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Preparing to Demonstrate the Value of Your Services within an Altered Quality Landscape

For the past several years, ANCOR members and other providers of services to persons with intellectual and developmental disabilities (I/DD) have focused on the changing health care landscape and its impact on services for people with I/DD, particularly concerning quality. Public and private innovations — integrated care, managed care, and alternate payment models — abound. The common factor among these various approaches is a desire to improve quality by achieving the Triple Aim of better care, better health, and lower cost.[1] To be competitive in new marketplaces, whether acute health care or long-term services and supports (LTSS), providers must understand the current (and emerging) environment and develop strategies that enable them to demonstrate the quality and value of services and supports they provide. This Issue Brief is intended to help I/DD providers better understand these developments and the challenges they present, particularly with respect to LTSS, then how to transform challenges into opportunities in the organizations they lead.

A Changing Policy Landscape

Perhaps it goes without saying that national and state policy objectives designed to drive improved quality in services provided to individuals with I/DD often take place within a managed care environment that is supported with Medicaid funding. Moving long-term services and supports into managed care models for many vulnerable populations, including the elderly and persons with disabilities, continues to be of high interest to state Medicaid programs. For the I/DD population, this movement began slowly; yet, steady growth has been attained in the past four years with six states taking steps toward managed care. Today, there are

1 https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

seven states – Arizona, Michigan, Wisconsin, North Carolina, Kansas, Iowa, Tennessee – with statewide managed long-term services and supports for people with I/DD. In addition, three states – Arkansas, New York, and Texas – are taking steps to transition to MLTSS. State policy goals in moving to managed care for individuals with I/DD typically include a desire to increase overall value for public funds that are expended and to achieve organizational and personal outcomes, such as addressing wait lists or increasing employment.

Through managed care, states are exploring alternate payment methodologies (APMs) to drive quality improvements. Alternative payment methodologies are instituted at a macro level, through health plans that are responsible for the delivery of many different kinds of LTSS to individuals, rather than at the individual provider level. Also referred to as Value-Based Purchasing, APMs focus on payment strategies that reward value rather than volume. These frameworks rely on clear definitions of value – quality outcomes delivered in a cost-effective manner – on which to build a contractual understanding for managed care payments.

State APM innovations have been launched with the support and expertise of the US Department of Health and Human Services (HHS) and others. HHS initiated the a public-private partnership, the Health Care Payment Learning and Action Network (HCP LAN), in 2015 to drive APM development and to facilitate a shift from the fee-for-service traditional payment model to one that pays for quality and improved health. **Findings from a 2018 survey completed by this learning network noted the growth of APMs:**

59%
of healthcare payments flowed through some type of APM

90%
of healthcare payers believe APM activity will increase[3]

90%
of healthcare payers also believe that APM will result in better quality of care

The US Centers for Medicare and Medicaid Services (CMS), part of HHS, is also focused on "building the knowledge base and capacity of states to begin increasing state adoption of strategies that tie together quality, cost, and outcomes in support of community-based LTSS."[4] CMS' Innovation Accelerator Program was launched in 2014 to support state Medicaid agencies'

2 http://ancor.org/sites/default/files/ancor_mltss_report_-_final.pdf
3 https://hcp-lan.org/2018-apm-measurement/2018-infographic/
4 https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/community-integration-ltss/index.html

capacities by offering technical assistance, tools and cross-state learning opportunity. The most recent learning collaborative launched under this effort includes ten states – Hawaii, Indiana, Kentucky, Louisiana, Minnesota, Missouri, New Jersey, Ohio, Texas, and Washington - with a focus on improving the quality of the Home and Community Based Services (HCBS) workforce, improving plan member satisfaction and quality of life, and improving care coordination across the health care system.[5] Of the key challenges, provider capacity/engagement, data limitations, stakeholder buy-in, and lack of standardized measures were most significant.

With these overarching national policy objectives towards value-based, an urgent call to action is the development of a consensus on what are key quality measures and outcomes for LTSS in HCBS settings, especially those that serve individuals with I/DD. To respond to this critical need there are various efforts underway, however, most are still under early development and achieving consensus among numerous and vocal stakeholders remains elusive. Some efforts of significance to the I/DD world are described below.

