of care
  - 3) investing smartly

Importance of Medicare Alignment

Medicare Alignment

- DOH/CMS recently met and there is continued excitement!
- Medicare and Medicaid jointly pay for approx. 50% of all health care expenditures in NYS.
- Aligning Medicaid VBP Roadmap with CMS VBP Innovations is best thinkable strategy to create irrevocable momentum for aligned Statewide payment reform.
- Opportunities for savings here are:



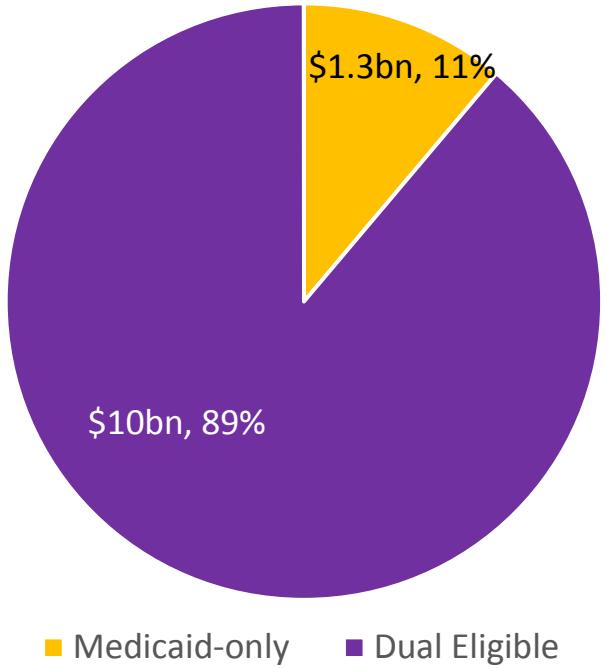
Importance of Medicare Alignment

Duals:

- Dual-Eligible MLTC members represent the majority of both Spend and Member Volume:

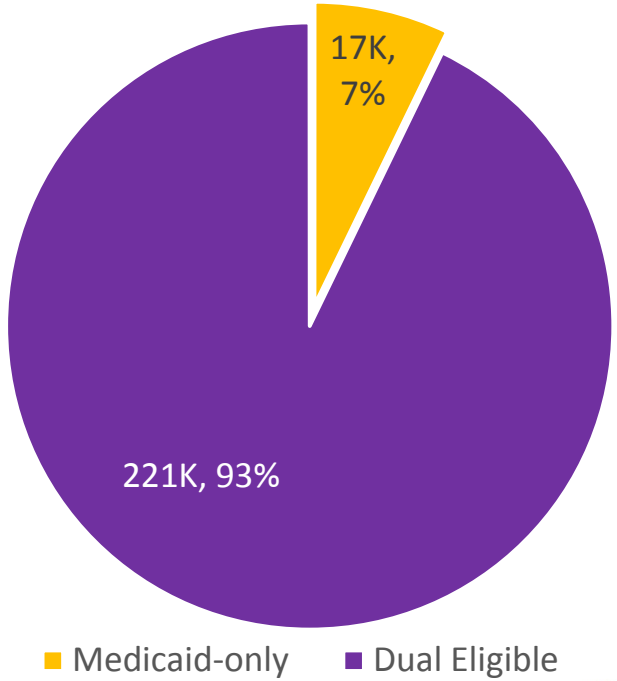
Medicaid-only MLTC Beneficiary Costs relative to Dual-Eligible MLTC Beneficiary Cost

Total Spend in 2014: $11.3bn



Medicaid-only MLTC Beneficiary Volume relative to Dual-Eligible MLTC Beneficiary Volume

Total Members in 2014: 238K



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What's in it for CMS? Why would CMS allow separate path for NYS?

- SIM plans explicitly invite States to request for Medicare Reforms (as part of All-Payer strategy)
- CMS' ambitious goals will not be met without embracing initiatives such as NYS
- CMS has repeatedly publically embraced NYS Medicaid VBP efforts, including invitation to align
- *NYS VBP Models offer a 'next step forwards' to many of the current Medicare Innovation Models*
  - *ACOs (Medicare ACOs – Medicare Shared Savings Program; Pioneer; Next Generation)*
  - *Bundles (Bundled Payments for Care Improvement Program; Oncology Care Model)*
  - *Primary Care Initiatives (Comprehensive Primary Care Initiative; Cardiovascular Disease Risk Reduction Model)*

Suggested approach is simple:

- New York State will allow its VBP Contractors to enroll Medicaid beneficiaries to be enrolled in Medicare Innovation Models that are Level 1 or higher (ACOs, Bundles, Primary Care Initiatives)

- CMS will in turn allow Medicare beneficiaries to be enrolled in NYS Medicaid VBP Arrangements

- Although some providers have significant Medicare VBP experience & infrastructure build up, NYS VBP Arrangements will generally be more attractive for providers:
  - CMS models work with 'haircuts': discount to overall rate that CMS wants before it will allow shared savings
  - NYS generally has larger suggested shared savings percentages
  - NYS models will be adaptable to local needs than CMS Innovation Model

- MCOs do not become responsible for the Medicare FFS part of their dually eligible Medicaid members
- NYS has offered to CMS to be the administrative 'broker' and 'data-handler' for the Medicare FFS beneficiaries that are enrolled in Medicaid VBP arrangements

One Promising New Model?
Independence at Home Demonstration

Service Delivery:

- Primary care teams provide services to Medicare FFS members with multiple chronic conditions in their homes.
- Home based primary care allows greater accountability from provider for all aspects of patients' care.

Payment Incentives:

- Incentive payments awarded to providers who reduce Medicare FFS expenses, meet designated quality measures.
- Consistent performers have opportunity for shared savings after meeting a minimum savings rate.

Participating Practices Requirements:

- Led by physicians or nurse practitioners.
- Organized for the purpose of providing physician services.
- Have experience providing home based primary care to patients with multiple chronic conditions.
- Serve at least 200 eligible beneficiaries.

