Medicare-Medicaid Plan Quality Ratings Strategy

Overview:

CMS is working to develop a star rating system for Medicare-Medicaid Plans (MMPs) established under the Financial Alignment Initiative to capture the breadth of plans' responsibility for delivering high quality care across the spectrum of Medicare and Medicaid benefits, and to serve as an aid for meaningful plan comparison by potential and current enrollees similar to other star rating systems developed by CMS. The MMP star rating system should also be robust enough to serve as a potential basis for quality-based payments for plans that would promote value-based payment systems, improved care coordination, and enhanced population health, as envisioned by the Secretary ("Better Care: Smarter Spending; Healthier People"—January 2015). The implementation of an MMP star rating system would occur in conjunction with revisions to the MMP reporting requirements in order to avoid duplicative or conflicting reporting requirements and reduce overall reporting burden. While a new, fully mature star rating system will not be in place during the testing of the Medicare-Medicaid capitated financial alignment model, we intend to start work now to prepare for potential future expansion of the capitated financial alignment model. We are not proposing to expand the capitated financial alignment model at this time. The decision of whether or not to expand the model will be made by the Secretary in coordination with CMS and the Office of the Chief Actuary based on whether findings about the initiative meet the statutory criteria for expansion under section 1114A(c) of the Social Security Act. This document describes our longer term vision for an MMP star rating system and how we propose to provide the public with information on MMP performance during the interim period and solicits public comment on both the vision for an MMP star rating system and our proposal for interim quality reporting.

At maturity, the MMP star ratings should:

- foster attainment of the six goals of the CMS Quality Strategy[*];
- measure quality across the full spectrum of Medicare and Medicaid services, including long term services and supports (LTSS) and treatment of behavioral health and substance abuse;
- reflect the care and quality-of-life goals of the populations served by MMPs;
- address the measurement goals for Medicare-Medicaid enrollees identified by stakeholders, including NQF and other consensus-based entities;

[*] The Six CMS Quality Strategy Goals are:

1. Making care safer
2. Strengthen person and family engagement
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment
5. Work with communities to promote best practices of healthy living
6. Make care affordable

- build on the strengths of the existing MA and Part D star ratings;
- leverage the Medicaid quality measurement systems in states with an existing quality infrastructure, in particular the state-specific measures in use for MMPs;
- prioritize, wherever possible, the use of outcome over process measures across the range of measurement domains;
- prioritize the use, wherever possible, of measures endorsed by consensus based entities;
- minimize plan and provider reporting burden, including through limiting the total number of measures, the use of encounter-based measures and the leveraging of existing reporting mechanisms;
- be based on measurement data that has been validated, including through the use of audits;
- incorporate, as appropriate and feasible, measures that allow comparison of MMP performance to other MMPs, to Medicare Advantage-Prescription Drug Plans, and to fee-for-service Medicare;
- maximize consistency, as practical and appropriate, across states.

Domains

Guided by these principles and informed by the measure development currently in progress, we envision an MMP star rating system that, at maturity, is based on the following domains. With the exception of Community Integration/LTSS, the domains would integrate existing and prospective Medicare Advantage and Part D measures with other new and prospective measures that are suitable for the domain and relevant to the Medicare-Medicaid population and the care delivery goals of MMPs:

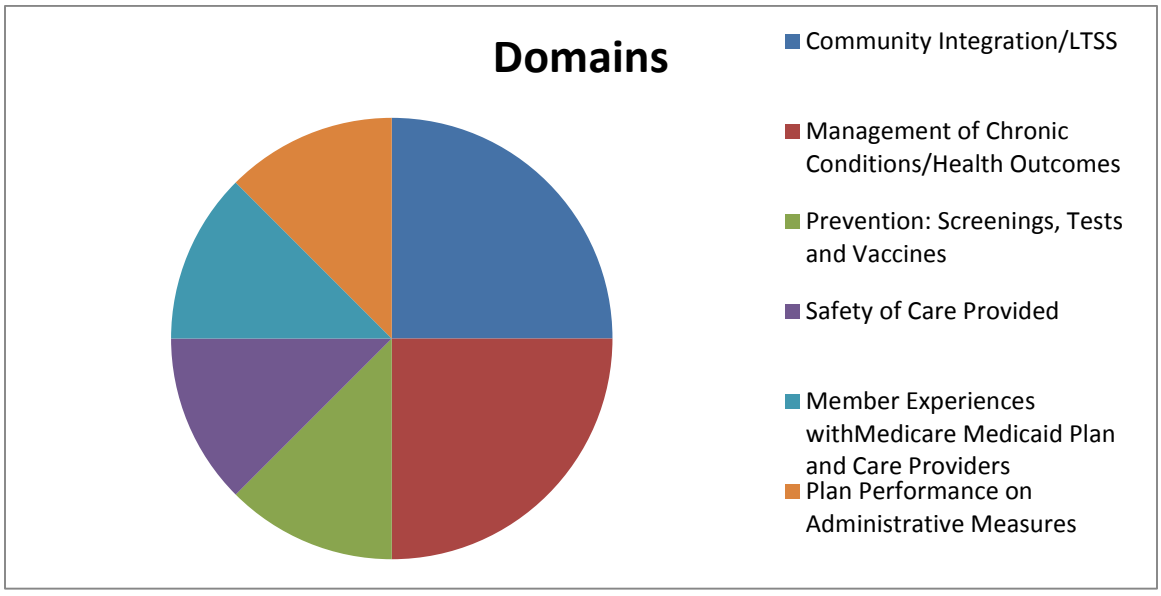
- Community Integration/LTSS
- Management of Chronic Conditions/Health Outcomes
- Prevention: Screenings, Tests, and Vaccines
- Safety of Care Provided
- Member Experiences with Health Plan and Care Providers
- Plan Performance on Administrative Measures

We envision that the Community Integration/LTSS domain and the Management of Chronic Conditions/Health Outcomes domains would each count for about one quarter of the overall MMP star ratings. This reflects the overarching goal of MMPs to keep enrollees healthy and at home in the community. The proposed weight given to Community Integration/LTSS domain stems from the importance of community integration and effective community-based and institutional LTSS in the lives of the most vulnerable Medicare-Medicaid enrollees. For the Medicare-Medicaid population, this domain would include measures that address the CMS Quality Strategy goals to make care safer, strengthen person and family engagement, promote

effective communication and coordination of care, promote best practices for healthy living in the community, and deliver care more affordably in the community setting.

The proposed weight given the domain for Management of Chronic Conditions/Health Outcomes reflects the higher burden of chronic conditions, including mental illness and substance abuse disorders, among Medicare-Medicaid enrollees and the attendant importance of plan processes to effectively manage these conditions. This domain would include measures that address the CMS Quality Strategy goals to promote effective communication and coordination of care, promote effective prevention and treatment, promote best practices of healthy living, and, by avoiding hospitalizations, make care affordable. This domain would include robust outcome measures both in the current Medicare Advantage measurement set and in development.

The remaining domains would together comprise the balance of the MMP star rating in roughly equal measure. The relative weights of each domain would reflect availability of measures, in particular outcome and member experience measures that address the priority areas of care for the Medicare-Medicaid population. In addition, the relative weight assigned to each domain should be based on policy goals that are consistent with the CMS Quality Strategy. For example, the domain for Prevention: Screenings, Tests, and Vaccines plays an important role in addressing the disparities in preventive care that affect Medicare-Medicaid enrollees, which is reflected in the weight proposed for this domain. Similarly, the Member Experiences domain plays a key role in assessing MMP performance in strengthening person and family engagement and promoting effective communication and coordination of care under a person-centered care model. The Safety of Care Provided domain directly addresses a key CMS Quality Strategy goal. The domain Plan Performance on Administrative Measures addresses key plan functions, including plans' abilities, through appeals processes, to promote effective communication and treatment and to make care affordable by, where appropriate, limiting coverage for ineffective or less cost-effective treatments.