In 2014, the National Quality Forum (NQF) was tasked by the Department of Health and Humans Services with reviewing quality measure development and developing a shared understanding and approach to assessing HCBS quality, in general, not specifically for the I/DD population; identifying gaps in measures; and highlighting opportunities for further measure development. The NQF engaged a working Advisory Committee which identified a conceptual framework for measure development that would be based on the characteristics of high-quality HCBS, broadly defined within these categories:

- Service Delivery and Effectiveness
- Person-Centered Planning and Coordination
- Choice and Control
- Community Inclusion
- Caregiver Support
- Workforce
- Human and Legal Rights
- Equity
- Holistic Health and Functioning
- System Performance and Accountability
- Consumer Leadership in System Development[6]

5 http://nasuad.org/sites/nasuad/files/Advancing%20MLTSS%20In%20VBP-HCBS%20conf%202018-August%2028%20115%20pm-Final.pdf

6 http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx

In a 2016 NQF report,[7] the Committee highlighted challenges in the development of HCBS quality measures. These included the decentralized nature of HCBS services, lack of standardization, variability in reporting requirements, and the administrative burden of dealing with so many measures. NQF recommended that HHS develop a core set of standardized measures to broadly address HCBS, and also supplemental measures tailored to specific populations (e.g. quality of life) and settings be formulated.

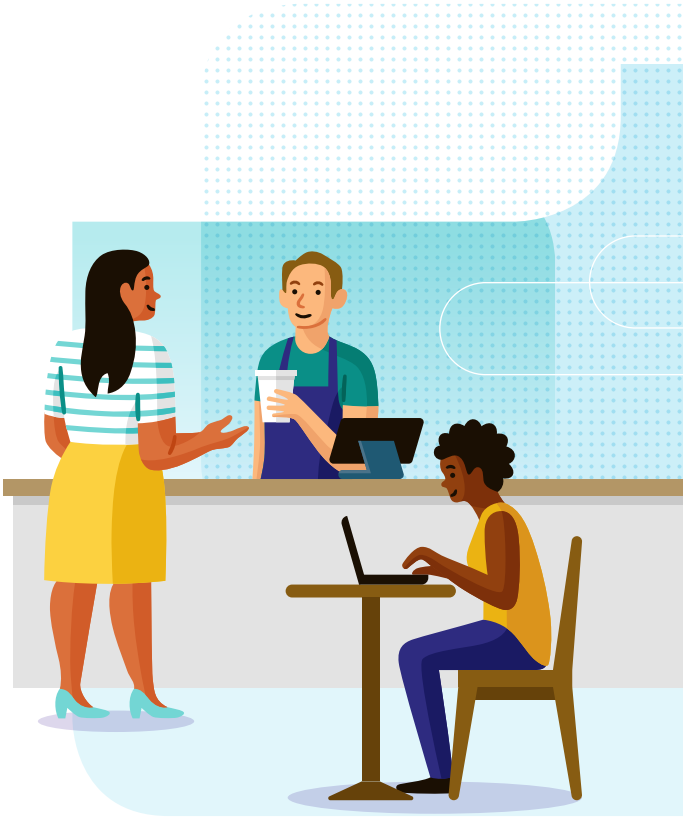
The NQF work provides a foundation for moving forward. The University of Minnesota's Rehabilitation Research and Training Center on HCBS Outcome Measurement received a five-year grant funded by the National Institute on Disability, Independent Living and Rehabilitation Research (within the Administration for Community Living) to validate and refine the NQF framework and to implement the framework to further develop measures for assessing the impact of HCBS on people with disabilities living in the community.[8]

There are efforts underway to begin operationalizing these concepts for the I/DD population. One such effort is the National Core Indicator (NCI) project. NCI is a voluntary effort by public developmental disability agencies to measure and track their own performance. NCI captures outcomes of services provided to individuals with I/DD in "buckets" such as: individual outcomes (including personal experience and employment — choice of job, hours worked, worker satisfaction); health, welfare and rights; system performance; staff stability; and family indicators, as well. NCI was recently cited as a resource to states seeking to build meaningful outcomes into managed care programs.[9]

The Council on Quality and Leadership (CQL) provides accreditation, training, certification and consultation to human service organizations and systems to improve quality of life and services for people with I/DD and others. CQL is leading another quality measurement effort to "connect the dots" relative to quality services and outcomes at both the system and individual levels. In particular, CQL is investigating the impact of organization practices consistent with its Basic Assurances and Personal Outcome Measures and outcomes impacting individual health and safety.

