Neighborhood Health Plan OF RHODE ISLAND™

910 Douglas Pike, Smithfield, RI 02917 : 1-800-963-1001 : nhpri.org

To: Debbie Correia Morales
Senior Consulting Manager
Conduent/EOHHS

From: Jay Buechner, PhD
Director of Evaluation and Improvement

Date: September 22, 2017

Re: Neighborhood's Response to the Proposed "Quality Framework and Methodology for Comprehensive and Specialized LTSS Accountable Entities"

Thank you for the opportunity to review the proposed quality guidance prepared by EOHHS for use in contracts between the Medicaid MCOs and the Specialized LTSS Accountable Entities in the next phase of the AE program. Clearly, much thought has gone into preparing the guidance document. After review of the proposal, our response and recommendations are as follows.

Neighborhood strongly supports EOHHS' vision for the Specialized LTSS AEs, to promote the creation of networks of long-term care providers focused on keeping members healthy and living in the community while preventing unnecessary hospital utilization and improving quality. As the state's sole managed care partner in implementing the LTSS AEs, we encourage EOHHS to consider a more collaborative and incremental approach to measuring and incentivizing quality in these AEs. The Specialized LTSS AEs are a new program with no replicable regional or national experience or performance benchmarks and limited data sources to support measurement of quality of care and quality of life outcomes. Neighborhood would welcome the opportunity to collaborate with EOHHS on all aspects of the LTSS AE model, including incentives based on quality. We have been recognized for the quality of our Medicaid managed care for well over a decade, and we have invested significant resources in the development of quality measurement for LTSS since before the implementation of Rhody Health Options, and we will gladly bring that experience to a collaboration focused on the Specialized LTSS AE program.

More concretely, Neighborhood is concerned that the methodology proposed by EOHHS has aspects that may not be appropriate for the organizations we believe will be candidates for the Specialized AEs, and we are making a number of general and specific recommendations relative to those concerns. These concerns derive from our experience with LTSS providers under the Rhody Health Options program. They include –

- The small numbers of members and measurable events we anticipate being covered under the Specialized AEs. We believe the number of members covered will be in the hundreds, as compared with the membership of many thousands or tens of thousands in each of the pilot AEs.

- The organizational structure of the Specialized AEs and the provider types that will lead the AEs. The Specialized AEs will almost certainly be led by LTSS providers, including home care providers and nursing facilities. Their ability to impact performance measures appropriate to a general population will be limited, especially among LTSS recipients.
- The measurement capacity and access to data the Specialized AEs will have. Our experience with LTSS providers is that there is great variability in their measurement skills, and their access to and ability to process information outside their own data systems is very limited.

Our primary objective is that the quality incentive on shared savings be structured so that MCOs and AEs have the flexibility to focus on high-priority opportunities for improvement and to align with the MCOs' priorities for improvement across all LTSS providers. As in previous responses, we are requesting a meeting with the appropriate EOHHS staff and consultants to review and expand on our written recommendations.

Recommendations

1. **Reconsider or remove measures that require medical chart review across multiple types and sites of care.**
   These measures include Depression Screening and Follow-up and Advanced Care Planning, where such information is not available in electronic health records. Neither the MCOs nor the AEs will have access to the full spectrum of medical records required to measure these items accurately, and the measurement burden of chart review is extreme. If retained, these measures should be evaluated for accuracy and cost through a small pilot program before being attached to any reporting requirements or incentives.

2. **Eliminate all measures that are not currently specified or defined.**

   These include Patient/Client Satisfaction, Caregiver Support/Burden, and Social Isolation. Much work will be required to define and operationalize these measures, and all will involve considerable cost to collect accurately and uniformly. The measurement burden and perception of risk associated with these measures will be a considerable disincentive for LTSS providers to participate in the Specialized AE program.

3. **Focus on a small number of measures that are clearly specified and whose relevance to their purpose will be understood by the LTSS providers who establish Specialized AEs.**
   From the Proposed Medicaid Specialized LTSS Common Measure Slate, these include Falls with Major Injury (presumably measured by hospital emergency department and inpatient claims), Discharge to the Community from Nursing Home (or Home Care), ED Utilization, and 30-Day All-Cause Readmission. Consider adding hospital inpatient utilization, as well. In each case, the measures should be adjusted so that they are appropriate to all LTSS provider types and are tested for small numbers problems.

4. **Make the first year of operations a baseline year to test and refine measures with no quality filter on shared savings, and only add new measures in subsequent years after a similar period of baseline measurement.**
   The proposed guidance for the Specialized LTSS AEs is for the most part still too vague for implementation in year one, and the AEs will not want to be put at risk with this level of uncertainty. The AEs and MCOs both need time to identify and understand the data sources and collection methodologies for many of the proposed measures.

5. **As we did in response to the Specialized LTSS AE Guidance relating to TCOC, Neighborhood is assuming and strongly recommends any cost of care or quality calculations be carried out independently by the health plan and are not combined with data under fee-for-service Medicaid.**
   Instead, Neighborhood recommends the separation of LTSS AE contracting and requirements carried out by the health plan and state. Note that this is also consistent with our recommendation covering the Quality Framework and Methodology for Comprehensive Accountable Entities, where we strongly opposed the use of all-payer data for quality incentives.

Other specific recommendations

1. **Eliminate the comparison of AE performance to MCO performance** in computing the quality score. This comparison would require the MCOs to extend the measurement of all non-HEDIS/non-health plan measures to include their non-AE members/providers, which will be administratively burdensome and costly to both the health plans and non-AE providers. There are five such measures in the proposed measure slate: Developmental Screening in the First Three Years of Life; Tobacco Use: Screening and Cessation Intervention; Screening for Clinical Depression and Follow-up Plan; Social Determinants of Health (SDOH) Screen; and Self-assessed Health Status. Among the 57 ACO Menu measures there are an additional 29 non-HEDIS/non-health plan measures

2. **Do not include the "home-grown" measures** for social determinants of health and self-assessed health status. Although of great interest, these measures will be difficult and costly for the AEs to collect and there is no evidence supporting the use of either of these measures for improvement of clinical quality. Especially note that any direct data collection from Medicaid members typically results in high rates of non-response, even with the resources available to MCOs, such as staff supporting member services. Without those resources, AEs will like have even larger rates of non-response. Instead, continue to focus on SDOH measurement and collection under the Incentive program and allow time for the formulation of consensus and collaboration on the measurement of SDOH across the state inclusive of SIM, EOHHS, health plans and AEs. We believe a widely implemented and well supported system will prove a better choice for SDOH data collection than a system developed only for use in Rhode Island.