ASPE RESEARCH BRIEF

HHS OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY

PERFORMANCE MEASURES IN MLTSS PROGRAMS

Introduction

As states move their Medicaid populations with long-term services and supports (LTSS) needs from fee-for-service arrangements into managed care environments, they are increasingly interested in performance measures that are most appropriate for these populations. This Brief provides an overview of the performance measures that some of the more established managed LTSS (MLTSS) programs are using to monitor the services provided to beneficiaries and to improve overall quality in MLTSS.[1]

Regulations that govern Medicaid managed care[2] as well as the Centers for Medicare and Medicaid Services' (CMS's) recent guidance to states on the essential elements of an MLTSS program[3] both reference the state's use of performance measures for oversight and quality improvement activities. In addition, many programs must report Medicaid 1915(c) home and community-based services (HCBS) waiver performance measures because these programs operate "combo" waivers which pair a 1915(c) HCBS waiver authority with a 1915(a) or (b) managed care waiver authority. These performance measures must demonstrate that the state meets the 1915(c) assurances federal law requires, several of which are directly related to quality. In the last few years, there has also been a trend for CMS to require performance measures responsive to the 1915(c) assurance for MLTSS programs using the 1115 demonstration waiver authority, particularly for those programs moving populations served under a 1915(c) into an 1115 waiver.[4]

Using Measures to Gauge Performance

Performance measures are a key component of a comprehensive quality improvement strategy. Well crafted performance measures can help states and managed care organizations (MCOs) gauge whether or not established processes are working as planned (process measures) and if members served by the MCO experience good outcomes (outcome measures). Performance measures are also a vehicle for MCOs to provide evidence to the state demonstrating they are meeting the terms of their contracts. States rely on both process and outcome measures in their MLTSS performance measure compendiums.

Process Measures

Process measures tend to focus on the timelines of key MCO activities such as service plan development, reporting and responding to critical incidents, and frequency of required care coordinator contacts with members. Process measures also address the delivery of services in the service plan -- did the member receive their services?

The following are some examples of the measures that states use to assess MCO and provider processes:

- Percent of timely screenings, assessments, and reassessments (based on state standard).

- Percent of service plans developed/initiated in a timely manner (based on state standard).

- Percent of members receiving participant-directed services within X days (state standard) from referral to the provider.

- Percent of members receiving timely care coordination contacts.

- Percent of complaints/grievances received and resolved.

- Percent of members diagnosed with diabetes who received diabetes management services.

- Percent of provider late/missed visits by service type.

Outcome Measures

Outcome measures can help states and MCOs monitor member health and well-being. They can gauge whether members' needs are being met, whether they are being met in a way that addresses their personal goals, and whether the program is supporting the individual to participate as fully as they wish in their community.

Some MLTSS states also report on the effect of the MLTSS program on system outcomes. For example, Tennessee and Texas track MCOs contributions to rebalancing the states' long-term care profile by transitioning members out of nursing facilities.

Examples of outcome measures being used by states include:

- Percent of members competitively employed.

- Percent reduction in member falls.

- Percent reduction in emergency room visits.

- Percent increase in number of persons transitioned from nursing facilities to the community.

- Percent decrease in number of members entering nursing facilities.

- Percent increase in community tenure of persons transitioned from nursing facilities.

- Percent decrease in hospital readmissions.

- Percent decrease in psychiatric hospitalizations.

- Percent decrease in episodes of law enforcement involvement.

- Percent decrease in mental health crisis interventions.

- Percent living in a private residence alone, with spouse or non-relative.

- Increase in:
  - Annual dental exams,
  - Diabetes management,
  - Annual gynecological exams.

- Number of potentially preventable hospital readmissions.

- Number of potentially preventable complications.

Among these examples are a few that address health outcomes. This is an area that states are interested in, but about which many proceed with caution. States tend to be in agreement that measuring health outcomes in MLTSS programs is important, especially since one of the hallmarks of MLTSS is coordination of LTSS and medical care with the intent of maximizing member health outcomes. However, as many individuals in these programs are dually eligible for both Medicaid and Medicare, some Medicaid agencies are reluctant to include health outcomes until their programs are fully integrated with Medicare. While MCOs may be expected to coordinate with Medicare providers that their members use, ultimately they do not have control over Medicare providers in a Medicaid-only MLTSS program. The states argue that neither they nor their MCOs should be held accountable for outcomes over which they do not exert control. This concern should abate as increasing numbers of states participate in the CMS Demonstration to Integrate Care for Dual Eligible Individuals.

Experience of Care and Quality of Life

States often turn to member surveys as a way to measure person-centered outcomes. CMS' MLTSS guidance makes it clear that states should assess members' experience of care and quality of life, typically accomplished through surveys.

MLTSS programs rely on an array of surveys for measuring LTSS outcomes and quality of life including the family of Participant Experience Surveys (for intellectual disabilities/ developmental disabilities [ID/DD], Aged/Disabled and Brain Injured HCBS populations),[5] the participant survey associated with Core Indicators[6] (for the ID/DD population), and the Mental Health Statistic Improvement Program Survey (for persons receiving behavioral health services). In addition, some states have developed their own surveys.

