Managed Long-Term Care

Clinical Advisory Group Meeting 4

Meeting Date: April 18, 2016

April 2016

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

- MLTC Total Cost of Care
- Revisiting Themes from Second Meeting
- Selecting Quality Measures
- Pilot Opportunities– Potential Interest

Meeting 4

- Review Opportunities & VBP Options
- Quality Measures
- Discussion of regulatory concerns and other barriers
- VBP Pilots

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Content Overview

Part I:
- Review Opportunities & VBP Options
    - Savings within each care path
    - Care Partnerships
    - Quality Initiative Pools

Part II:
- Quality Measures
    - Recap Selected Measures
    - Review Additional Considerations

Part III:
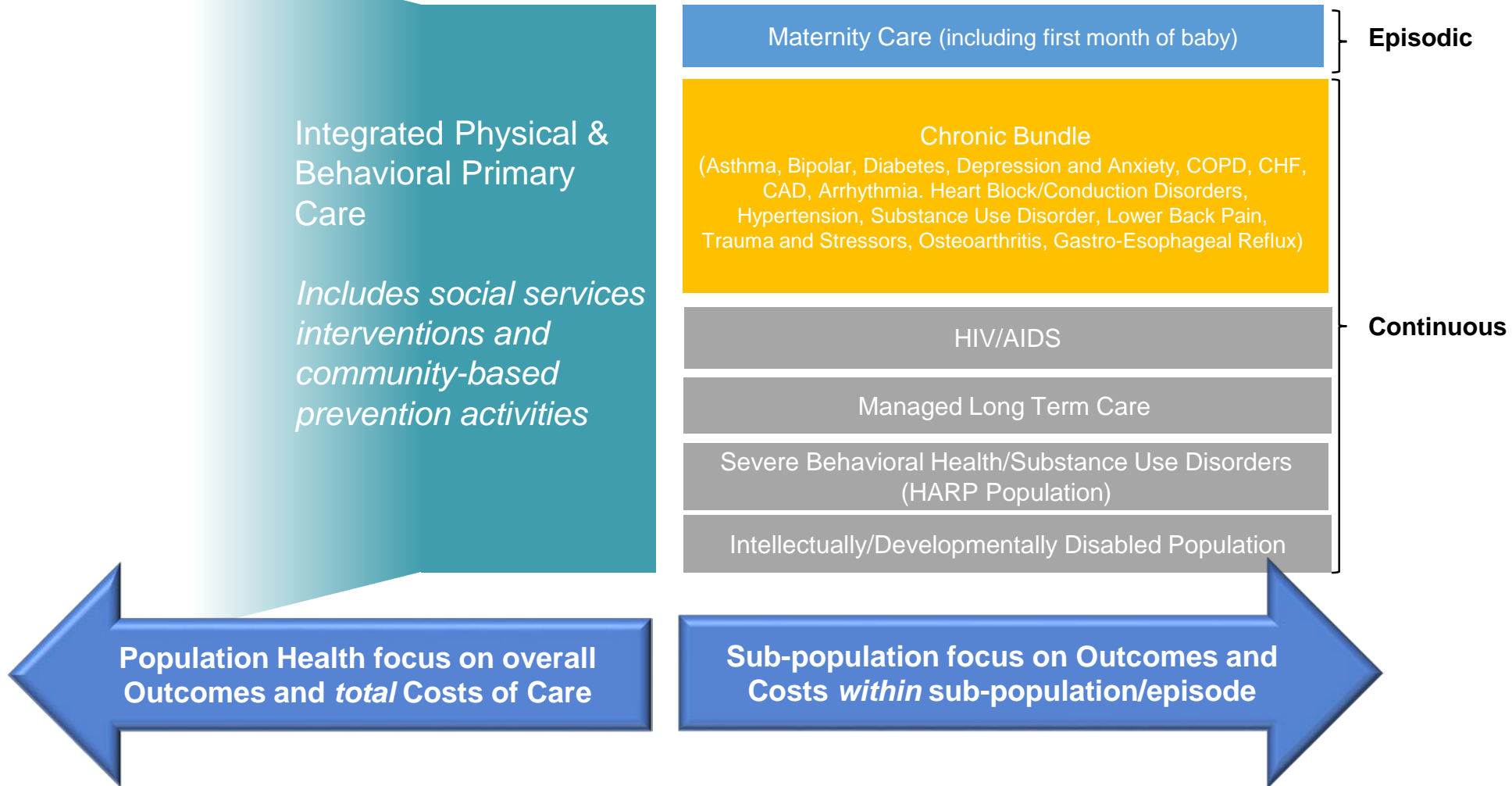- Regulatory concerns and other barriers

Part IV:
- Value Based Payment Pilots

Part I

A. Review Opportunities & VBP Options

The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function

Integrated Physical & Behavioral Primary Care

Includes social services interventions and community-based prevention activities

| Maternity Care (including first month of baby) | Episodic |

Chronic Bundle
(Asthma, Bipolar, Diabetes, Depression and Anxiety, COPD, CHF, CAD, Arrhythmia. Heart Block/Conduction Disorders, Hypertension, Substance Use Disorder, Lower Back Pain, Trauma and Stressors, Osteoarthritis, Gastro-Esophageal Reflux)

HIV/AIDS

Managed Long Term Care

Severe Behavioral Health/Substance Use Disorders (HARP Population)

Intellectually/Developmentally Disabled Population

Continuous

← **Population Health focus on overall Outcomes and *total* Costs of Care**

→ **Sub-population focus on Outcomes and Costs *within* sub-population/episode**

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Opportunities for savings within each and across the entire care path

Nursing Home

Home Care

- Prevent All-Cause Hospitalizations

- Transition lower acuity members to community settings

- Care planning to enhance members activities of daily living (ADLs) and reduce care needs

- Preventing or delaying institutional care

- Prevent All-Cause Hospitalizations

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Likely Roadmap adaptations

- Explicit inclusion of two separate subpopulations that can be contracted:
  - Home care based
    - most likely contracted by home care agency and other partners
  - Nursing Homes based
    - most likely contracted by nursing home and other partners
- Both based on MLTC assessment

- Allowing 'carve out' of supplementary services in contracting discussions between VBP contractor and MLTC
  - Dental, podiatry, optometry

MLTC Quality Incentive & Nursing Home Quality Initiative Pools

MLTC Quality Incentive

Focused on Home care: Quality, Satisfaction, Compliance, and Efficiency (PAH)

Funding: 2% premium withhold.
$130m available for '15/16

2014 was the inaugural year
Point to point metrics added in 2015

Nursing Home Quality Initiative

Focused on Nursing Home care quality: Quality, Satisfaction, Efficiency (PAH)

Funding: > 1% premium withhold.
$50m/year

Initiative is in it's 3rd year

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Quality Incentive Pool Expansion Proposal

On the table within DOH:

- 3 – 5 year plan
  - Grow total funds from 2% to 5% of total dollars
  - MLTC side of the coin:
    - 2% still allotted for MLTC Quality Incentive
    - Funds > 2% used for avoidable hospitalization NH side of the coin
    - $50m allotted for Nursing Home Quality Initiative
    - Funds > $50m used for reduction in hospitalizations
  - See further for discussion on ways to broaden the focus on avoidable hospitalization

Managed Long-Term Care (MLTC), Dual Eligibles and Shared Savings

The dual eligible population may seem relatively small (some 15% of Medicaid members are also eligible for Medicare), but these 700,000 individuals comprise 27% of total Medicaid spending.

Many of these individuals use long term care services (LTCS) as well as hospital and other services; the former costs are covered by Medicaid (often through a MLTC plan), the latter are generally covered by Medicare. Preventing avoidable hospital use in this population is part of DSRIP's goals, and should be equally incentivized through payment reform. Improving palliative care, for example, can greatly enhance the quality of care and quality of life for some patients. If the Medicare dollars cannot be (virtually) pooled with the State's Medicaid dollars, and savings in Medicare cannot be shared with Medicaid providers (or vice versa), the impact of payment reform for this population threatens to be limited, and long term care providers will have difficulty achieving scale in VBP transformation.