- https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/iah_factsheet.pdf

Independence at Home Demonstration

Current Status:

- NYS DOH working with CMS, Medicare to show savings in Medicare

- Proposal to CMS by Jason Helgerson for Medicare/Medicaid-aligned IAH.
- CMS aware of large implications of IAH for Medicaid

- Until now, Medicaid has not been involved in the equation

- The fact that IAH does not assume Medicare Managed Care has proven to be a success-factor
  - Direct 'control' by CMS of the program
  - No opt-out patterns due to restriction of patient choice

- Including Medicaid seems logical next step because interventions will directly support reducing avoidable nursing homes admissions etc.

Independence at Home Demonstration

- Affordable Care Act payment model saves more than $25 million in first performance year!!
- 100% of participating practices improved quality in at least three of the six quality measures for the demonstration in the first performance year.
- Practice Incentive Payments = $11,668,023
- July 2015 - Demonstration extended for two years!!

Part II

A. Data Impressions for Value-Based Contracting

Four Important Costs Drivers for the MLTC population are Price, Volume, PACs and Service Mix

Cost Drivers

Price

The price of a service can vary based on providers' own costs (e.g. wages).

Volume

The volume of services rendered (e.g. nursing home use).

PACs

Potentially avoidable complications (e.g. exacerbations).

Service Mix

The mix of services and intensity of care received during the episode (e.g. inpatient vs. outpatient point of care).

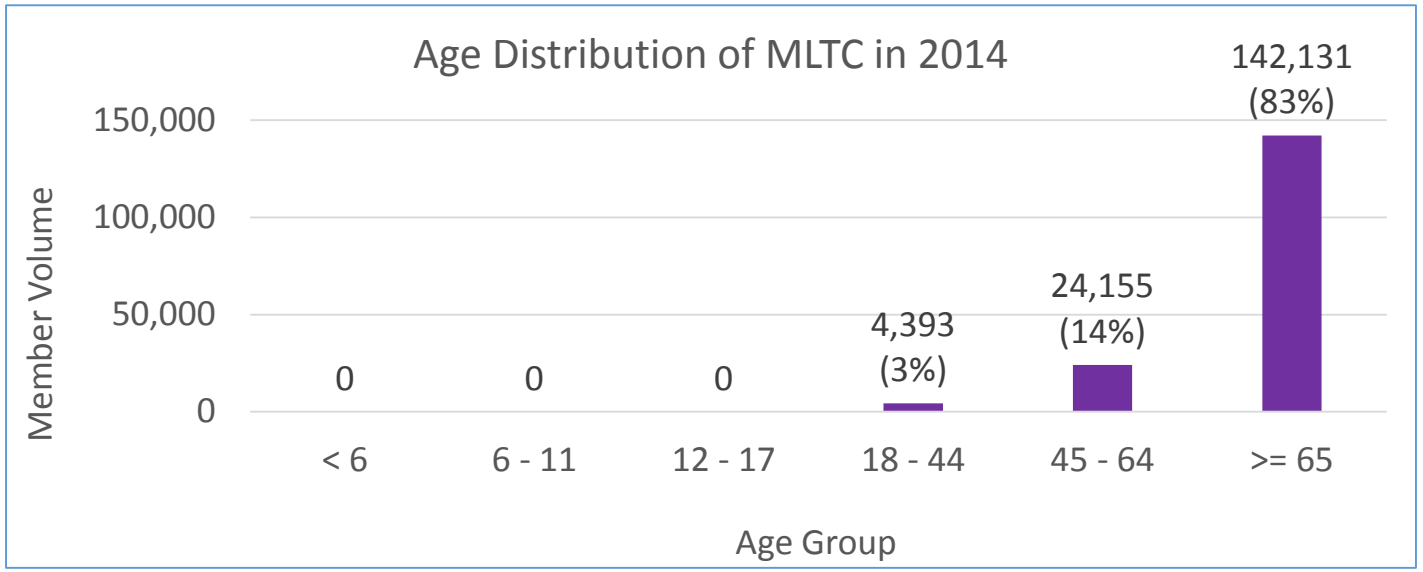
MLTC members account for $11.3 billion in Annual Medicaid Spend

Total Annual Cost of MLTC (to the State)
$11.3bn

Total annual cost to MLTC based on 2014 data and incorporates the State's expected transition of Nursing Home care into MLTC.

Annual Member Volume
238K Members

Average Cost per MLTC Member
($11.3bn / 238K members)
$47,606



Costs Included:
- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.
- Caveat: Costs at $11.3bn are based on 2014 data and account for the planned future nursing home transition.

Source: 01/01/2014 – 12/31/2014 Medicaid claims (Salient Interactive Miner)

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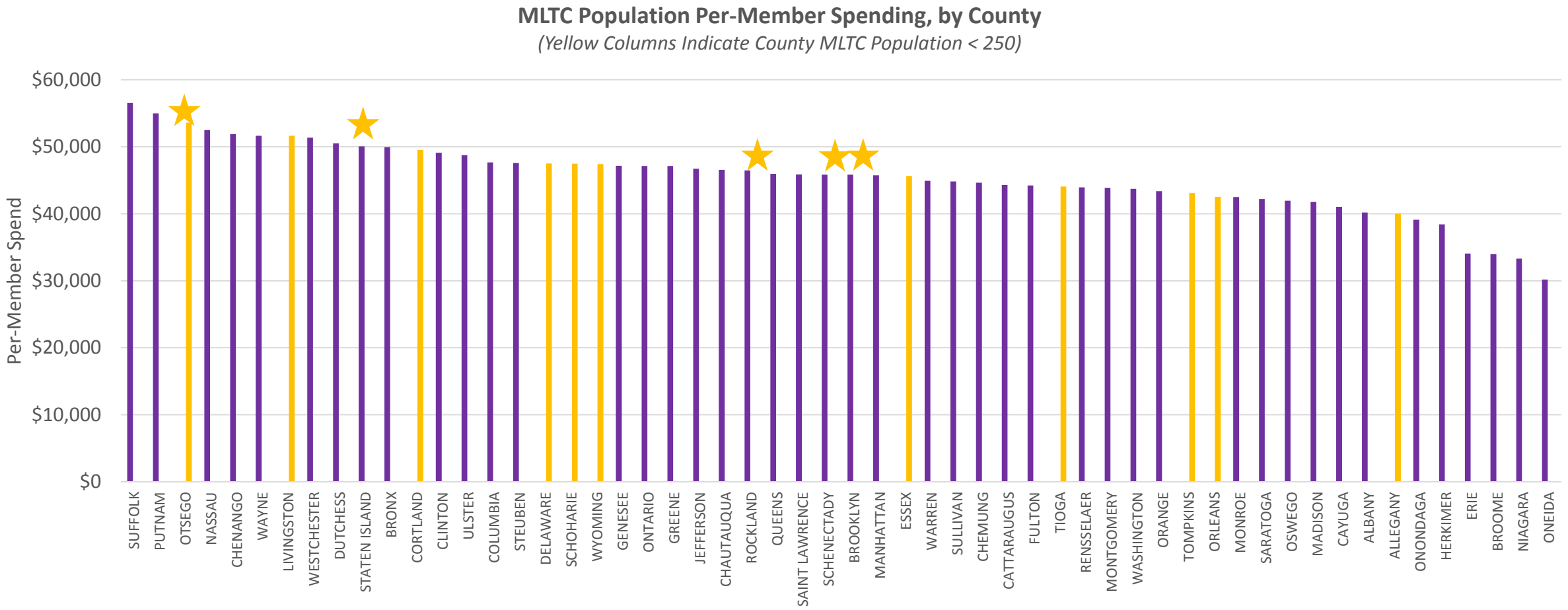
Per-member MLTC Spending Ranges from $30,190 to $56,554