7 https://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx
8 https://rtcom.umn.edu/
9 http://nasuad.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success_0.pdf

Finally, another effort of note is Tennessee's Quality Improvement in LTSS (QuLTSS). This is an initiative of Tennessee's Medicaid program – TennCare - to promote the delivery of high quality LTSS through payment reform and workforce development.[10] For QuLTSS, quality is defined from the perspective of the person receiving services and his/her family/caregivers. TN's quality improvement focuses on a few key areas of significant state policy interest. Not surprising, workforce stability, particularly for individuals with I/DD, is a critical factor in defining quality from this perspective. With this in mind, Tennessee is using workforce outcomes that build to a pay-for-performance structure by first providing one-time investments for capacity building and financial incentives for provider organizations to adopt practices such as workforce data collection, evidence-based approaches to workforce, and aligning direct support professional (DSP) wage increases with training and competency. [11]



Preparing Your Organization to Capture the Quality and Value of Services it Provides

With this as a backdrop, providers seeking to stay ahead of the curve should consider how their services and supports align with the emerging quality framework described above. It is important they make investments in processes and systems that help them demonstrate the impact of services provided with a focus on value - i.e. the quality of life of those served and the cost-effectiveness of supports. To assist providers of I/DD services in this effort, we identify several practical tips to help managers effectively design, gather, and use data for quality improvement and reporting purposes.

10 http://nasuad.org/sites/nasuad/files/Advancing%20MLTSS%20In%20VBP-HCBS%20conf%202018-August%2028%20115%20pm-Final.pdf
11 Id.

Tips for Demonstrating the Value of Your Quality

1

Identify the Data You Have and Locate Where It Is

When considering the quality landscape, providers must determine what quality measures or performance indicators they are interested in tracking. Identify the data points needed to track for these measures; are the data located in a central location? Is it stored electronically or in paper? In many cases, organizations are likely already tracking specific data points; these metrics may take the form of state reporting requirements (e.g. critical incident reporting, medication error reporting, etc.) or they may be defined and reported internally to measure quality, costs, or other key metrics.

Providers that are already tracking these types of metrics would likely agree that while the data are available, it can often be time consuming to aggregate and analyze the materials to arrive at the insights associated with the data. This bring us to our next tip.

2

Identify What You are Reporting On and if You Can Answer the Big Questions

While the industry lacks consistent standards for HCBS quality measures for the I/DD population, the time to prepare for them is now. One of your greatest assets are the stakeholders within your agency who hold a wealth of information and experiences. Survey stakeholders across your organization to pinpoint what data are important to their various roles. If you find you cannot answer those big questions, it is time to scrutinize your current process and search for improvements that can help collect better data. This exercise is not about storing data for the sake of doing so; rather, it is about the centralization of data and quantifying provider activity to allow you to be nimble when those standards finally arrive.

3

Understand the Need for Advanced Health Information Technology

For over three decades, both the public and private sectors have encouraged the development of interoperable health information technology (HIT) to improve clinical and population health outcomes, increase quality and safety, decrease cost, and allow for better research data. A robust health IT infrastructure is vital to survive in the managed care and VBP environment, as quality will become the measure by which you are paid for delivering services.

4

Importance of Interoperability

At its heart, interoperability provides for a more person-centered experience as the individual can be viewed as a whole to create more seamless, quality care. Interoperability is defined as the ability of systems and devices to exchange and interpret data. Many states use Health Information Exchanges (HIEs) or Regional Health Information Organizations (RHIOs) which allow providers and patients to access and share electronic medical information. The real-time sharing of health information among an individual's integrated care team, including providers, doctors, nurses, pharmacists, hospitals, and others, allows for a 360 degree view of a person's history to improve outcomes, increase transparency and efficiency, and empower individuals. Most recently, in February 2019, CMS proposed a new rule to prevent information blocking and advance interoperability and individual access to health information.[12] The ability to view social and human services data in tandem with medical information to provide care that is informed by all of an individual's experiences is paramount.