To remedy this, the State is working with CMS to create aligned shared savings possibilities within Medicaid and Medicare. In anticipation, the State aims to treat potentially avoidable hospital use as 'quality outcomes' for this subpopulation, improving the quality of life for these members, and rewarding MLTC providers when certain levels of reduced avoidable hospital use are reached. Such arrangements could be treated as Level 1 VBP arrangements, and would be eligible for financial incentives. Even if the savings would primarily accrue to Medicare, the State will not pass on the opportunity to make significant strides in meeting the needs of this part of the dual eligible population. Improved quality and reduced overall costs can also be realized by delaying or avoiding nursing home admissions through targeted interventions amongst the MLTC population residing at home.

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Medicare side of the coin – Alignment a priority – but obstacles are real

Medicare Alignment
- Update on coordination with Medicare
  - NYS has submitted proposal to CMS
    - The state is committed to continue to maximize synergy and benefit between the programs and minimize complexity for members, providers and plans.
    - Reality is that elections are coming and CMS is not very open for new things
      - ~~Independence at home~~
      - ~~Direct alignment with FFS savings for duals~~
    - MLTC is most likely candidate for progress – will take at least a year…
    - Rumors about 'dual-ACOs'

Building on what we have?
Medicare/Medicaid model frameworks

- Programs of All-Inclusive Care for the Elderly (PACE)
  - Both Medicare and Medicaid pay for PACE services (on a capitated basis)
  - Members are required to use PACE physicians
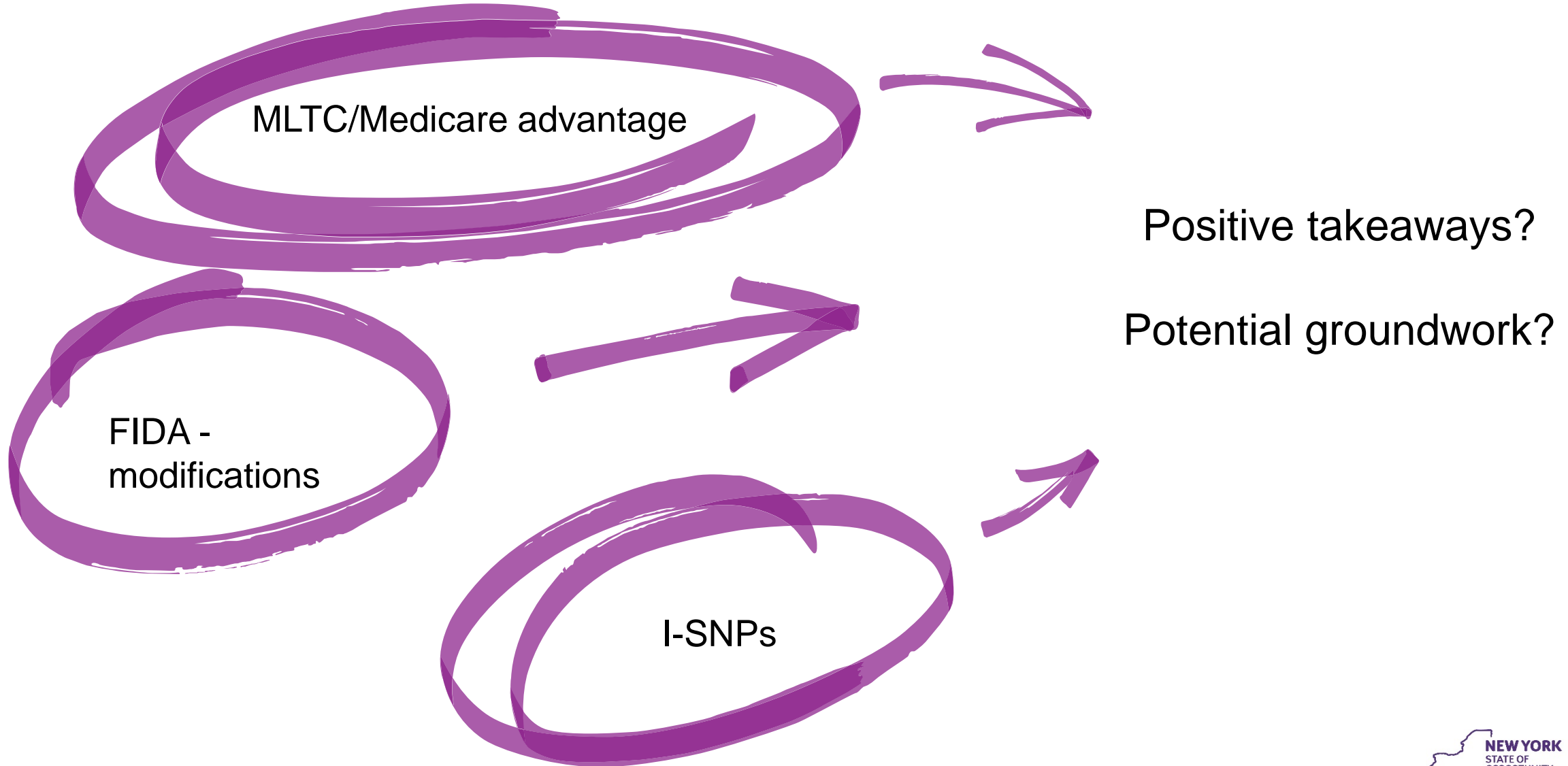 - Interdisciplinary team develops care plans and provides on-going care management

A promising Framework?
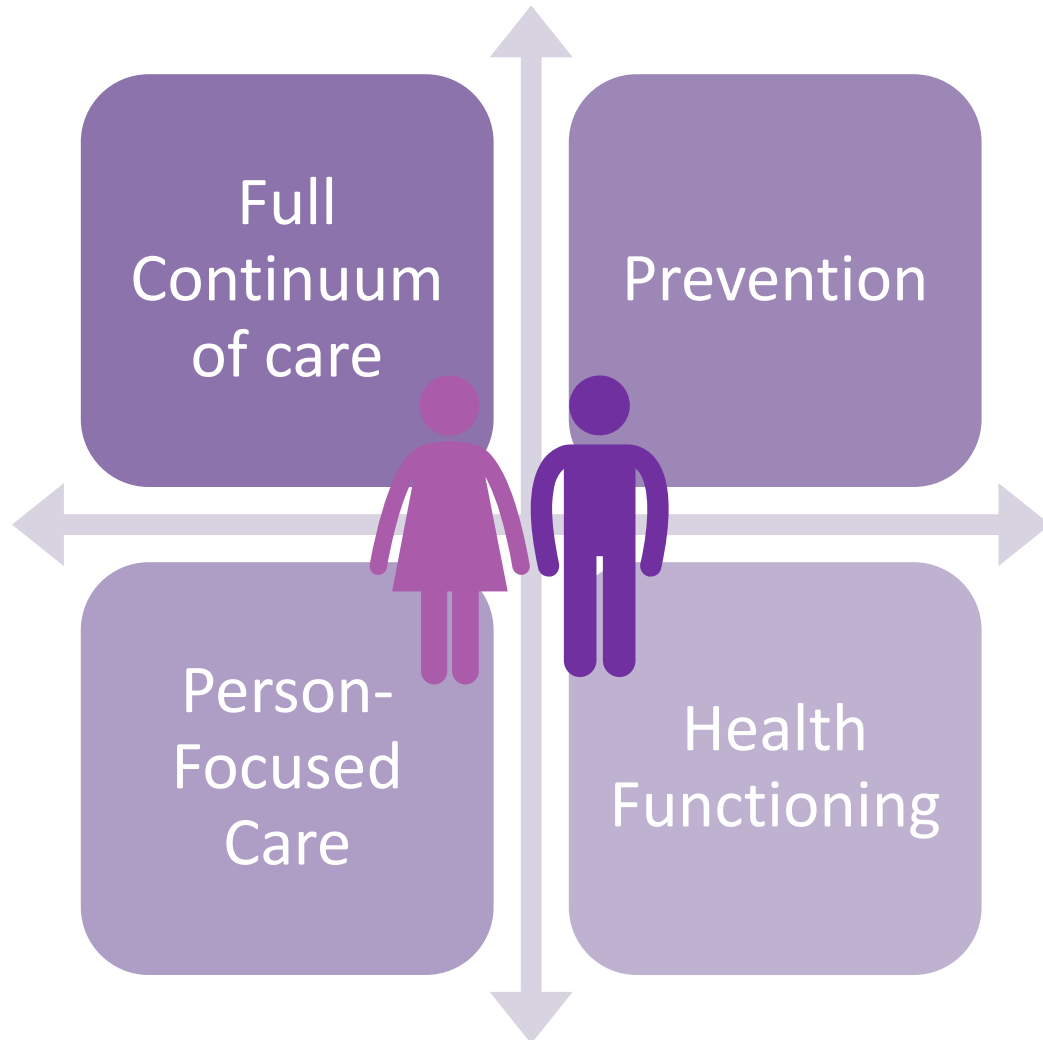
What modification is needed?