Counties with largest MLTC populations (absolute numbers)

Source: 01/01/2014 – 12/31/2014 Medicaid claims (Salient Interactive Miner)

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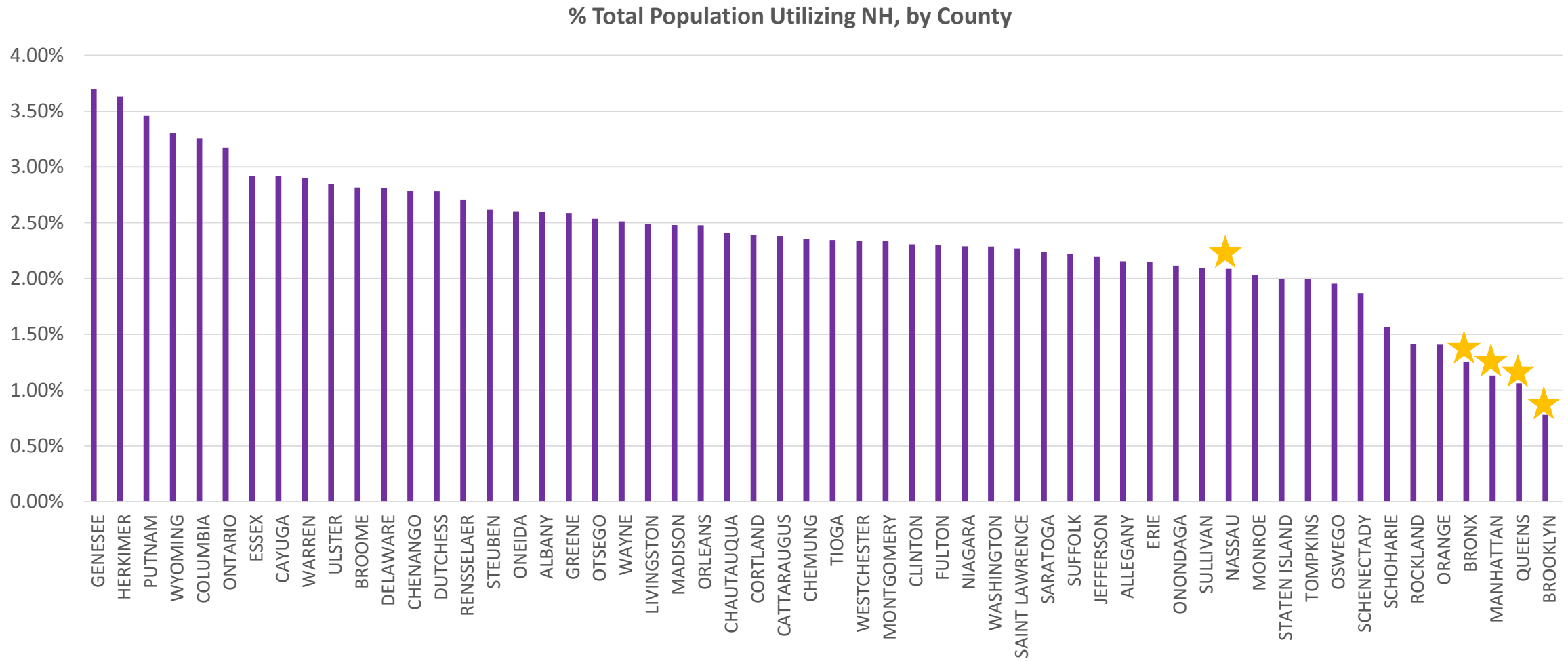
Nursing Home Utilization Lower in Populous Counties



Counties with largest MLTC populations (absolute numbers)

Source: 01/01/2014 – 12/31/2014 Medicaid claims (Salient Interactive Miner)