Benefits of Interoperability

- Improve quality and outcomes
- Improve safety by reducing errors
- Streamline procedures by eliminating superfluous paperwork
- Engage the individual and their circle of supports in the health information process
- Reduce overall medical costs
- Allow for data analysis across populations

5

Requirements to Look for in Health IT Solutions

If you're in search of a health IT platform, here are some vital attributes that you will need to effectively measure quality:

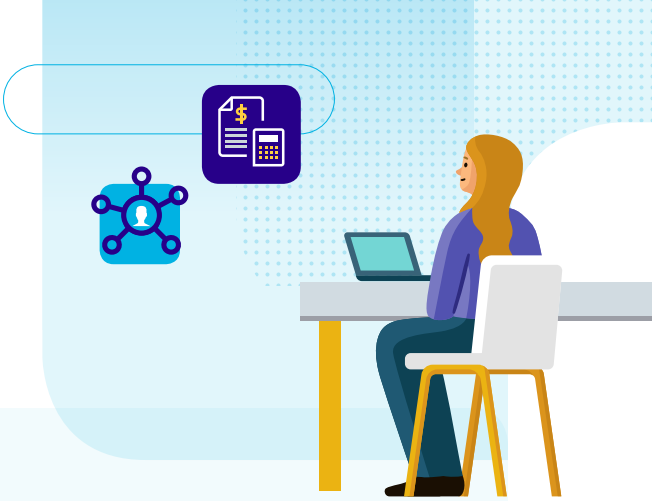
- Secure storage of member and employee data
- Care plan management and electronic service authorization
- Seamless access to pertinent member data for member's circle of supports
- Paperless scheduling and billing
- Robust performance report building and exporting
- Powerful but easy to learn user interface—an IT platform is no good if its users don't adopt it
- Mobile user interfaces/ cloud-based data access

6

Evaluate Your Current System

If you are currently using an electronic health record or other technology, evaluate if it has the capabilities you will need to measure and analyze quality metrics. Undergo an assessment of your current system to ensure you are using it to its full potential. Identify if you have existing workflows that could benefit from automation and secure data storage, then assess if your current system is capable of adapting to the future. Consider creating a roadmap to guide more efficient use and encourage usage across your agency.

Tips for How You Can Prepare



1

Become an Engaged Stakeholder

Quality measurement in the I/DD world has become a burgeoning industry. The earlier participating organizations get on board — collecting and self-reporting data, identifying areas for improvement, being in touch with their local regulators and participating in quality discussions, and becoming comfortable with a value/quality paradigm — the more likely you can help influence the benchmarks that will later be standardized. Whether or not the scope, timeline, specifications, or data collection methodology for quality measures are finalized, the fact that you are already collecting this data, quantifying your activity and centralizing data retrieval means you are reducing the burdens to your workflows and preparing for the future.

If your state is just beginning conversations about the potential for managed care, value based payments (VBP) for Medicaid services, or reporting to HIEs, make sure to have your voice and concerns heard. Even if your state isn't yet engaged, educate yourself on what other states are doing so you are ready if/when quality measurement comes to your state Medicaid program. One of the best ways to learn is by listening to the experiences of others, by attending conference sessions or webinars, reading digests of state work, and speaking with your colleagues in other states.

2

Build Costs into Your Budget

As standards and the regulatory environment continue to change, agencies should prepare to include the costs and preparations for health IT as a constant part of their budget. Since quality is likely to become the method on which agencies are to be paid, the time for beginning the change is now - in reporting, in recognition, and in identifying what you need to do to get ahead. The earlier you can implement a Health IT solution, the easier the transition will be when the changes come to your state. No one likes change – undergoing a significant technology implementation and transforming internal organizational processes while also adapting to new regulatory requirements is doable but not suggested.

3

Conduct a Comparative Analysis

Look at data that your state may already be collecting to use as a benchmark to see how your agency compares. For providers who aren't utilizing a sophisticated system, you can take small measures to start the process and identify improvements. Apply learnings and best practices from population level data insights to develop an understanding of how your agency will need to shift its current practices.

4

Utilize the Data You Have

Data means absolutely nothing if you don't have the proper tools to analyze it. If you're ahead of the game and are already collecting data, the next step is to use it to drive improvements and demonstrate your value. The key here is to identify the baseline requirements of the standards you're trying to reach.

Start small, select an achievable list of standards to get started, and then expand on standards and data collected later on. For example, if you're worried about absenteeism then start tracking related metrics, even if it is just in Microsoft Excel.

The key to success is the ability to make data insights actionable to help organizations improve their processes to achieve better outcomes for the individuals they support. Drawing on data-driven reports, organizations can develop strategies and interventions to drive real results.