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Other Medicare/Medicaid with potential?

MLTC/Medicare advantage

FIDA - modifications

I-SNPs

Positive takeaways?

Potential groundwork?

Part II:

Quality Measures

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Review - Critical Considerations When Designing VBP

- Quality measures focused on:
  - <u>Full Continuum of care</u> – From Home Care through Nursing Home transition

  - <u>Prevention</u> – Vaccination, Medication Management, Depression interventions

  - <u>Person-focused care</u> - non-disease orientated care, focused on the whole-person to ensure comprehensive, continuous and coordinated care to individuals over time and in the context of their multi-morbidity
    - Patient survey(s) to collect feedback on care quality and satisfaction

  - <u>Health functioning of the individual</u> - measures that capture population-specific outcomes on physical activity
    - For example:
      - Activities of Daily Living (ADLs)
      - Cognitive, psychological/mental and social functioning (interpersonal skills and community living)

Review of CAG selected measures – MLTC Quality Incentive Initiative

Topic	Quality Measure
MLTC QI Quality Measures	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
NH QI Quality Measures	Percent of long stay high risk residents with pressure ulcers
	Percent of long stay residents who received the pneumococcal vaccine
	Percent of long stay residents who received the seasonal influenza vaccine
	Percent of long stay residents experiencing one or more falls with major injury
	Percent of long stay residents who have depressive symptoms

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Review of CAG selected measures – Nursing Home Quality Initiatives

Topic	Quality Measure
NH QI Quality Measures (continued)	Percent of long stay low risk residents who lose control of their bowel or bladder
	Percent of long stay residents who lose too much weight
	Antipsychotic use in persons with dementia
	Percent of long stay residents who self-report moderate to severe pain
	Percent of long stay residents whose need for help with daily activities has increased
	Percent of long stay residents with a urinary tract infection
MLTC QI Satisfaction Measures	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 quality of home health aide or personal care aide services within the last 6 months as good or excellent

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Areas of Additional Measurement Identified by the CAG

Measurement gaps and additional review identified by Advisory Group

Medication

Avoidable Hospitalization

Weight Control

CMS 5 Star

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

1

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

2

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.

3

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

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Selection of Medication Measures – CAG to Select

Topic	Quality Measure (* = OQPS measure)	Description	Measure Steward	Data Source	Type	NQF #
Medication	Care for Older Adults (COA) – Medication Review	Percentage of adults 66 years and older who had a medication review during the measurement year; a review of all a patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	NCQA	Claims Data/ Clinical Data	Process	0553
	Use of High-Risk Medications in the Elderly	There are two rates for this measure: - The percentage of patients 65 years of age and older who received at least one high-risk medication. - The percentage of patients 65 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	NCQA	Claims Data/ Clinical Data	Process	0022
	Drug Education on all Medications Provided to Patient/Caregiver	Percentage of home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems (since the previous OASIS assessment).	CMS	Clinical Data	Process	Not Endorsed
	Medication Administration*	Percentage of members who managed their medications independently	OQPS	UAS/ Clinical Data	Process	Not Endorsed

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Selection of Medication Measures – CAG to Select (continued)

Topic	Quality Measure (* = OQPS measure)	Description	Measure Steward	Data Source	Type	NQF #
Medication	Drug Education on High Risk Medications Provided To Patient/Caregiver at Start of Episode	Percentage of home health episodes of care in which patients/caregivers were educated about high-risk medications at start/resumption of care, including instructions on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems.	CMS	Clinical Data	Process	Not Endorsed
	Improvement in Management of Oral Medications*	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly (by mouth).	CMS	UAS/ Clinical Data	Outcome	0176
	Stabilization in Management of Oral Medications*	Percentage of home health episodes of care during which the patient improved or stayed the same in ability to take their medicines correctly (by mouth).	CMS	UAS/ Clinical Data	Outcome	Not Endorsed

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Selection of Medication Measures – CAG to Select (continued)

Topic	Quality Measure (* = OQPS measure)	Description	Measure Steward	Data Source	Type	NQF #
Medication	Substantial Decline in Management of Oral Medications	Percentage of home health episodes of care during which the patient's ability to take their medicines correctly (by mouth) got much worse.	CMS	Clinical Data	Outcome	Not Endorsed
	Emergent Care for Improper Medication Administration or Medication Side Effects	Percentage of home health episodes of care during which the patient required emergency medical treatment from a hospital emergency department related to improper medication administration or medication side effects.	CMS	Clinical Data	Outcome	Not Endorsed

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Selection of Medication Measures – CAG to Select (continued)

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
Medication	Medication Reconciliation Post-Discharge (MRP)	The percentage of discharges during the first 11 months of the measurement year (e.g., January 1–December 1) for patients 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.	NCQA	Claims Data/ Clinical Data	Process	0554
	Adherence to Chronic Medications	The measure addresses adherence to three types of chronic medications: statins, levothyroxine, and angiotensin converting enzyme inhibitors (ACEIs)/angiotensin receptor blockers (ARBs). The measure is divided into three sub measures: Measure A: The percentage of eligible individuals who had at least two prescriptions for statins and who have a Proportion of Days Covered (PDC) of at least 0.8 during the measurement period (12 consecutive months). Measure B: The percentage of eligible individuals who had at least two prescriptions for levothyroxine and who have a PDC of at least 0.8 during the measurement period (12 consecutive months). Measure C: The percentage of eligible individuals who had at least two prescriptions for ACEIs/ARBs and who have a PDC of at least 0.8 during the measurement period (12 consecutive months).	CMS	Clinical Data	Process	0542

Selection of Medication Measures – CAG to Select (continued)

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
Medication	Annual Monitoring for Patients on Persistent Medications (MPM)	This measure assesses the percentage of patients 18 years of age and older who received a least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report the following three rates and a total rate: - Rate 1: Annual Monitoring for patients on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB): At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. - Rate 2: Annual monitoring for patients on digoxin: At least one serum potassium, one serum creatinine and a serum digoxin therapeutic monitoring test in the measurement year. - Rate 3: Annual monitoring for patients on diuretics: At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Total rate (the sum of the three numerators divided by the sum of the three denominators)	NCQA	Claims Data/ Clinical Data	Process	2371

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Selection of Medication Measures – CAG to Select (continued)

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
Medication	Potential Medication Issues Identified And Timely Physician Contact at Start of Episode	Percentage of home health episodes of care in which the patient's drug regimen at start/ resumption of home health care was assessed to pose a risk of clinically significant adverse effects or drug reactions and whose physician was contacted within one calendar day.	CMS	Clinical Data	Process	Not Endorsed
	Potential Medication Issues Identified And Timely Physician Contact	Percentage of home health episodes of care during which the patient's drug regimen was assessed to pose a risk of significant adverse effects or drug reactions and whose physician was contacted within one calendar day (since the previous OASIS assessment).	CMS	Clinical Data	Process	Not Endorsed

CAG Request for a Weight Control Measure

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
Weight Control	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25	CMS	Claims Data/ Clinical Data	Process	0421

CAG Request for Broader Hospitalization Measures

- Potentially Avoidable:
  - Current efficiency measure in use with MLTC Quality Incentive & Nursing Home Quality Initiative
  - Good start, but limited in scope

- Returning to points raised in the previous CAG
  - A broader all-cause hospital use measure that creates more opportunity for shared savings
  - .. And that can be derived from claims data

National Validation Underway for Broader <u>Potentially Avoidable Hospitalization Measures</u>

Current MLTC QI & Nursing Home QI (PAH) efficiency measure:

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

Adopt & grow with existing MLTC QI & NH QI Efficiency Measure?
- CMS is potential expanding to 19 potentially avoidable conditions

Opportunity for All-Cause Hospitalization Measure

Leverage New York–Reducing Avoidable Hospitalizations (NY–RAH) Demo?