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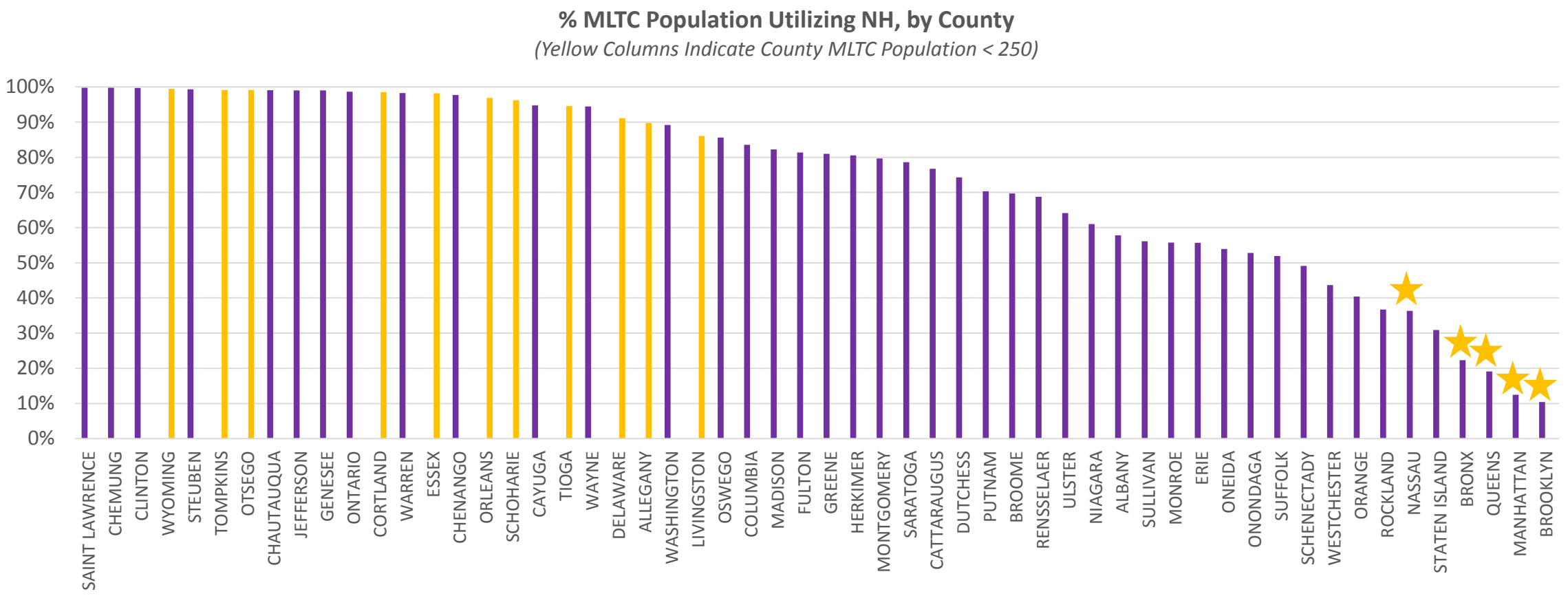
Upstate Counties See Inflows into MLTC from NH Transition



Counties with largest MLTC populations (absolute numbers)

Source: 01/01/2014 – 12/31/2014 Medicaid claims (Salient Interactive Miner)

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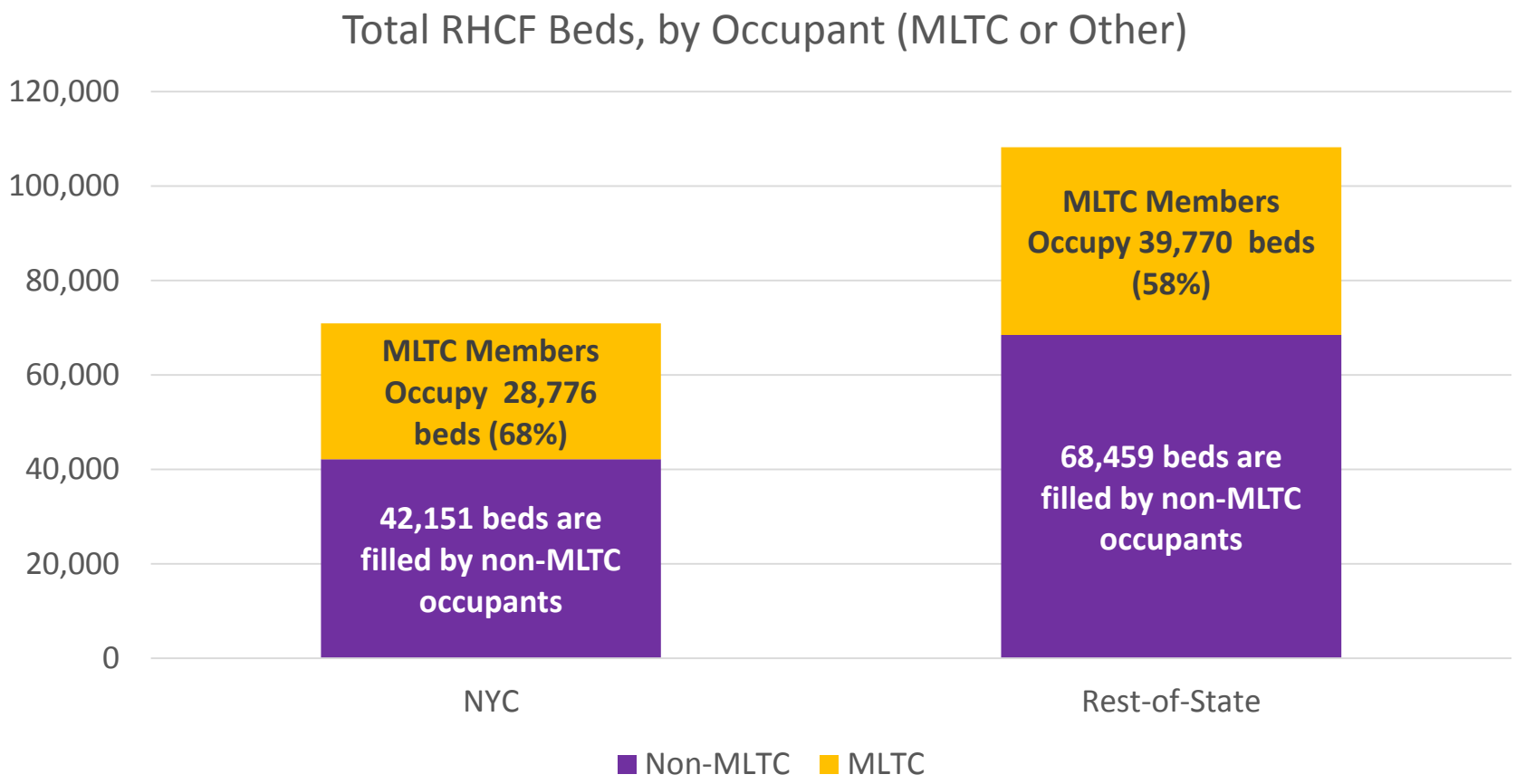
MLTC NH Utilizers Fill 60%+ of all RCHF Beds Statewide