This schematic of the domains comprising an MMP star rating is aspirational. To make it a reality will require the development and testing of valid measures, in particular outcome measures that would comprise the building blocks of each domain.

Despite recent and renewed emphasis on measures of care coordination and LTSS, gaps exist for tested, endorsed, actionable and outcome-oriented measures in these areas for Medicare-Medicaid enrollees. CMS has a number of initiatives underway that are aimed at addressing these gaps in performance/quality measurement. For example, the Center for Medicare is contracting with the National Committee for Quality Assurance (NCQA) to develop a set of consensus-based measures aimed at care coordination for Medicare Advantage that will eventually replace the recently retired Special Needs Plan (SNP) structure and process measures, and with Econometrica, Inc., to adapt existing quality measures endorsed by the National Quality Forum (NQF) for the Program of All-Inclusive Care for the Elderly (PACE). CMS is working to test a set of measures for managed long term services and supports (MLTSS) programs. CMS is a member of the Pharmacy Quality Alliance (PQA) and uses several PQA measures for the Part D star ratings. The PQA is a consensus-based, multi-stakeholder membership organization that develops and maintains measures focused on health care quality and patient safety with a focus on the appropriate use of medications. CMS is also working with the NQF Measure Application Partnership (MAP) Dual Eligible Beneficiaries Workgroup in developing recommendations for quality and performance measures for Medicare-Medicaid enrollees to include these areas. Additional efforts are underway on measures for CAHPS surveys, as well as development of encounter data based measures. However, as with all measure development activities, the time horizon for this work, from initiating efforts to testing measures to implementing them as part of a program, is likely to be long.

Below we provide our current vision of the types of measures that would serve as the core measures for each domain, highlighting in particular those measures that are still in development in order to make clear the measure development and testing that is necessary to fulfill our vision.

Community Integration/LTSS

This domain is lacking in valid, endorsed outcome measures at present. However, there is substantial work underway that we believe holds promise to create a robust set of outcome measures for this domain. In particular, we believe the following measures hold promise to capture the essential elements of plan performance in this area:

- Admission to an Institution (Nursing Facility [NF] or Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions [ICF/IID]) from the Community (testing planned through recently-awarded contract)
- Short Stay NF or ICF/IID Institution Discharge to the Community (testing planned through contract)

- Long Stay NF or ICF/IID Institution Discharge to the Community (testing planned through contract)
- Adapted NF/Home Health/PACE Outcome Measures (testing planned for PACE plans)
    - Falls with Injury
    - Pressure Ulcers (rate and prevention)
    - Percent of Long-stay NF residents with Increased Need for Help with Activities of daily Living

We are also concerned with the lack of valid, endorsed survey-based measures for LTSS outcomes, an essential component of measuring person-centered care delivery. We seek comment on the survey instruments that could serve as the basis for a survey-based outcome measures in this area, and in particular the potential to use elements of the Home and Community Based Services Experience Survey. We are also interested in comments on the potential for developing outcome measures from surveys used by states for quality assurance for state waiver programs, and in particular the National Core Indicators—Aging and Disability tool.

The state of development of process measures is more advanced in this area. We would expect that current MMP core measures for completion of Comprehensive Health Risk Assessments and Reassessments would be included in this domain, as well as state-specific measures on development and updating on the plan of care. While our preference is to prioritize outcome (including survey-based) measures, we seek comment on additional structure and process measures, including measures of care coordinator-to-member ratios, which would measure delivery of LTSS, in particular the integration of LTSS with health care delivery.