- Tools from Interventions to Reduce Acute Care Transfers (INTERACT) will be the principal intervention
  - INTERACT tool contains unplanned hospitalization rate measure

- Affords the opportunity to align with federal/national validation cycle

- *Challenge is time frame and potential need for clinical data gathering – for discussion!*

INTERACT tool all-cause unplanned hospitalizations

Measures Frequency of all-cause **unplanned** hospitalizations from the entire facility

Excludes planned admissions for a non-emergency surgical procedure or revision of a surgical procedure, blood transfusions, or chemotherapy

Rate includes only those residents who are admitted to the hospital on inpatient status as opposed to observation status

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Other more broad Hospital Use Measures that are used in formal studies / measure sets – claims based *and risk adjusted*

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
Hospitalizations	Acute Care Hospitalization During the First 60 Days of Home Health	Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.	CMS	Claims Data	Outcome	Not Endorsed
	Acute Care Hospitalization	Percentage of home health episodes of care that ended with the patient being admitted to the hospital.	CMS	Claims Data	Outcome	Not Endorsed
	Emergency Department Use with Hospitalization	Percentage of home health episodes of care during which the patient needed urgent, unplanned medical care from a hospital emergency department, immediately followed by hospital admission.	CMS	Clinical Data	Outcome	Not Endorsed

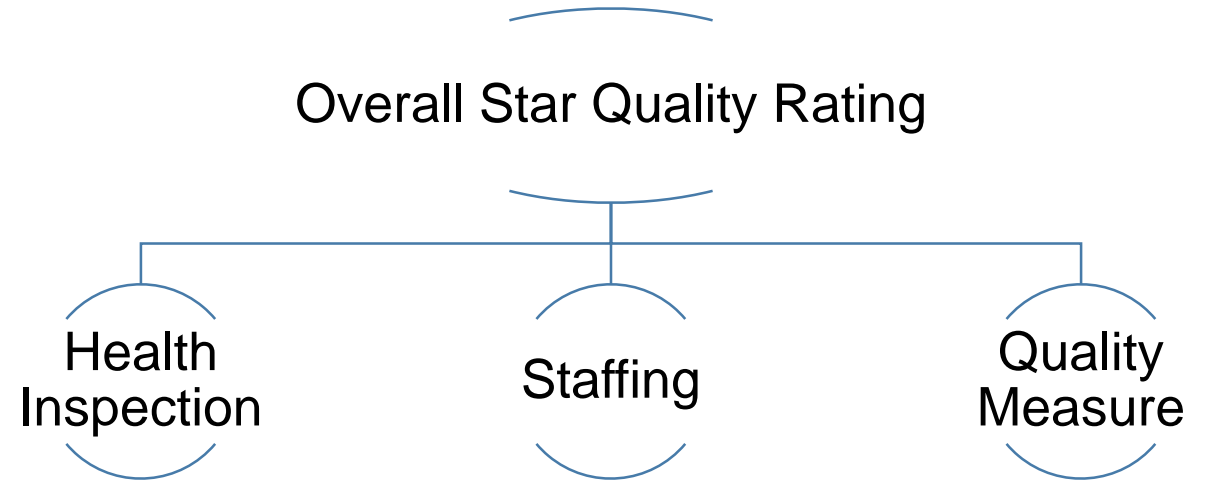NEW YORK STATE OF OPPORTUNITY. | Department of Health

Other more broad Hospital Use Measures that are used in formal studies / measure sets – claims based *and risk adjusted*

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
Hospitalizations	Proportion admitted to the ICU in the last 30 days of life	Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life *Can be broadened to all-cause: Dartmouth*	American Society of Clinical Oncology	Claims Data/ Clinical Data	Process	0213
	Inpatient Days per Decedent During the Last Six Months of Life, by Gender and Level of Care Intensity	Rates for inpatient care per capita were computed using only the portion of the event (hospital stay or ICU stay) falling within the six-month period prior to death.	Dartmouth Atlas	Claims Data/ Clinical Data	Outcome	Not Endorsed

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Other more broad Hospital Use Measures that are used in formal studies / measure sets – claims based *and risk adjusted*

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
Spend	Total Medicare Spend in last year / 6 months of life	The trends across regions and hospitals show that in 2010, compared to 2007, patients were: • Less likely to be in the hospital during the last six months of life; • More likely to be enrolled in hospice care during the last six months of life; • Less likely to die in the hospital; • More likely to see more than ten physicians during the last six months of life; and • Just as likely to spend time in intensive care units (ICUs) during the last six months of life, with virtually no change from 2007 to 2010.	Dartmouth Atlas	Claims Data/ Clinical Data	Outcome	Not Endorsed
ER	Proportion with more than one emergency room visit in the last days of life	Percentage of patients who died from cancer with more than one emergency room visit in the last days of life *Can be broadened to all-cause: Dartmouth*	American Society of Clinical Oncology	Claims Data/ Clinical Data	Process	0211

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Closer look at CMS 5 Star

Overall Star Quality Rating

Health Inspection

Staffing

Quality Measure

- Measure domains include plan, compliance and facility level measures
- Focus on measures that are person centered outcome measurement

Part III:

Regulatory concerns and other barriers

Example Regulatory Concerns

Assessment
- Alignment of UAS-NY and OASIS Assessments
- Expand the current Patient Review Instrument (PRI) DSRIP waiver across the state and eliminate the current rules placed on assessor qualifications

Benefits
- Require MLTC Plans to cover safety monitoring as a covered benefit under Medicaid benefits

Care Coordination
- There is a need for coordination among plans' assessment processes & communicating assessment visits to facilities

Care Management
- Rectify overlaps b/n regulatory and procedural requirements for care planning and management
- Allow ACFs and Assisted Living Facilities to utilize Advanced Health Home Aides
- Revise Medicaid reimbursement rules to permit payment for remote consults with psychiatrists and other specialty physicians
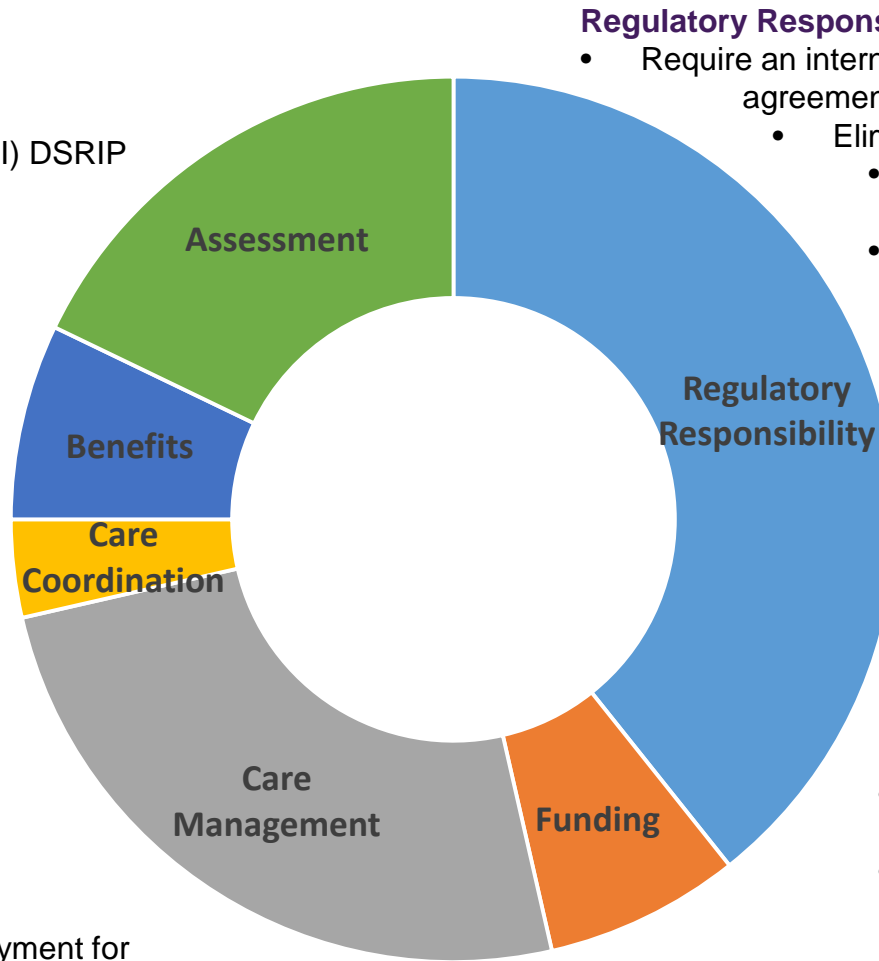
Regulatory Responsibility
- Require an internal appeals exhaustion requirement in the MLTC agreement
  - Eliminate duplication in medical record charting.
    - Allow MLTC's to use licensed agencies rather than certified agencies to deliver care.
    - Allow Nurse Practitioners and Physician Assistant Services to practice in nursing homes within the full scope of their professional licenses.
      - Modify training required of 'Paid Feeding Assistants' to align with federal regulations.
      - Adopt billing codes for unbundled services payment options in ADHC (Adult Day Health Care) programs.