Source:
01/01/2014 – 12/31/2014 Medicaid claims (Salient Interactive Miner)
NYS DOH 2016 projected estimate data https://www.health.ny.gov/facilities/nursing/rhcf_bed_need_by_county.htm

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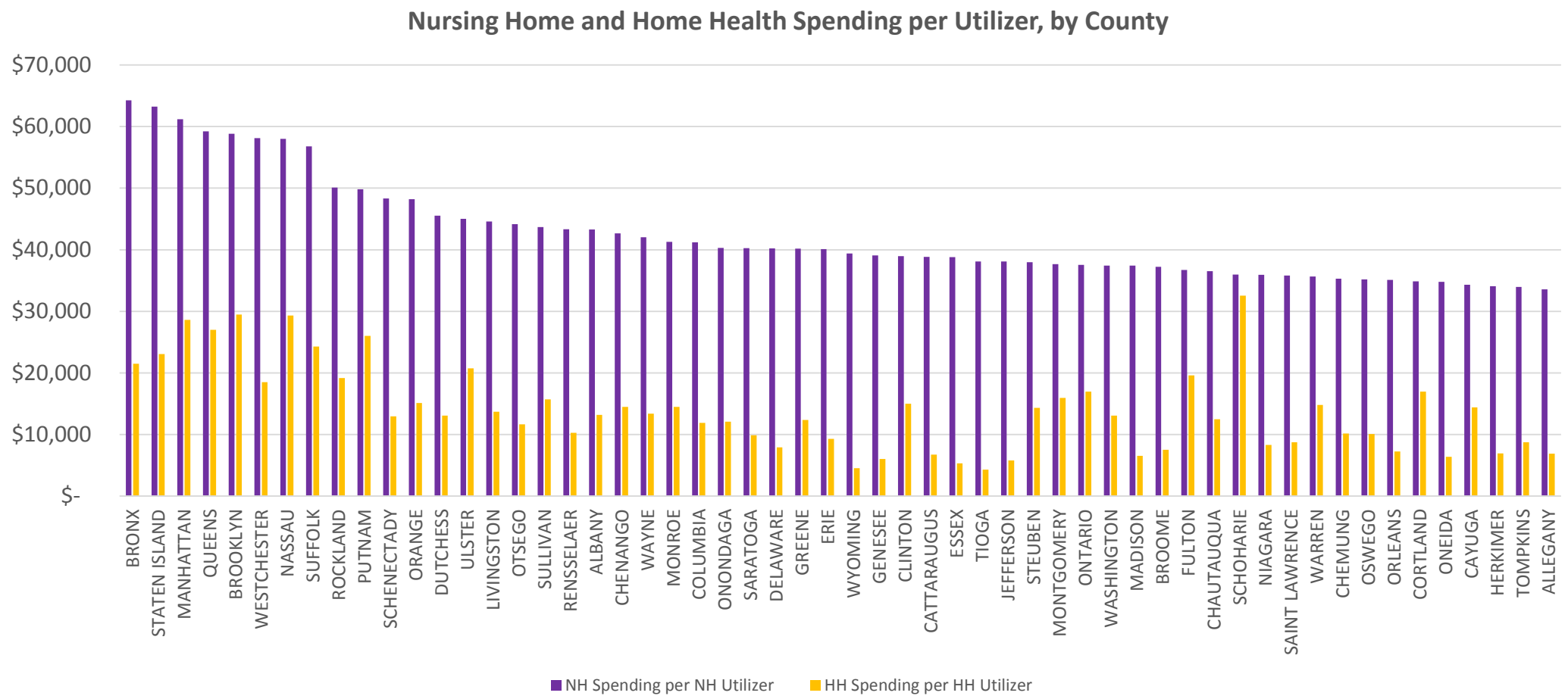
On a Per-Utilizer Basis, Nursing Homes Cost Up to $42,700 more per year than Home Health Utilizers



Source: 01/01/2014 – 12/31/2014 Medicaid claims (Salient Interactive Miner)

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Potential for Supportive Care at Home?

One scenario:

- Current nursing home utilization across the State is higher, at 2.42%, than average utilization in NYC, at 1.12%.
- MLTC accounts for, on average, 55% of nursing home utilizers across the State.
- If all counties' utilization outside NYC services were reduced to the NYC rate, the differential would be $925.7 million.

Effect: The potential to use these resources to enhance supports at home for these 23,000 people (at an assumed enriched 1.5 times the current $18,462 average) creates a potential pool of nearly $300 million for reinvestment in innovative care models.

	NYC	Rest of State
Average HH Cost	$ 27,111	$ 18,462
Average NH Cost	$ 60,994	$ 45,558
NH/HH Cost Ratio	2.25	2.47

Part II

B. Introduction to Quality Measures

Managed Long Term Care

The Goal of the Measure Review Process

The measure review process used in other CAGs was to decide on measures by category.

- Categories for MLTC could include Activities of Daily Living, Prevention, and Cognition.

After reviewing the list, assign measures to a categorization "bucket."

CATEGORY 1
Approved quality measures that are felt to be both clinically relevant, reliable and valid, and feasible.

CATEGORY 2
Measures that are clinically relevant, valid and probably reliable, but where the feasibility could be problematic. These measures should be investigated during the 2016 or 2017 pilot.

CATEGORY 3
Measures that are insufficiently relevant, valid, reliable and/or feasible.

Measure Review Process

What best represents the number of measures available…

- Over 200 measures were gathered in preparation of the typical review process
  - Appendix contains full list

Sources include:

- CMS 5 Star
- CMS 2 Star
- CMS OASIS

- To not design new measures but pick from the tremendous selection of available measures
- Select measures that:
  - Have clinical relevance
  - Have reliability and validity
  - Are feasible
  - Cover full spectrum of care
  - Are meaningful

Quality Measures

Given the plethora of measures in each sector of care, we would like to consider:

Combining aspects of the MLTC Quality Incentive and Nursing Home Quality Initiative to form the basis of MLTC VBP arrangement

Let's Consider!

