Quality Measurements in Long Term Services and Supports (LTSS)

Presented to One Care Implementation Council

by

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Brief Bio

- Served on staff to the US House of Representatives, Select Committee on Aging (1982-1988); primary drafter of Disability Benefits Reform Act of 1984, which ensured that SSDI and SSI beneficiaries received accurate, fair and consistent decisions; ending the Reagan purge of the Disability programs.
- Served on staff at the Office of the Secretary, US DHHS (1988-1992), with legislative and regulatory oversight of Social Security and health care for people with disabilities.
- Executive of New Jersey statewide trade association representing providers serving people with developmental disabilities (1997-2011), led advocacy to create Medicaid buy-in and to maximize federal revenues in waiver.
- Deputy Commissioner of Human Services (2012-2016) in New Jersey, led the development and successful implementation of Medicaid MLTSS, integrating physical, behavioral and LTSS for seniors and people with disabilities.
- Serve on Child and Adult Medicaid & CHIP Core Set Review Workgroup (2019-2021) contracted through Mathematica by CMS; successfully added the first LTSS outcome measurement to the Core Set.

Importance of LTSS in Dual Eligible Population

- Dual eligibles are more likely to require LTSS compared to typical Medicare/Medicaid enrollee because of their poor health and higher levels of health impairments.
- Dual eligible beneficiaries account for about one-third of total costs to the federal government and the states in each program, although they represent about 15 percent of Medicaid beneficiaries and 20 percent of Medicare beneficiaries (MACPAC 2021)
- Nationally, 32% of all Medicaid expenditures are for LTSS.
  - Seniors and people with physical disabilities comprise 55% of that total cost (generally broken out in this way in research papers).
  - People with I/DD comprise approximately 25% of LTSS costs and
  - People with behavioral health comprised 6% and multiple other populations comprise the rest.
- LTSS users represent a substantial (41.8%) of total Medicaid spending. (2018 RTI study for ASPE, USDHHS).

MASS OneCare LTSS Experience of Care

- There is a significant reduction in the percentage of respondents being offered an LTS Coordinator (2017-2019);
- More than 25% of respondents felt their needs were somewhat or not at all identified and discussed (although there was a statistically significant improvement over past three years in the percentage feeling their needs were identified and discussed).
- Less than half of respondents reported using or needing LTSS, despite the demographics that people who are dual eligible are more likely to need and use LTSS. (One Care demographics show: 84-86% of beneficiaries report having at least two disabilities or health conditions; 67% of beneficiaries having physical disabilities and 52% with long term illness.

Other CMS Measurement reporting Requirements for LTSS for One Care

- Number of appeals related to denials or limited authorization of HCBS.
- Number of care plans completed within 90 days of enrollment.
- LTSS clean claims paid within 30, 60 and 90 days.

Ideal Quality Measurements for LTSS

- It is important to go beyond measures of satisfaction, process and health and safety and address social determinants of health and person-centered goals as quality of life.

- Experience of Care questions, such as whether an individual was offered an LTS Coordinator and whether their needs discussed during the assessment do not provide an understanding of whether LTSS is providing the necessary supports for an individual to live in the most integrated setting appropriate to need.

Potential for use of National Core Indicators (NCI) and NCI for Aging and Disability (NCI-AD)

- NCI (for people with I/DD) and NCI-AD measure and track the performance in the DD system and in Medicaid, aging and disability agencies and can crosswalk/evaluate system-wide compliance across the HCBS settings rules. **Massachusetts already uses the NCI.**

- Specific domains: community participation, choice and decision-making, relationships, satisfaction, service coordination, care coordination, access, safety, health care, wellness, medications, rights and respect, self-direction, work, everyday living, affordability, planning for future and control.

- States may add questions to the NCI-AD regarding services for mental/behavioral health and drug and alcohol addiction.

NCI-AD Domain: Care Coordination Specific Indicators

- Proportion of people discharged from the hospital or long term care (LTC) facility who feel comfortable going home;

- Proportion of people making a transition from hospital or LTC facility who have adequate follow-up; and

- Proportion of people who know how to manage their chronic conditions

Timeline and Costs for NCI-AD

- New states received a year of Technical assistance (TA) (June-May)
- Collect data in second year (June-May). State specific report completed that Fall/Winter.

Cost:

- $25,000 fee for NCI-AD membership in the TA year and ongoing for project direction, management, data management, analysis and reporting.

- State internal cost of conducting survey $85-100,000 to cover baseline sample of 400 recipients. If wanting to over-sample, there is an additional cost. State will need at least .25 FTE for staff to provide oversight to the project.

- States may receive at least 50% administrative cost as FFP and if use the External Quality Review Organization (EQRO) can receive 75% in federal funds.

Racial Disparity in LTSS and Quality Measurements

- The LTSS setting is characterized by racial and ethnic disparities in financing, access, quality and service delivery (Gorges et al 2019)

- Older adults from communities of color and indigenous people are more likely to experience cumulative adversity in their lifetime, the outcomes of which are magnified by the lack of health insurance and adequate access to health care over the life course. (Buchmueller et al., 2016; Chen et al., 2016).

- Among those who utilize home and community-based services, the quality of care for racial/ethnic minority users has been lower than for white users. (Towne et al., 2015).

- The coronavirus has shown why the quality of LTSS should not only be measured by clinical measures but needs to include comprehensive measures of well-being such as quality of life. The inclusion of quality of life is particularly salient for LTSS racial/ethnic minority users who already reported lower quality of life (Shippee et al., in press) and higher risk for isolation in LTSS prior to the pandemic (Li & Cai, 2014).