Funding
- Allocate new funding for P4P arrangements to be distributed as performance incentives
- Medicaid should reimburse NH and ALPs for EHR leases and software licenses as capital rather than operating expenses
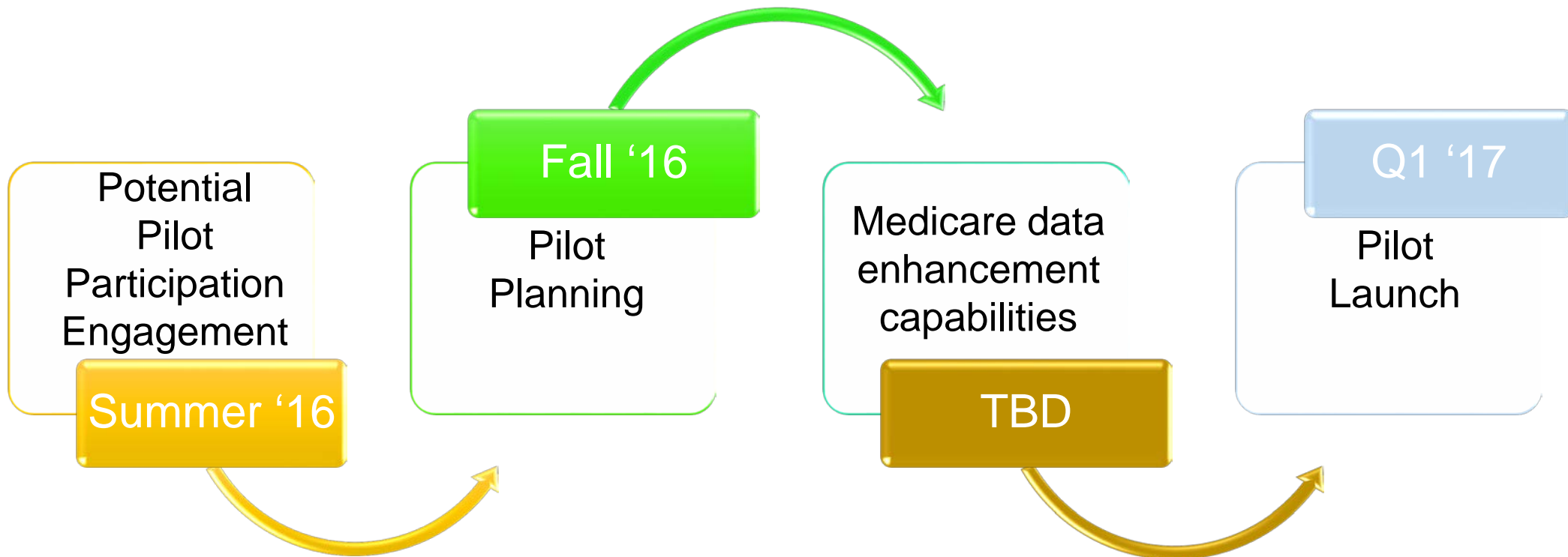
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Part IV:

Piloting a VBP Arrangement

Pilot Interest & Timeline

Continually looking for organizations that are
- Motivated
- Forward thinking
- Focused on member care quality

Potential Pilot Participation Engagement

Summer '16

Fall '16

Pilot Planning

Medicare data enhancement capabilities

TBD

Q1 '17

Pilot Launch

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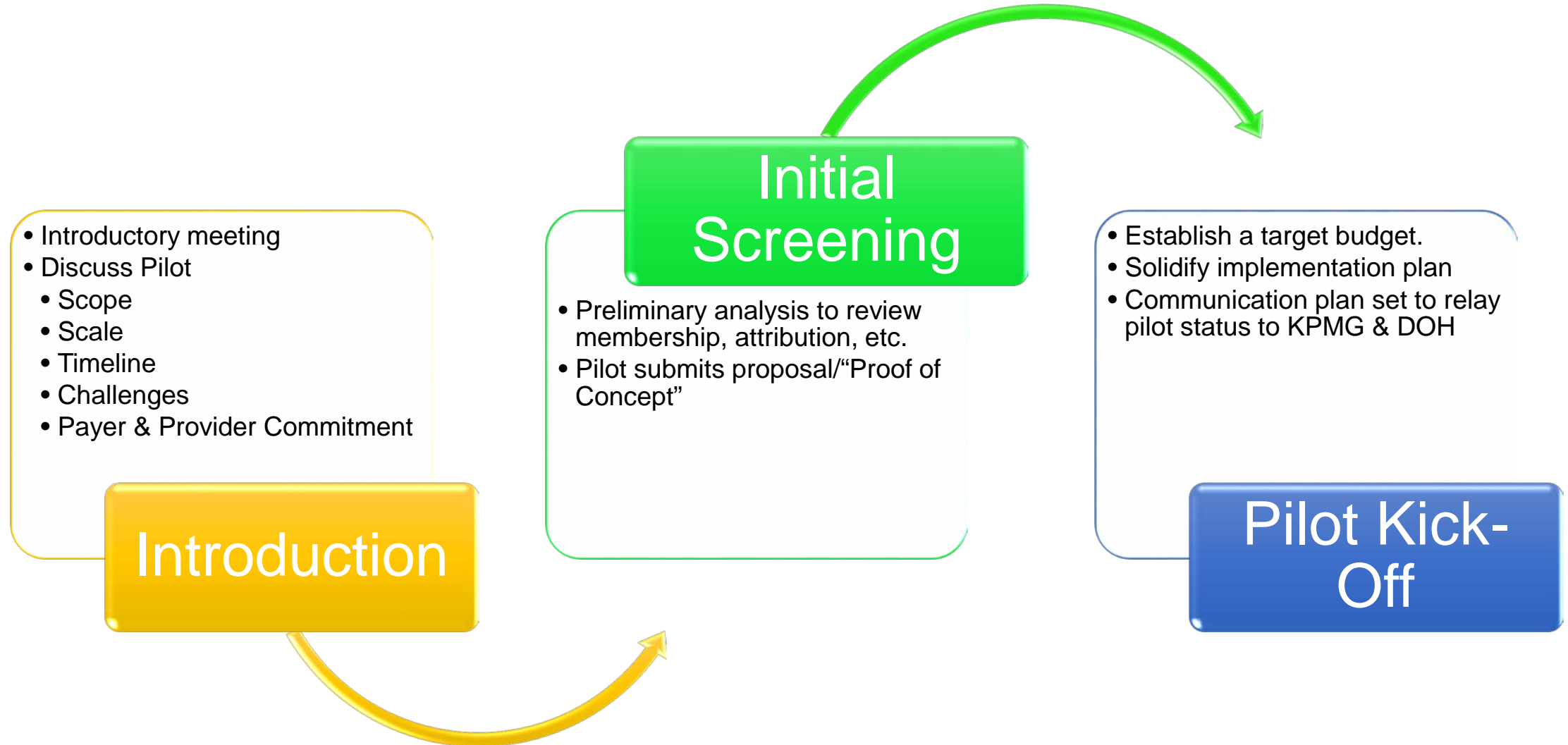
Pilot Opportunities

Initial VBP

- A Home Care organization that can employ innovative care models to delay or prevent nursing home admissions and reduce avoidable hospitalizations.
- A nursing home organization willing to engage in P4P around reducing avoidable hospitalizations, step down/return to community programs, and possible other key quality measures.