MLTC Quality Incentive

MLTC Quality Incentive

- Designed to focus on home care quality. A separate nursing home incentive is in place.
- 2014 was the inaugural year of the MLTC Quality Incentive.
- Measures were selected during a series of workgroup meetings between OPQS, health plans and advocates.
- 5 new quality measures were added for 2015 as point to point metrics became available.
- 2015 rankings have been completed & Incentive payments are soon to be distributed!

MLTC Quality Incentive

The 2015 Managed Long-Term Care (MLTC) Quality Incentive is comprised of four areas:

1. Quality Measures
   - Calculated using January – June data from the UAS-NY.
2. Satisfaction Measures
   - Survey completed every two years MLTC & mainstream Medicaid plans. Last survey closed March 2015.
3. Compliance Measures
   - Based on the timely submission of required reports or assessments information.
4. Efficiency Measures
   - A series of identifying data from the UAS-NY dataset will be used to identify enrollees' potentially avoidable hospitalizations in the 2014 SPARCS inpatient dataset.

The incentive is based on the achieved points each plan earns in the four areas. A total of 100 points are available for the incentive.

MLTC Quality Incentive

Quality Measures (50 points):

- Percentage of members who did not have an emergency room visit in the last 90 days
- Percentage of members who did not have falls resulting in medical intervention in the last 90 days
- Percentage of members whose pain was controlled
- Percentage of members who were not lonely and distressed
- Percentage of members who received an influenza vaccination in the last year
- Percentage of members who responded that a health plan representative talked to them about appointing someone to make decisions about their health if they are unable to do so
- Percentage of members who remained stable or demonstrated improvement in pain intensity
- Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care (NFLOC) score
- Percentage of members who remained stable or demonstrated improvement in urinary continence
- Percentage of members who remained stable or demonstrated improvement in shortness of breath

The points for quality measures are awarded based on the statewide range of scores:

Plan Rate	Points Awarded for a Measure	Example Based on 5 Points per Measure
<50th statewide percentile	No points	0.00 points
>= 50th to <75th statewide percentile	50% of the possible points	2.50 points
>= 75th to <90th statewide percentile	75% of the possible points	3.75 points
>=90th statewide percentile	100%, full points	5.00 points

MLTC Quality Incentive

Satisfaction Measures (30 Points):

The satisfaction measures are based on the 2015 MLTC Member Satisfaction Survey results.

- Percentage of members who rated their managed long-term care plan as good or excellent
- Percentage of members who responded that they were usually or always involved in making decisions about their plan of care
- Percentage of members who reported that within the last 6 months the home health aide or personal care aide services were always or usually on time
- Percentage of members who rated the helpfulness of the plan in assisting them and their family to manage their illnesses as good or excellent
- Percentage of members who rated the quality of care manager or case manager services within the last six months as good or excellent
- Percentage of members who rated the quality of home health aide or personal care aide services within the last 6 months as good or excellent

The points for satisfaction measures are awarded based on plan performance compared to the statewide average:

Plan Performance	Points Awarded for a Measure	Example Based on 5 Points per Measure
Results significantly lower than the statewide average	No points	0 points
Results not significantly different from the statewide average	50% of the possible points	2.5 points
Results significantly higher than the statewide average	100%, full points	5 points

MLTC Quality Incentive

Compliance Measures (10 points):

Compliance measures are based on the timely submission of required reports or assessments information. The compliance component consists of one measure from each of the following four areas:

Medicaid Encounter Data System (MEDS), Medicaid Managed Care Operating Report (MMCOR), Ratio,

and Provider Network. Each measure is worth a maximum of 2.5 points.

Category	Measure Description	Time frame
Provider Network	No statement of deficiency for failure to submit Provider Network data during the measurement year 2014.	Quarterly submissions within 2014
MEDS	No statement of deficiency for timeliness or completeness of MEDS III submission for measurement year 2014.	MEDS III data submitted for 2014
MMCOR	No statement of deficiency for timeliness or completeness of MMCOR submission for measurement year 2014.	MMCOR reports submitted for 2014
Ratio	MEDS vs. MMCOR ratios of at least 75%-encounter data gross dollars must represent at least 75% of MMCOR reported medical expense for measurement year 2014.	MEDS data and MMCOR reports submitted for 2014

MLTC Quality Incentive

Efficiency Measure (10 points):

Potentially Avoidable Hospitalization (PAH) is a measure of efficiency. A PAH is an inpatient hospitalization that might have been avoided if proper outpatient care was received in a timely fashion. The hospitalization is identified as potentially avoidable if the primary diagnosis is any one of the following conditions: heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection.

The Uniform Assessment System for New York (UAS-NY) 2014 data will be used for this measure.

The points for the efficiency measure are awarded based on plan performance compared to the statewide Average:

Plan Performance	Points Awarded	Example Based on 10 Points per Measure
Results significantly higher than the statewide average	No Points	0 points
Results not significantly different from the statewide average	50% of possible points	5 points
Results significantly lower than the statewide average	100%, full points	10 points

Nursing Home Quality Initiative

The 2015 Nursing Home Quality Initiative is comprised of three areas:

1. Quality Measures
2. Compliance Measures
3. Efficiency Measures

- The 2015 NHQI is worth a maximum 100 points.

Current Status:

- Assessment is in it's 3rd year, rankings have been posted & Incentive payments are pending

- Uses MDS data - OPQS has began talks with interRAI to get the nursing home tool online

Nursing Home Quality Initiative

Quality Component (70 points)

Quality measures are calculated from MDS 3.0 data, the NYS employee flu vaccination data, nursing home cost report data for the percent of contract/agency staff used, and the CMS five-star quality rating for staffing.

The 2015 NHQI includes 14 quality measures with each measure being worth a maximum of 5 points. Four quarters of 2014 MDS 3.0 data are used.