Management of Chronic Conditions/Health Outcomes

In keeping with our overall goal for the care provided by MMPs—maximizing enrollees' healthy days at home—the outcome measures in this domain should include measures for avoiding hospitalizations and hospital readmissions, survey measures on enrollees' self-assessment of mental and physical health, and measures for the management of chronic conditions prevalent among Medicare-Medicaid enrollees. The following array of existing and in-development measures could be elements of this domain:

- Hospitalization for Potentially Preventable Complications (NCQA testing for MA; Used to evaluate FAI demos on a statewide basis)
- Hospital Readmissions (NQF#1768) (MA measure is over 65 only)
- Improving or Maintaining Mental Health (HOS)
- Improving or Maintaining Physical Health (HOS)
- Blood Pressure Control (NQF#0018)
- Blood Sugar Control (NQF#0059)

We are also interested in the potential use of disease-specific hospitalization measures, including for diabetes, hypertension, and chronic obstructive pulmonary disease.

There is a wider array of NQF-endorsed process measures for this domain, including a number of measures currently used for the Medicare Advantage and Part D star ratings. We are interested in particular in employing process measures for conditions prevalent among Medicare-Medicaid enrollees in the absence of valid outcome measures for these conditions and in incorporating existing or in-development process measures for the treatment of mental illness and substance abuse. We seek comment on measures that could fill these gaps in general, and on the potential use of the following measures for MMPs:

- Follow up after Hospitalization for Mental Illness (Current MMP Core Measure; MA Display Measure) (NQF# 0576)
- Care Transition Record Following Inpatient Discharge (Current MMP Core Measure) (NQF #0648)
- Antidepressant Medication Management (Current MMP Core Measure; MA Display Measure) (NQF# 0105)

Prevention: Screenings, Tests, and Vaccines

This domain is by its nature comprised of process measures. We envision employing a combination of existing Medicare Advantage and Part D measures, including for cancer screenings and vaccinations, and adding additional measures of particular relevance to the Medicare-Medicaid population. We seek comment on potential measures, including the use of Long Term Care Minimum Data Set data for a pneumonia vaccination measure focused on residents of long term care (LTC) facilities, as well as on the following specific measures:

- Screening for Clinical Depression and Follow-up (variant on MMP Core Measure) (NQF #0418)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (MMP Core Measure (Combines 2 MA Display Measures) (NQF #0004)
- Cervical Cancer Screening (State specific measure) (NQF #0032)

Safety of Care Provided

We envision this domain as including measures that focus on drug safety as well as the safety of care provided in LTC settings. We seek comment in particular on potential MDS measures for the safety of care provided in LTC settings as well as the potential for measures based on the number of critical incident or abuse reports for members receiving LTSS. We also seek comment regarding options for medication safety and reconciliation measures and in particular on measurement on efforts to reduce inappropriate use of antipsychotics in nursing facilities or other settings.

Member Experience with Medicare-Medicaid Plan and Service Providers

This domain is comprised of measures based on CAHPS surveys. We are interested in comments regarding potential adaptations to the CAHPS survey to elicit member responses on their experience with the full range of services provided by MMPs, including LTSS. In particular, we seek comment on basing MMP quality measures on survey responses to the adapted CAHPS survey questions used for evaluation of the demonstrations.

Plan Performance on Administrative Measures

We are interested in ways to supplement Parts C and D measures with measures that capture the breadth of MMP performance, including through the collection of additional data on plan performance. In particular, we seek comments to inform development of measures for timeliness and accuracy of LTSS appeals that would be analogous to current measures for Parts C and D appeals.

Methodological Issues

In addition to stakeholder feedback on potential measures, we also seek responses to a number of questions to inform our development of a calculation methodology. While we are committed to giving extra weight to outcome measures over process measures, we seek comments on different methods for relative weighting of outcome, process, and member experience measures. In addition, we seek comment on the methodology for calculation of both individual measures and the overall rating, including the calculation of cut points for star ratings, and the interaction of domain and measure weights in the calculation of an overall rating. Stakeholders may also use this as an initial opportunity to raise concerns on a range of technical issues, including the methodology for data validation on specific measures and the potential use of different data sources for plan measurement, including the Long Term Care Minimum Data Set. We are also interested in how inter-state variation, and in particular differences among state MMP eligibility criteria and nursing home level of care criteria, could impact MMP-to-MMP comparison, especially for nursing home diversion/community integration measures.

