

## Performance Standards and Quality Measures for FIDA Program

*The following principles and recommendations are submitted to the New York State Department of Health and members of the FIDA work group on quality by the Duals Taskforce of Health Care for All New Yorkers. This paper is focused on performance standards and quality measures in anticipation of the discussion of this topic at the October 22, 2012 meeting of the work group. We look forward to discussion of the many other issues included in the work group's charge at some future date.*

### PRINCIPLES:

1. Effective managed care programs for dually eligible persons should have clear and enforceable performance standards for participating managed care plans.
2. In order to address the diversity within the dual eligible population, the state should develop standards for cultural competency, including disability literacy.
3. The state should utilize a combination of standard reporting measures and newer specialized measures to monitor plan performance and program quality.
4. Gaps in existing quality measures should be addressed in order to provide a full and accurate snapshot of member experiences. Gaps should be addressed creatively using all available data sources.
5. Performance standards and quality measures for each health plan should be publically available in a readily accessible system. Enrollees should have access to a tool that summarizes quality data and allows for comparisons across plans.

### RECOMMENDATIONS REGARDING PERFORMANCE STANDARDS

1. Performance standards should be expressed in contractual terms. Supplementary materials may or may not create enforceable expectations.
2. Performance standards should include specific requirements regarding:
  - a. **Network capacity**
    - Provider networks need to demonstrate clinical expertise in caring dual eligibles, utilizing primary care physicians experienced with the elderly and disabled as well as specialists in areas such as mental health, substance abuse, rheumatology, and pediatric special needs care.
    - All plans, and especially any plans granted exemptions to specialist requirements, need to have processes in place for approving out of network care and arranging transportation for members.
    - Specialists and primary care providers should be required to enter into agreements with plans indicating both readiness to care for members and readiness to participate in interdisciplinary care coordination teams. Plans should be required to file these agreements with the state, updating their filings as network membership changes over time.

b. ***Member engagement and satisfaction***

- Expectations regarding the need to maximize consumer engagement and satisfaction should be clearly stated.
- Contractual requirements for participant feedback sessions and advisory committees should be supplemented with the following programmatic requirements:
  - Specific timelines for expeditious action with regard to enrollment, assessment and initiation of services, particularly services such as Consumer Directed Care, non-emergency transportation, DME, and specialty care.
  - A process for self-monitoring member disenrollment and developing interventions in areas cited as the motivation for voluntary disenrollment.
  - A process for tracking and reporting grievances and appeals.

c. ***Care management***

- Expectations regarding care management should be detailed to include level of staffing and cultural competency of care coordination teams, frequency of contacts with members (with setting specified) and requirements for provider participation in the care coordination team.
- Plans should be required to have processes in place to ensure connections between health care providers and community supports, including family members and community-based agencies providing social services to members.
- Tailored approaches to screening and assessment should be required, with attention to factors affecting the elderly and disabled, including nutrition, drug and alcohol use, falls, underlying mental and cognitive conditions and housing insecurity.

d. ***ADA compliance and community re-balancing***

- SDOH should be explicit regarding the programmatic preference for care in the community as opposed to institutionalization as per *Olmstead*.
- Plans should also be required to have a nursing facility transition and diversion program, to help members maintain independence in the community and transition back after hospital discharges to institutions.
- Plans should be provided with incentives to provide assistive technologies and assistance with housing supports that will enable members to transition and maintain independence in the community.
- Current contractual requirements for compliance with the ADA should be supplemented by a description of monitoring and enforcement activities.
- For example, contracts should include a timeline for accessibility surveys by a third party to gauge provider accessibility, physical structure, policies, practices and procedures.<sup>1</sup>
- The state should provide resources to plans to help maximize compliance, including model compliance plans, trainings for plan staff, and model member education materials.<sup>2</sup>

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<sup>1</sup> Mudrick, N.R., Breslin, M.L., Liang, M., Yee, S., (2012). Physical Accessibility in Primary Care Health Settings: Results from California on-site reviews, Disability and Health Journal, Vol. 5, July 2012.

## RECOMMENDATIONS REGARDING QUALITY MEASURES

1. Reporting measures known to produce reliable and valid, evidence based data, that are relevant to elderly and disabled members should be utilized.<sup>3</sup>

2. Standard reporting measures should be supplemented by more specialized measures in the critical areas of person centered planning, screening for poor health literacy, beneficiary autonomy, and community supports.<sup>4</sup> Data collected from plans in these areas could include:

- Plan reports on person centered care coordination/care management to include team staffing, member contacts, health literacy screening, provider participation and related outcomes.<sup>5</sup>
- The degree of member participation in person-centered planning.<sup>6</sup>
- The level of unmet need v. satisfaction with community supports for members and member care-givers.<sup>7</sup>
- Assessment measures, which could likely draw upon elements of the new Uniform Assessment System and should include plan responses to risks and unmet need.<sup>8</sup>
- Outcomes related to collaboration and communication across provider settings or lack thereof (negative markers to include transfers without complete records, lack of hospitalization notifications, contraindicated medications).<sup>9</sup>

3. Specialized measures for member satisfaction and engagement should include:

- Annual rates of disenrollment, both voluntary and involuntary with responsive interventions noted.
- Percentages of members who received assessments and services within specified timelines (expeditious action), to include consumer directed care, transportation, DME, and eligibility determinations.
- Numbers and types of monthly grievances and appeals, with information regarding how and under what time frame they were resolved.<sup>10</sup>

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<sup>2</sup> The Center for Independence of the Disabled, N.Y., performed an extensive review of ADA compliance plans filed by Managed Long Term Care Plans in NY in September of 2012 and found a pervasive lack of compliance with contractual requirements.