Future VBP

- Arrangements with more flexible continuum of services to meet individual needs
- Opportunities for alignment with Medicare may be available

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Pilot Process – Planning Stage

- Introductory meeting
- Discuss Pilot
  - Scope
  - Scale
  - Timeline
  - Challenges
  - Payer & Provider Commitment

Introduction

Initial Screening

- Preliminary analysis to review membership, attribution, etc.
- Pilot submits proposal/"Proof of Concept"

- Establish a target budget.
- Solidify implementation plan
- Communication plan set to relay pilot status to KPMG & DOH

Pilot Kick-Off

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Next Steps

- This was the last of four Clinical Advisory Group Meetings

- Next Steps:

Continuous group communication and updates

| CAG report sent out for comment | Invitation for pilot interest | Pilot Planning |

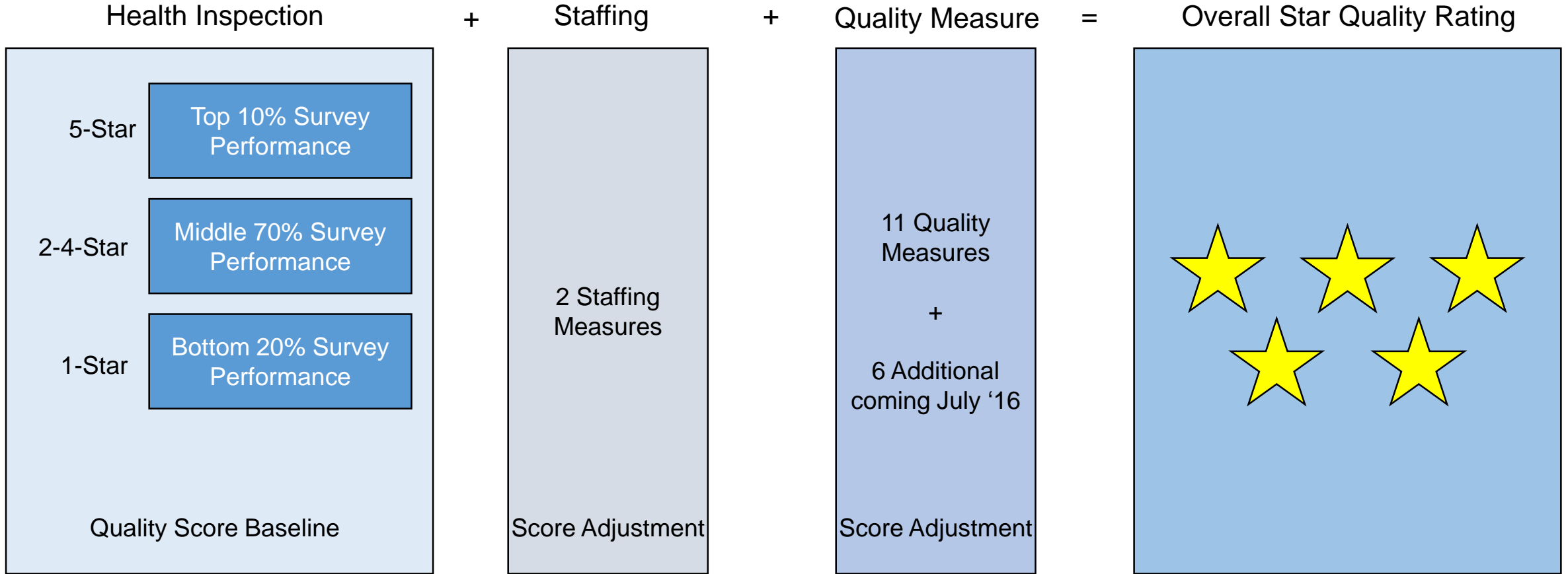NEW YORK STATE OF OPPORTUNITY. | Department of Health

Appendix

CMS 5 Star

Additional information regarding measurement sections & calculation

Calculation of Overall Star Quality Rating

| Health Inspection | + | Staffing | + | Quality Measure | = | Overall Star Quality Rating |

Health Inspection

5-Star
> Top 10% Survey Performance

2-4-Star
> Middle 70% Survey Performance

1-Star
> Bottom 20% Survey Performance

Quality Score Baseline

Staffing

2 Staffing Measures

Score Adjustment

Quality Measure

11 Quality Measures

+

6 Additional coming July '16

Score Adjustment

Overall Star Quality Rating

*If the Health Inspection rating is 1-Star, overall quality rating cannot be upgraded by more than 1-Star. This is because the Staffing and Quality Measure domains are self-reported domains and not weighed as heavily as quality the Health Inspection domain, where are conducted by actual onsite visits from trained surveyors.

Source – Five-Star Nursing Home Quality Rating System

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Health Inspection Domain

- Assessment components format:
  - Annual inspection survey
  - 36-months of (ad-hoc) complaints surveys

- Health inspection category ratings – based on deficiency scope and severity based on past 3 years.
  - Points are assigned based on extent of deficiency and whether or not it is cited as "past non-compliance"
  - Surveys are weighted based on how recent they were administered

- This survey domain is critical to the rating system, as it forms the baseline; Final scoring comes from adding or subtracting stars from this baseline with the Staffing and Quality Measures scores.
  - In order account for survey variation nationally, 5-star quality rating is benchmarked by state average, rather than national average

- Survey focus areas:
  - Medication management
  - Skin care
  - Resident needs
  - Nursing home administration
  - Environment
  - Kitchen/food services
  - Resident rights
  - Quality of life

Staffing Domain

- The Staffing Domain rating is based on 2 measures:
  - Total nursing hours per resident day (RN + LPN + nurse aide hours)
  - RN hours per resident day
    - Includes: RNs, RN director of nursing and nurses with administrative duties
- Measures have been case-mix adjusted to account for differences in resident health across nursing homes.
- The source data is the CMS form – CMS-671 (Long Term Care Facility Application for Medicare and Medicaid) from the Online Survey Certification and Reporting (OSCAR).
  - Includes both full time and part time employees
  - Does not include "private duty nursing staff, hospice staff and feeding assistants
- A rating of 1-5 is assigned based on a combination of how well staffed a facility is in comparison to other freestanding facilities across the nation and staffing thresholds, identified by CMS.