CMS cautions states about employing survey instruments and approaches that have not undergone rigorous testing on the population(s) served by their MLTSS program.[7] Relying on an instrument not validated on the target population can lead to erroneous results. Managed care member surveys of the non-LTSS population often rely on phone, Internet and mail survey modes. These survey approaches may not be appropriate for members with intellectual and/or sensory impairments. Accurate feedback from members with such impairments may require in-person survey administration.

Two promising LTSS survey development initiatives are under way. One is for the Aged/Disabled population modeled after the ID/DD Core Indicators survey[8] and another is a cross-disability experience of care survey. The latter is being funded by CMS, modeled on the Consumer Assessment of Healthcare Providers and Systems (CAHPS)[9] approach, and will support comparison of person-centered outcomes across populations, programs (including fee-for-service and MLTSS) and states.[10]

Summary

MLTSS programs are using a variety of process and outcome measures to monitor their MLTSS programs. States and CMS are placing greater emphasis on member outcomes -- both person-centered as well as health outcomes. Some of these outcomes can be derived from claims/encounter data and others by directly asking the members themselves about their experiences of care. Nevertheless, there remains a role for process metrics in overseeing MCO contract compliance related to member assessment, service delivery and member protections. In concert, both types of measures allow stakeholders to gauge the effectiveness of MLTSS programs in providing needed services and supports, delivered in a manner desired by members, and which maximize members' health, functioning and quality of life.

Endnotes

1. This Brief draws predominantly on the experience of MLTSS programs in Arizona, Michigan, Minnesota, North Carolina, Pennsylvania, Tennessee, Texas and Wisconsin. More detailed information on performance measures in each of these programs may be found in Jackson et al., *Quality in Managed Long-Term Services and Supports Programs*, Truven Health Analytics, 2013.

2. Medicaid managed care regulations may be found in CFR 438. Available at http://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol4/CFR-2011-title42-vol4-part438/content-detail.html. Accessed August 30, 2013.

3. CMS, Center for Medicaid and CHIP Services, 2013. *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs*. Available at http://www.medicaid.gov/CHIP/CHIP-Program-Information.html. Accessed August 30, 2013.

4. Medicaid 1915(c) HCBS waiver quality requirements are specified in various appendices of Version 3.5 of the waiver application. Available at http://157.199.113.99/WMS/faces/portal.jsp. Accessed August 30, 2013.

5. Truven Health Analytics (as The MEDSTAT Group, Inc.) for CMS. Participant Experience Survey (PES) Tools. Available at http://nasuad.org/hcbs/article/participant-experience-survey-pes-tools. Accessed March 5, 2014.

6. Available at http://www.nationalcoreindicators.org. Accessed October 11, 2013.

7. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/CMCS-EQR-Protocols.pdf. Accessed October 23, 2013.

8. Under development by the National Association of State Units on Aging and Disability (NCI-AD), *Expanding the National Core Indicators for Aging and Disability Services* was presented at the 2013 National Association of States United for Aging and Disabilities (NASUAD) HCBS Conference. Available at http://www.nasuad.org/documentation/HCBS_2013/Presentations. Accessed October 11, 2013.

9. CAHPS is a family of measure sets, focusing on consumers' experience with different aspects of the health care delivery. Separate CAHPS instruments have been developed and tested for assessing consumer experience of health plans, hospitals, dental services, Medicaid, home health, nursing home, prescription drug plan, clinician and group, behavioral health, patient-centered medical home, and Medicare Advantage plans.

10. Available at http://www.medicaid.gov/AffordableCareAct/Downloads/TEFT-Q-and-A-9-25.pdf. Accessed October 11, 2013.

STUDY OF MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS: LESSONS LEARNED FROM EARLY IMPLEMENTERS

Reports Available

Addressing Critical Incidents in the MLTSS Environment: Research Brief
HTML	http://aspe.hhs.gov/daltcp/reports/2013/CritIncidRB.shtml
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Did They or Didn't They?: A Brief Review of Service Delivery Verification in MLTSS
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Environmental Scan of MLTSS Quality Requirements in MCO Contracts
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How Have Long-Term Services and Supports Providers Fared in the Transition to Medicaid Managed Care? A Study of Three States
Executive Summary	http://aspe.hhs.gov/daltcp/reports/2013/3LTSStranses.shtml
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Participant-Directed Services in Managed Long-Term Services and Supports Programs: A Five State Comparison
Executive Summary	http://aspe.hhs.gov/daltcp/reports/2013/5LTSSes.shtml
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Performance Measures in MLTSS Programs: Research Brief
HTML	http://aspe.hhs.gov/daltcp/reports/2013/PerfMeaRB.shtml
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Quality in Managed Long-Term Services and Supports Programs

Executive Summary http://aspe.hhs.gov/daltcp/reports/2013/LTSSquales.shtml

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