- Percent of contract/agency staff used – Scoring method: Threshold
- CMS five-star quality rating for staffing – Scoring method: 1 & 2 Star = 0 points, 3 Stars = 1 point, 4 Stars = 3 points, 5 Stars = 5 points
- Percent of employees vaccinated for influenza – Scoring method: Threshold
- Percent of long stay high risk residents with pressure ulcers – Scoring method: Quintile
- Percent of long stay residents who received the pneumococcal vaccine* – Scoring method: Quintile
- Percent of long stay residents who received the seasonal influenza vaccine* – Scoring method: Quintile
- Percent of long stay residents experiencing one or more falls with major injury – Scoring method: Quintile
- Percent of long stay residents who have depressive symptoms – Scoring method: Quintile
- Percent of long stay low risk residents who lose control of their bowel or bladder – Scoring method: Quintile
- Percent of long stay residents who lose too much weight – Scoring method: Quintile
- Antipsychotic use in persons with dementia – Scoring method: Quintile
- Percent of long stay residents who self-report moderate to severe pain – Scoring method: Quintile
- Percent of long stay residents whose need for help with daily activities has increased – Scoring method: Quintile
- Percent of long stay residents with a urinary tract infection – Scoring method: Quintile

* A higher rate is better

Nursing Home Quality Initiative

Compliance Component (20 points)

The compliance component consists of three areas: CMS' five-star quality rating for health inspections, timely submission of nursing home certified cost reports, and timely submission of employee influenza immunization data.

- CMS Five-Star Quality Rating for Health Inspections (regionally adjusted)
  - Scoring method: 1 star = 0 points, 2 stars = 2 points, 3 star s= 4 points, 4 stars = 7 points, 5 stars = 10 points
- Timely submission of employee influenza vaccination data
  - Scoring method: Five points for submission by the deadline
- Timely submission of certified and complete nursing home cost reports
  - Scoring method: Five points for timely, certified and complete submission of the 2014 cost report

Nursing Home Quality Initiative

Efficiency Component (10 points)

To align with the other CMS quality measures, the Potentially Avoidable Hospitalizations rate will be calculated for each quarter, then averaged to create an annual average. The PAH measure is risk adjusted.

- Potentially Avoidable Hospitalizations
  - Scoring method: Quintile 1=10 points, Quintile 2=8 points, Quintile 3=6 points, Quintile 4=2 points, Quintile 5=0 points

Is a Combination Sufficient or are Other Measures Needed?

- Broad overarching measures
    - Longevity or others?
- Areas overlooked in the combination of MLTC Quality Incentive Initiative and Nursing Home Quality Initiative?
    - Sufficient identification of potentially avoidable costs?
- Nursing Home assessment tool – transition to more usable InterRAI?
- Current measures that exist that need to be elevated
    - Vaccinations?
    - Pressure sores/Pressure ulcers?

We will explore the best date for the 3rd CAG meeting, shortly after the holidays!

Meeting 3 tentative agenda:

- Recap of Second Meeting
- Streamlining Regulatory & Assessment opportunities
- Deeper dive into Quality Measures

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Appendix

December 2015

Quality Measures

CMS 5 Star

- Percent of residents whose need for help with activities of daily living has increased
- Percent of residents who received an antipsychotic medication
- Percent of residents who newly received an antipsychotic medication
- Percent of high risk residents with pressure ulcers (sores)
- Percent of residents who have/had a catheter inserted and left in their bladder
- Percent of residents who were physically restrained
- Percent of residents with a urinary tract infection
- Percent of residents who self-report moderate to severe pain (Long Stay)
- Percent of residents experiencing one or more falls with major injury
- Percent of residents with pressure ulcers (sores) that are new or worsened
- Percent of residents who self-report moderate to severe pain (Short Stay)

Quality Measures

CMS 2 Star

- Improvement in Ambulation/locomotion
- Improvement in Bed Transferring
- Improvement in Bathing
- Improvement in Pain Interfering With Activity
- Timely Initiation of Care
- Drug Education on all Medications Provided to Patient/Caregiver
- Influenza Immunization Received for Current Flu Season (Home Health)
- Improvement in Dyspnea (Shortness of Breath)
- Acute Care Hospitalization

Outcome Measures

CMS OASIS

- Improvement in Ambulation/locomotion
- Improvement in Upper Body Dressing
- Improvement in Lower Body Dressing
- Improvement in Grooming
- Stabilization in Grooming
- Improvement in Bathing
- Stabilization in Bathing
- Improvement in Eating
- Improvement in Toilet Transferring
- Stabilization in Toilet Transferring
- Improvement in Bed Transferring
- Stabilization in Bed Transferring
- Improvement in Management of Oral Medications
- Stabilization in Management of Oral Medications
- Improvement in Light Meal Preparation
- Stabilization in Light Meal Preparation

Quality Measures

CMS OASIS (continued)

- Improvement in Bed Transferring
- Stabilization in Bed Transferring
- Improvement in Management of Oral Medications
- Stabilization in Management of Oral Medications
- Improvement in Light Meal Preparation
- Stabilization in Light Meal Preparation
- Improvement in Phone Use
- Stabilization in Phone Use
- Improvement in Pain Interfering with Activity
- Improvement in Speech and Language
- Stabilization in Speech and Language
- Improvement in Toileting Hygiene
- Stabilization in Toileting Hygiene
- Substantial Decline in 3 or more Activities of Daily Living
- Depression Assessment Conducted
- Improvement in Confusion Frequency
- Stabilization in Cognitive Functioning

Quality Measures

CMS OASIS (continued)

- Improvement in Anxiety Level
- Stabilization in Anxiety Level
- Improvement in Dyspnea (Shortness of Breath)
- Improvement in Status of Surgical Wounds
- Improvement in Urinary Tract Infection
- Improvement in Urinary Incontinence
- Improvement in Bowel Incontinence
- Improvement in Behavior Problem Frequency
- Emergency Department Use without Hospitalization
- Emergency Department Use with Hospitalization
- Discharged to Community
- Acute Care Hospitalization
- Timely Initiation of Care
- Physician Notification Guidelines Established
- Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate
- Pain Assessment Conducted
- Pressure Ulcer Risk Assessment Conducted

Quality Measures

CMS OASIS (continued)