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CMS 5 Star Measures

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
CMS 5 Star	**Percent of residents whose need for help with activities of daily living has increased**	This measure, based on data from the Minimum Data Set (MDS) 3.0 assessment of long-stay nursing facility residents, estimates the percentage of long-stay residents in a nursing facility whose need for assistance with late-loss Activities of Daily Living (ADLs), as reported in the target assessment, increased when compared with a prior assessment. The four late-loss ADLs are: bed mobility, transfer, eating, and toilet use. This measure is calculated by comparing the change in each ADL item between the target assessment (OBRA, PPS or discharge) and a prior assessment (OBRA, PPS or discharge). Long-stay nursing facility residents are those with a nursing facility stay of 101 cumulative days or more.	CMS	Clinical Data	Outcome	0688
	Percent of high risk residents with pressure ulcers (sores)	CMS currently has this measure in their QMs but it is based on data from MDS 2.0 assessments and it includes Stage 1 ulcers. This proposed measure will be based on data from MDS 3.0 assessments of long-stay nursing facility residents and will exclude Stage 1 ulcers from the definition. The measure reports the percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s). High risk populations are those who are comatose, or impaired in bed mobility or transfer, or suffering from malnutrition.	CMS	Clinical Data	Outcome	0679

Overlap with selected measures in bold

CMS 5 Star Measures

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
CMS 5 Star	Percent of residents who have/had a catheter inserted and left in their bladder	This measure reports the percentage of low risk long-stay residents who have had an indwelling catheter in the last seven days prior to the assessment reference date on the target MDS 3.0 assessment (which may be an assessment completed for an Omnibus Reconciliation Act required clinical reason (OBRA), Prospective Payment System reason (PPS) or discharge assessment). Long-stay residents are those residents who had more than 100 days of nursing facility care.	CMS	Clinical Data	Process	0686
	Percent of residents who were physically restrained	The measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents who were physically restrained. The measure reports the percentage of all long-stay residents in nursing facilities with a selected target assessment during the selected quarter (3-month period) who were physically restrained daily during the 7 days prior to the MDS assessment (OBRA, PPS or discharge).	CMS	Clinical Data	Process	0687
	Percent of residents with a urinary tract infection	This Minimum Data Set (MDS) 3.0 based measure estimates the percentage of long-stay residents who have a urinary tract infection on the target MDS assessment (OBRA, PPS, or discharge). In order to address seasonal variation, the proposed measure uses a 6-month average for the facility. Long-stay nursing facility residents are those with more than 100 cumulative days in the facility.	CMS	Clinical Data	Outcome	0684

Yellow highlighted rows do not overlap with previously reviewed/selected measures
Overlap with selected measures in bold

CMS 5 Star Measures

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
CMS 5 Star	**Percent of residents who self-report moderate to severe pain (Long Stay)**	This measure reports the percentage of long-stay residents, of all ages, in a nursing facility, who reported almost constant or frequent pain, and at least one episode of moderate to severe pain, or any severe or horrible pain in the 5 days prior to the Minimum Data Set (MDS) OBRA, PPS, and/or discharge assessment during the selected quarter. This measure is risk adjusted for resident cognitive status. Long-stay residents are identified as residents who have had at least 100 days of nursing facility care. A separate measure (NQF#0676, Percent of Residents Who Self-Report Moderate to Severe Pain (Short-Stay)) is to be used for residents whose length of stay is less than or equal to 100 days.	CMS	Clinical Data	Outcome	0677
	Percent of residents experiencing one or more falls with major injury	This measure is based on data from all target MDS 3.0 assessments of long-stay nursing home residents (OBRA, PPS or discharge). It reports the percentage of residents who experience one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) in the last quarter (3-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	CMS	Clinical Data	Outcome	0674

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Overlap with selected measures in bold

CMS 5 Star Measures

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
CMS 5 Star	Percent of residents who received an antipsychotic medication	This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period.	CMS	Clinical Data	Process	Not Endorsed
	Percent of residents with pressure ulcers (sores) that are new or worsened	This measure reports the percent of short-stay residents, or patients with Stage 2-4 pressure ulcers that are new or worsened since the prior assessment. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments of nursing home residents, the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Version 1.2 for Inpatient Rehabilitation Facility (IRF) patients and the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set Version 1.01 and Version 2.01 assessments of LTCH patients. Data are collected in each of the three settings using standardized items that have been harmonized across the MDS 3.0, IRF-PAI Version 1.2 and LTCH CARE Data Set Version 1.01 and Version 2.01. For residents in a nursing home, the measure is calculated by examining all assessments during an episode of care for reports of Stage 2 -4 pressure ulcers that were not present or were at a lesser stage on the prior assessment. For the LTCH and IRF setting, this measure is calculated by review of a patient's discharge assessment for reports of Stage 2 -4 pressure ulcers that were not present or were at a lesser stage at the time of the admission assessment.	CMS	Clinical Data	Outcome	0678

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Overlap with selected measures in bold

CMS 5 Star Measures

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
CMS 5 Star	Percent of residents who self-report moderate to severe pain (Short Stay)	This measure reports the percentage of short-stay residents, of all ages, in a nursing facility, who have reported almost constant or frequent pain, and at least one episode of moderate to severe pain, or any severe or horrible pain, in the 5 days prior to the target assessment. This measure is based on data from the Minimum Data Set (MDS 3.0) OBRA, PPS, and/or discharge assessments. Short-stay residents are identified as residents who have had 100 or fewer days of nursing facility care. A separate measure (NQF#0677, Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)) is to be used for residents who had at least 100 days of nursing facility care.	CMS	Clinical Data	Outcome	0676
	Percent of residents who newly received an antipsychotic medication	This measure reports the percentage of short-stay residents who are receiving an antipsychotic medication during the target period but not on their initial assessment.	CMS	Clinical Data	Process	Not Endorsed

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Overlap with selected measures in bold

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CMS 5 Star Measures – July implementation

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
CMS 5 Star	Percentage of short-stay residents who were successfully discharged to the community	Includes hospitalizations that occur after nursing home discharge but within 30-days of stay start date	CMS	Claims Data	Outcome	Not Endorsed
	Percentage of short-stay residents who have had an outpatient emergency department visit	Successful discharge defined as those for which the beneficiary was not hospitalized, was not readmitted to a nursing home, and did not die in the 30 days after Discharge	CMS	Claims Data	Outcome	Not Endorsed
	Percentage of short-stay residents who were re-hospitalized after a nursing home admission	Outpatient ED visit measure has same 30-day timeframe as the re-hospitalization measure and considers all outpatient ED visits except those that lead to an inpatient admission (which are captured by the re-hospitalization measure)	CMS	Claims Data	Outcome	Not Endorsed

Yellow highlighted rows do not overlap with previously reviewed/selected measures
Overlap with selected measures in bold

CMS 5 Star Measures – July implementation

Topic	Quality Measure	Description	Measure Steward	Data Source	Type	NQF #
CMS 5 Star	Percentage of short-stay residents who made improvements in function	Measures the percentage of short-stay residents who made functional improvements during their complete episode of care	CMS	MDS	Process	Not Endorsed
	Percentage of long-stay residents whose ability to move independently worsened	Measures the percentage of long-stay nursing residents who experienced a decline in their ability to move around their room and in adjacent corridors over time	CMS	MDS	Process	Not Endorsed
	Percentage of long-stay residents who received an antianxiety or hypnotic medication	Measures the percentage of long-stay residents in a nursing facility who receive antianxiety or hypnotic Medications	CMS	MDS	Process	Not Endorsed

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Overlap with selected measures in bold

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Regulatory concerns and other barriers

Requests & Rationale on concerns submitted by the Clinical Advisory Group

CAG Submitted Regulatory Concerns – Regulatory Concerns

#	Category	Request	Rationale
1	Regulatory Concerns	Require an internal appeals exhaustion requirement in the MLTC agreement	Requiring an internal appeals exhaustion requirement could provide members with faster resolution than going to a Fair Hearing. Going directly to a Fair Hearing is laborious & extensive for all parties involved.
2	Regulatory Concerns	In the MLTC Adverse Notices; replace a requirement that the rationale show improvement in physical or mental health with Medical Necessity for services	Allowing reduction in services due to other factors other than improvement in physical or mental health will allow the opportunity to generate savings while still being held accountable to quality measures.
3	Regulatory Concerns	There is a need to clarify and remedy when full procedural responsibilities are triggered for contracted agencies versus when procedural responsibilities aligned only with an individual function being performed by the agency should be triggered.	There is a need to align discharge responsibilities and related service/fiscal liabilities across MLTC, CHHA/LTHHCP and LHCSA parties. Responsibility for supervision and assurance of compliance with personnel requirements and policies should be delineated to the responsible agency.
4	Regulatory Concerns	Eliminate duplication in medical record charting.	When multiple parties are involved in the care of a member there tends to be duplication of medical record charting and maintenance due to each having their own set of regulations & requirements. There is a need to establish a single, comprehensive medical record systems which could be accessed among responsible participating parties.
5	Regulatory Concerns	Allow MLTC's to use licensed agencies rather than certified agencies to deliver care.	Allowing MLTC's to use licensed agencies to provide expanded services is a cost effective way to deliver care. Since the state mandates that members enroll in the MLTC, in doing so the MLTC has full responsibility for the member as does the certified agency and license agency; it also removes a layer of regulatory requirements.
6	Regulatory Concerns	Extend the timeframe for securing written physician orders in home care from 30 days to 365 days.	This will align state & federal (CHHA) regulations and reduce inconsistencies between CHHA and licensed home care services agency regulations. It will also provide home care agencies with a reasonable period to obtain written documentation from physicians.