Interim Quality and Performance Information on MMPs

While the ultimate goal is to develop a rating system that encapsulates the full range of the care provided to Medicare-Medicaid enrollees and recognizes the integration of two systems, the limited demonstration time frame and the lead time necessary for development of new long-term supports and services (LTSS) measures means a comprehensive star rating system for MMPs would not be possible until after the demonstrations are currently scheduled to end. Nevertheless, through the use of existing Part C and D measures in combination with core MMP reporting requirements, we believe we can provide useful information on how MMPs perform on important quality measures and how individual MMPs perform on these measures compared to one another for each demonstration.

CMS proposes that, until there are adequate measures to assess the full range of MMP functions, including delivery of LTSS, MMPs should not receive star ratings for overall performance or for individual domains or measures. Instead, CMS proposes that, starting in 2016 and during subsequent years of the demonstrations, we make data available on MMP performance on Parts C and D quality measures and Financial Alignment Initiative core reporting requirements, including how individual MMPs perform compared to other MMPs in a given demonstration, on the Medicare-Medicaid Coordination Office (MMCO) website on www.cms.gov. For example, we could incorporate eight measures now included in the 2015 core reporting requirements for all MMPs in all states (see Attachment A). These eight measures would add important measures addressing the treatment and management of mental illness and substance abuse, and measure MMP success in fostering community living. The overall picture of MMP performance data would be linked via the Medicare.gov Medicare Plan Finder to consumers and researchers. We believe this interim solution provides consumers and researchers with useful performance data while we construct the MMP star rating system. We seek comment on this interim proposal and on the measures to include for public display.

Comments should be sent in pdf form to MMCOcapsmodel@cms.hhs.gov by 5 pm EST, December 21, 2015. Please identify the organization or individual submitting comments in the title of the document.

Attachment A: Additional MMP Measures for Public Reporting

Measure	Description	Collection under Capitated Financial Alignment Demonstration
Antidepressant Medication Management	The percentage of members 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. (NQF #0105)	Measure DMC03 of 2015 Medicare Part C & D Display Measures; Measure AMM-AD of Core Set of Adult Health Care Quality Measures for Medicaid (2015 Adult Core Set)
Care Transition Record Following Inpatient Discharge	Members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary care provider or other health care professional designated for follow-up care. (NQF #0648)	Measure 3.1 of MMP Reporting Requirements; Measure CTR-AD of 2015 Adult Core Set
Comprehensive Health Risk Assessment	Members with an assessment completed within 90 days.	Measure 2.1 of MMP Reporting Requirements
Screening for Clinical Depression and Follow-up	Members age 18 and older with an outpatient visit that were screened for clinical depression using a standardized tool with appropriate follow-up plan documented. (NQF #0418)	Measure 6.1 of MMP Reporting Requirements; Measure CDF-AD of 2015 Adult Core Set
Follow-up After Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge. (NQF #0576)	Measure DMC01 of 2015 Medicare Part C & D Display Measures; Measure FUH-AD of 2015 Adult Core Set

Measure	Description	Collection under Capitated Financial Alignment Demonstration
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	1) The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. 2) The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. (NQF #0004)	Measures DMC14 and DMC15 of 2015 Medicare Part C & D Display Measures; Measure IET-AD of 2015 Adult Core Set
Nursing Facility Diversion	For members who did not reside in a NF for more than 100 continuous days during the previous reporting period, CMS and the State will evaluate the percentage of nursing home certifiable members who did not reside in a NF for more than 100 continuous days during the current reporting period.	Measure 9.2 of MMP Reporting Requirements
Care Plan	Members with a care plan completed within the timeframe established in the three-way contract	State-specific measure within MMP Reporting Requirements.