Key Medicare Advantage Plans Quality and Performance Drivers: What every Community-Based Organization Should Know

Part 2: Medicare Advantage Webinar Series

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Participants will be able to identify several key drivers for Medicare Advantage (MA) quality and performance standards.

Participants will learn how home and community based services can support MA quality and performance initiatives.
Myriad MA Plan standards & regulatory sources (The short list!)

- Social Security Act
- Centers for Medicare & Medicaid (CMS) regulations
- The National Association of Insurance Commissioners (NAIC)
- Health Maintenance Organization (HMO) Act
- Health Insurance Portability and Accountability (HIPAA)
- Accreditation Standards
- State Insurance and Health standards
- Medicare Managed Care Manuals
- And more...
CMS’ MA Quality Perspective

- **The MA Quality Strategy**: Plans’ quality improvement strategies should focus on improving overall care that Medicare enrollees receive across the full spectrum of services
  - CMS continuous quality improvement efforts
  - Culture of improving quality of care and services in MA
  - Improve the quality of care for enrollees
  - Beyond just STAR Ratings
Quality Improvement Program (QIP)

- Section 1852(e) of the Social Security Act requires MA Plans to establish a Quality Improvement (QI) Program.
  - Assess and document activities related to quality initiatives on an ongoing basis
  - Modify interventions and/or processes as necessary
  - Report the status and results of their QIP to CMS upon request
- Conduct a Chronic Care Improvement Program (CCIP) as part of their QI Program standards.
“Quality assurance or quality improvement" means maintenance of high quality of health care by constantly measuring the organizational effectiveness.

HMOs are heavily regulated with respect to quality assurance issues.

HMOs are required to have quality improvement plans that address:

- Monitoring and evaluation of clinical issues
- Credentialing and recredentialing
- Peer review
- Data collection and analysis
- Health promotion and outreach

Medicare Advantage Plans are required to develop Quality Improvement Program.
21 chapters provide the road map for Medicare Advantage Plan regulations, compliance, and operations requirements

Routinely monitored & updated

Examples:
Chapter 3 Marketing
Chapter 5 Quality
Chapter 11 Application Process
Chapter 16b Special Needs Plans
Chapter 17c Enrollment & Disenrollment
Special Provisions for Special Needs Plans (SNPS)

- SNPs are a type of Medicare Advantage Plan
- SNPs tailor their benefits, provider choices, etc. to best meet the specific needs of the groups they serve
- SNPs must meet all of the MA regulations and the standards for the Model of Care
SNP Model of Care (MOC)

• The MOC:
  • Foundation for SNP quality, care management, and care coordination processes
  • Provides the basic framework under which the SNP will meet the needs of each of its enrollees

• MOC must be approved by the National Committee for Quality Assurance (NCQA)
  • 1-3 year approval
  • MOC scores impact STAR Rating
  • Considers: community needs assessment, comprehensive nature of addressing identified population health needs, utilization of local resources, etc.
Chronic Care Improvement Program (CCIP)

- Focus on effective management of chronic disease
- Improve care and health outcomes for enrollees with chronic conditions
- Effective management of chronic disease is expected to:
  - Slow disease progression
  - Prevent complications and development of comorbidities
  - Reduce preventable emergency room and inpatient utilization
  - Improve quality of life
  - Reduce health care costs for the Plan and member
Accreditation

• Health Plan Accreditation is one form of quality/performance accountability utilized by CMS
• Accreditation is a comprehensive health plan evaluation process
• CMS approved accrediting organizations:
  • National Committee on Quality Assurance
  • Utilization Review Accreditation Commission
Consumer Feedback

• MA Plans conduct annual consumer satisfaction surveys
• Survey: MA and Prescription Drug Plan Consumer Assessment of Health Plan

• Survey results are:
  • Reported to accrediting bodies and CMS
  • Publicly reported by CMS in the Medicare & You Handbook
  • Impact the accreditation scores and Medicare Star Ratings of the MA Plans
  • Used by beneficiaries to inform their MA Plan selection decisions
  • Used by the State Health Insurance Assistance Program (SHIP)

• Survey topics include:
  • How well practitioners communicate with patients
  • Ease of getting needed care and seeing specialists
  • Getting appointments and care quickly
  • Coordination of members’ health care services
  • Ease of getting prescriptions filled
  • Rating of health care quality
Healthcare Effectiveness Data Information Set (HEDIS)

- One of health care’s most widely used performance improvement tools
- **90 measures across 6 domains of care:**
  - Effectiveness of care
  - Access/availability of care
  - Experience of care
  - Utilization and risk adjusted utilization.
  - Health plan descriptive information
  - Measures collected using electronic clinical data systems
- Relies on members getting key elements of care from their doctors and reporting on care
- Requires intensive data chasing
- Significant impact on accreditation rating/STAR Rating
Health Outcomes Survey (HOS)

A tool used to collect and analyze data (annually)

Results are reported on select beneficiaries cohort two years later

The Medicare HOS instrument includes:

• Physical and mental health status
• Sampling of HEDIS Effectiveness of Care measures
• CMS specific questions
• Questions on race, ethnicity, primary language, sex, and disability status

HOS is administered to MA Plans with more than 500 enrollees
Star Ratings

• Support CMS’s efforts to transform health care delivery with a strong focus on person-centered care.
• Provide beneficiaries with a health plan quality report card
• Focus on aspects of care within the control of the plan
• Reward high performing MA Plans
  • Quality bonus
  • Open Enrollment
• Ratings 1-5 stars
Sample Star Ratings Criteria

- Diabetes care: Blood sugar controlled
- Medication reconciliation post-discharge
- Osteoporosis management in women who had a fracture
- Reducing the risk of falling
- Readmissions
- Part D medication adherence for hypertension
- Medication Therapy Management (MTM) Program
Numerous studies estimate that social determinants such as availability of basic resources, income level, access to transportation and health literacy can impact health outcomes by 80%.*

- CHRONIC Care Act
  - Expands MA program specific options for Plans to address SDOH
  - Specific Instructions to D-SNPs focused on person-centered care
- 21st Century Cures Act
  - Addresses SDOH as a factor in quality outcomes, changes risk adjusted rates for high need consumers
- CMS April 2019 Call Letter
  - Supplemental Benefits expansion-focus on community based supports

# Supplemental Benefits

**February 2018: Enactment of the CHRONIC Care Act**
- Legislation impacts services to consumers with complex health and social needs
- Provides for a variety of new MA Plans options & certain supplemental benefits that are not “primarily health related” to qualified enrollee populations based on health status or disease state
- Expands telehealth services

**Catalyst for CMS MA Call Letters expanding definitions of supplemental benefits**
- Services or items used to compensate for physical impairments
- Services or items that improve the functional or psychological impact of injuries or health conditions
- Services or items that reduce avoidable emergency and health care utilization
- STAR Ratings to include opioid management

**Examples of newly allowable benefits**
- Adult day care services
- In-home support services
- Support for caregivers of enrollees
- Medically-approved non-opioid pain management
- Stand-alone memory fitness benefit
- Home and bathroom safety devices and modifications
- Transportation
Value to MA Plans

- Data collection/reporting to identify members’ SDOH needs
- Support for addressing SDOH needs, e.g., nutrition, EBP, transportation, housing, health literacy, caregiver support, etc.
- Engagement in population health management
  - MOC
  - CCIP initiatives
- Early alert /preventive care intervention
- HCBS resource expertise
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<td>CBO Implications: The Consumer</td>
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<td>Integration of care across healthcare/HCBS ecosystems</td>
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<td>Greater support for managing clinical and SDOH needs</td>
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QUESTIONS???