<sup>3</sup> See starter set and expansion set measurements recommended in *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*, Measure Applications Partnership, Final Report to HHS, June, 2012, p. 14.

<sup>4</sup> Cited as the measures most needed to fill critical gaps in: *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*, Measure Applications Partnership, Final Report to HHS, June, 2012.

<sup>5</sup> Pennsylvania has incorporated such reports into its monitoring efforts for Medicaid MCOs. See Kaiser Commission on Medicaid and the Uninsured, *Current and Emerging Issues in Medicaid Risk-based Managed Care: Insights from an Expert Roundtable*, September, 2012.

<sup>6</sup> Developed by the Commission on Accreditation of Rehabilitation Facilities and suggested in Appendix H, p. 83, of *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*, Measure Applications Partnership, Final Report to HHS, June, 2012.

<sup>7</sup> *Id.*, p. 84.

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*, p. 9.

4. Measures tailored to assessing the quality of long-term care services should be developed.

- We recommend drawing upon the research compiled by United Hospital Fund, which suggests that New York's health home measures provide a good foundation.<sup>11</sup>
- We strongly urge New York to include measures that reflect nursing facility utilization. Although no such measures have yet been endorsed by NQF,<sup>12</sup> New York should consider requiring plans to report:
  - Outcomes from their nursing facility transition and diversion programs, and
  - Nursing facility utilization rates, benchmarked against a standard described as meaningful by stakeholders.

5. New York should also modify existing consumer surveys to incorporate survey methods for members with serious mental illness and capture critical information about quality of life for those using long term care services. Survey information should be supplemented with the use of focus groups to pull in information from higher risk consumers.

- The United Hospital Fund (UHF) has reported on a number of model approaches to collecting quality of life information from beneficiaries which the state should explore.<sup>13</sup>
- We strongly urge the State to consider utilizing the AHPPAL Dashboard in particular, which was specifically designed to survey adults with disabilities' satisfaction with health plans.<sup>14</sup>
- Structural revisions to existing surveys should be considered to allow for shorter, more targeted inquiry at more frequent intervals to ensure actionable, timely data.<sup>15</sup>

6. Measures of success with providing behavioral health services should also be included. Here too, we recommend that the state utilize the measurement framework presented by UHF, which points to Health Home measures as a floor and calls for new data collection to measure of performance on standards for co-location of services, member progress toward self-defined goals and outcome disparities.<sup>16</sup>

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<sup>10</sup> See, Rosenbaum, S., Wilensky, S., Shin, P, & Whittington, R., *Managed Care and Medi-cal Beneficiaries with Disabilities: Assessing Current State Practice in a Changing Federal Policy Environment*, The George Washington university Medical Center, June, 2006. Plan self-reporting in this area should be supplemented by data from Area Offices for the Aging, Independent Living Centers, Community Health Advocates, the Ombudsman program, and state agencies (SDOH, OTDA and DFS).

<sup>11</sup> Alice Lind, *Measuring Quality for Complex Medicaid Beneficiaries in New York*, Medicaid Institute at United Hospital Fund, December, 2011.

<sup>12</sup> *Id.*, p. 20.

<sup>13</sup> Alice Lind, *Measuring Quality for Complex Medicaid Beneficiaries in New York*, Medicaid Institute at United Hospital Fund, December, 2011. P. 23-24.

<sup>14</sup> Susan Palsbo, PhD *Assessment of Health Plans and Providers by People with Activity Limitations (AHPPAL)*. Prepared with funding from National Institute for Disability and Rehabilitation Research Grant, the Center for Health Care Strategies, and the California HealthCare Foundation. January 2011.

<sup>15</sup> Alice Lind, *Measuring Quality for Complex Medicaid Beneficiaries in New York*, Medicaid Institute at United Hospital Fund, December, 2011.

<sup>16</sup> Alice Lind, *Measuring Quality for Complex Medicaid Beneficiaries in New York*, Medicaid Institute at United Hospital Fund, December, 2011.

7. Measures tailored to assessing the quality of care for multiple chronic conditions are another area for specialized measures. Again, we recommend that the state draw upon the measurement framework developed by UHF.<sup>17</sup> Outcome measures tailored to members with critical, sometimes low prevalence health needs that are not reflected in standard measures should be included.<sup>18</sup>

8. ADA compliance measures. In this area data could be collected on the following plan activities or features:

- Identification of members with disabilities in need of reasonable accommodations in accessing services or communicating with the plan;
- Documentation of notices to members of their right to reasonable accommodations;
- Documentation of plan guidance to members detailing how to request accommodations;
- Numbers of staff completing training on policies and procedures for ADA compliance;
- Up to date description of accessible in-network providers in each county served.

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<sup>17</sup> Alice Lind, *Measuring Quality for Complex Medicaid Beneficiaries in New York*, Medicaid Institute at United Hospital Fund, December, 2011.

<sup>18</sup> *Id.*