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CAG Submitted Regulatory Concerns – Regulatory Concerns

#	Category	Request	Rationale
7	Regulatory Concerns	Allow Nurse Practitioners and Physician Assistant Services to practice in nursing homes within the full scope of their professional licenses.	Success under VBP arrangements will require nursing homes to implement robust clinical protocols to avoid hospitalizations, re-hospitalizations and emergency department visits. Nursing homes will also increasingly be expected to retain residents who experience an acute exacerbation to the extent medically appropriate and to care for higher acuity residents after discharge from the hospital.
8	Regulatory Concerns	Modify training required of 'Paid Feeding Assistants' to align with federal regulations.	New York regulations require more extensive training for feeding assistants that support nursing home residents at meal time. As a result, many nursing homes continue to use certified nursing assistants (CNAs) to assist some residents at meals who might otherwise be fed by a paid feeding assistant.
9	Regulatory Concerns	Update admission and retention standards for ACFs based on current level of care that may be provided in the community.	The current admission and retention standards for ACFs are based on outdated notions of the level of care that may be provided in the community.
10	Regulatory Concerns	Allow licensed practical nurses (LPNs) and registered nurses (RNs) to perform nursing tasks in ACFs, Assisted Living Programs, Assisted Living Residences, and Special Needs Assisted Living Residences.	By allowing nurses in ACFs, Assisted Living Programs, Assisted Living Residences, and Special Needs Assisted Living Residences to perform tasks within their scope of practice, Medicaid beneficiaries living in these settings would receive more proactive, preventive services that can prevent emergency department visits and hospital admissions.
11	Regulatory Concerns	Adopt billing codes for unbundled services payment options in ADHC (Adult Day Health Care) programs.	Although DOH has adopted regulations to 'unbundle' the all-inclusive adult day health care rate to permit managed care plans to contract discrete series within the ADHC setting based on the needs of the registrant (patient), managed care plans and ADHCs have been hindered in contracting for unbundled ADHC services by the absence of managed care billing codes for these services.

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CAG Submitted Regulatory Concerns – Care Management

#	Category	Request	Rationale
12	Care Management	Rectify the overlap/duplication of effort in regulatory and procedural requirements for care planning and care management.	There is a need to streamline and align the respective roles that MLTC and agencies fulfill per contract rather than to continue to be structured around the FFS model which presumes full role of the home care agency versus the contracted role that the agency is actually playing under MLTC.
13	Care Management	Require a responsible party for procuring physician orders & sharing orders with parties who have regulatory obligations to documentation of orders in the record.	MLTCs, CHHAs/LTHHCPs, LHCSAs all have physician order obligations which are often duplicated due to not having a responsible party identified for procurement & distribution of physician orders.
14	Care Management	Implement similar process to Medicare's Presumptive Eligibility policy/process to determine eligibility for home care level of care	Using a similar process for determining home care eligibility using the start of care OASIS assessment and resulting home health resource groups could identify member acuity.
15	Care Management	Addressing assessors' health care qualifications and skills as caregivers	From staff observations during the assessment an assessor ignored transfer plans that were outlined in the person-centered care plan. In another instance an assessor continued with a MMSE assessment even though the resident could not respond through each segment.
16	Care Management	Certifying Advanced Home Health Aides to permit more efficient deployment of a limited supply of visiting nurses.	Certifying Advanced Home Health Aides will help people with complex conditions to remain in the community, permit more efficient deployment of a limited supply of visiting nurses, and support home health aide recruitment and retention efforts. AHHAs would be trained to administer certain medications (e.g., eye drops) and to flag changes in health status early to prevent a possible hospitalization or emergency room visit.
17	Care Management	Allow ACFs and Assisted Living Facilities to utilize Advanced Home Health Aides	Allowing Advanced Home Health Aides to practice within the scope of their training at ACFs and Assisted Living Facilities could be a cost effective way to assist with nursing duties and address workforce shortages.
18	Care Management	Revise Medicaid Reimbursement Rules to Permit Payment for Remote Consults with Psychiatrists and other Specialty Physicians	This would increase the ability of facilities to meet the specialized needs of their residents in an expeditious manner and reduce emergency department visits and hospital admissions.

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CAG Submitted Regulatory Concerns – Funding, Care Coordination and Benefits

#	Category	Request	Rationale
19	Funding	Medicaid reimbursement regulations should be amended to permit software licenses and Electronic Health Record (EHR) leases purchased by nursing homes and ALPs to be reimbursed as capital, rather than as operating expenses.	Due to VBP models requiring EHRs, health information exchange along the continuum, and robust data and analytics and encourage nursing homes and assisted living providers to invest in health information technology, Medicaid reimbursement regulations should be amended.
20	Funding	Allocate new funding for pay-for-performance arrangements to be distributed as performance incentives	New funding would allow for investment in innovative care models, EHRs, etc. Where as a premium withhold strains those upfront investments.
21	Care Coordination	There is a need for coordination among plans' assessment processes & communicating assessment visits to facilities	Due to lack of coordination among plans, instances have occurred where multiple assessors from multiple plans have visited the facility on the same day. Given the lack of communication with the facility, the facility was unable to dedicate staff to accompany them due to the unannounced visit.
22	Benefits	Require MLTC Plans to cover safety monitoring as a covered benefit under Medicaid benefits	In some cases safety monitoring is needed due to a members condition (e.g. due to dementia) which could prevent falls, ED visits, hospitalizations, etc.
23	Benefits	Allow access to Hospice services in the Assisted Living Program (ALP)	Allowing access to Hospice services in the ALP will give access to critical services and support and likely to reduce emergency room visits and/or hospitalizations for ALP residents.

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CAG Submitted Regulatory Concerns – Assessment

#	Category	Request	Rationale
24	Assessment	Alignment of UAS-NY and OASIS Assessments	Requiring time consuming, duplicative and costly assessments is burdensome to all parties involved (plans, facilities, members, etc.). Eliminating redundent MLTC, CHAA & LTHHCP could streamline the overall assessment process.
25	Assessment	Expand the current Patient Review Instrument (PRI) DSRIP waiver across the state and eliminate the current rules placed on assessor qualifications	The PRI is no longer an assessment tool used to set Medicaid reimbursement rates nor determine facility case mix. The MDS 3.0 is the tool now used by NYS for these functions. Other states place no restrictions on health professionals permitted to be an assessor. PRIs are now a DSRIP waiver item and the waiver should be broadened to include the lifting of the current assessor qualifications.
26	Assessment	Eliminate the Patient Review Instrument (PRI) Assessment	The PRI assessments tend to have minimal value due to hospital discharge staff's lack of familiarity with the patient and absence of a hospital purpose for the PRI. Upon admission to the nursing home, a complete assessment is conducted by the nursing home using the Resident Assessment Instrument.
27	Assessment	Grant access to UAS data on patients referred from licensed agencies.	Having access to UAS data on members referred from licensed agencies could assist in developing better care plans for the member.
28	Assessment	Adjustment to the UAS scoring for cognitive deficits and behavioral health conditions.	Adjustment to the UAS scoring id needed due to a wide understanding that the UAS understates the beneficiary risk when a beneficiary has sever dementia, cognitive impairment, or mental illness. The UAS risk score routinely under-values the risk associated with these beneficiaries and thereby their needs and expected resource use.

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