- Depression Interventions In Plan Of Care
- Diabetic Foot Care And Patient Education In Plan Of Care
- Falls Prevention Steps In Plan Of Care
- Pain Interventions In Plan Of Care
- Pressure Ulcer Prevention In Plan Of Care
- Pressure Ulcer Treatment Based On Principles Of Moist Wound Healing In Plan Of Care
- Depression Interventions Implemented
- Diabetic Foot Care And Patient/Caregiver Education Implemented
- Heart Failure Symptoms Assessed and Addressed
- Pain Interventions Implemented
- Treatment Of Pressure Ulcers Based On Principles Of Moist Wound Healing Implemented
- Drug Education on High Risk Medications Provided To Patient/Caregiver at Start of Episode
- Drug Education On All Medications Provided To Patient/Caregiver
- Falls Prevention Steps Implemented
- Potential Medication Issues Identified And Timely Physician Contact
- Pressure Ulcer Prevention Implemented
- Potential Medication Issues Identified And Timely Physician Contact at Start of Episode

Outcome Measures

CMS OASIS (continued)

- Influenza Immunization Received For Current Flu Season
- Influenza Immunization Offered and Refused
- Influenza Immunization Contraindicated
- Pneumococcal Vaccine Ever Received
- Pneumococcal Vaccine Offered and Refused
- Pneumococcal Vaccine Contraindicated
- Emergent Care for Injury Caused by Fall
- Emergent Care for Wound Infection, Deteriorating Wound Status
- Emergent Care for Improper Medication Administration or Medication Side Effects
- Emergent Care for Hypo/Hyperglycemia
- Development of Urinary Tract Infection
- Increase in Number of Pressure Ulcers
- Substantial Decline in Management of Oral Medications
- Discharged to the Community with an Unhealed Stage II Pressure Ulcer
- Discharged to the Community Needing Wound Care or Medication Assistance
- Discharge to the Community Needing Toileting Assistance
- Discharge to the Community with Behavioral Problems

Quality Measures

Additional Nursing Home Measures

- Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument
- Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument
- Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument
- Percent of Residents Who Have Depressive Symptoms
- Percentage of patients with established set goals for pain relief
- Percentage of patients with documented person-centered inter-professional care plan for acute or chronic pain
- Percentage of patients with chronic pain diagnosis with documentation of a pain assessment completed at initial visit using a standardized tool that addresses pain intensity, location, pattern, mechanism of pain, current functional status and follow-up plan
- Percentage of patients diagnosed with chronic pain with documentation of reassessment of pain at follow-up visits using a standardized tool that addresses pain intensity, location, pattern and current functional status
- Percentage of chronic pain patients who are referred to diagnostic and/or therapeutic procedures if the goals for pain control or functional status have not been met
- Percentage of patients diagnosed with chronic pain with referral to physical rehabilitation and/or behavioral management therapy
- Percentage of patients documented with achieving pain control goals after treatment
- Percentage of patients with adjustments made in treatment plan by practitioner when pain management plan is not effective
- Percentage of patients with documentation by the practitioner that summarizes the characteristics and causes of the patient's pain
- Percentage of patients with documented assessment for pain using standardized tool at each quarterly review

Quality Measures

Additional Nursing Home Measures (continued)

- Percentage of patients with documented assessment for pain using standardized tool on admission
- Percentage of patients with documented assessment of the impact of pain on function and quality of life
- Percentage of patients with documented reduction of pain symptoms
- Percentage of patients with periodic documented assessment by licensed nursing staff of effectiveness of pain management
- Percentage of patients diagnosed with chronic pain with documentation of screening for major depression and chemical dependency
- Percentage of patients diagnosed with chronic pain who are screened for chemical dependency before being prescribed opioid medication
- Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine
- Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine
- Percent of Residents Who Lose Too Much Weight
- Percent of Residents Who Received the Pneumococcal Vaccine
- Percent of Residents Who Received the Seasonal Influenza Vaccine
- Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine
- Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine
- Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder (Long-Stay)

Quality Measures

Additional MLTC Measures

- CARE: Improvement in Mobility
- CARE: Improvement in Self Care
- Change in Basic Mobility as Measured by the AM-PAC
- Change in Daily Activity Function as Measured by the AM-PAC
- Home health care: percentage of home health episodes of care during which the patient improved in ability to manage their oral medications
- Physical Activity in Older Adults
- Asthma Medication Ratio (AMR)
- Care for Older Adults (COA) – Medication Review
- Medication Reconciliation Post-Discharge
- Use of High-Risk Medications in the Elderly
- Adherence to Statin Therapy for Individuals with Coronary Artery Disease
- Adherence to Statins for Individuals with Diabetes Mellitus
- INR Monitoring for Individuals on Warfarin
- INR for Individuals Taking Warfarin and Interacting Anti-infective Medications
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
- Adherence to Antiplatelet Therapy after Stent Implantation

Quality Measures

Additional MLTC Measures (continued)

- Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus
- Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus
- Adherence to Chronic Medications
- Annual Monitoring for Patients on Persistent Medications
- Antipsychotic Use in Persons with Dementia
- Diagnosis and management of chronic obstructive pulmonary disease (COPD): percentage of patients with COPD who are prescribed appropriate therapy
- CARE: Consumer Assessments and Reports of End of Life
- Assessment of Health-related Quality of Life (Physical & Mental Functioning)
- Fall Risk Management
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Adult Kidney Disease : Patients on Erythropoiesis Stimulating Agent (ESA)--Hemoglobin Level > 12.0 g/dL
- Adult Kidney Disease: Hemodialysis Adequacy: Solute
- Adult Kidney Disease: Laboratory Testing (Lipid Profile)
- Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute
- Adult(s) taking insulin with evidence of self-monitoring blood glucose testing
- Adult(s) with diabetes mellitus that had a serum creatinine in last 12 reported months

Outcome Measures

Additional MLTC Measures (continued)

- Adult(s) with frequent use of acute migraine medications that also received prophylactic medications
- Advance Care Plan
- Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
- Age-Related Macular Degeneration: Dilated Macular Examination
- Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy
- Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia
- Average-risk residents with pressure ulcers
- Cervical Cancer Screening
- Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
- Chronic Stable Coronary Artery Disease: Lipid Control
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Hypertension: Blood Pressure Control
- Management of Urinary Incontinence in Older Adults

Quality Measures

Additional MLTC Measures (continued)

- Osteoporosis Management in Women Who Had a Fracture
- Osteoporosis Testing in Older Women
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Pneumococcal Vaccination Status for Older Adults
- Glycemic Control – Hyperglycemia
- Glycemic Control – Severe Hypoglycemia