


## OneCare Kansas Core Measures and Audit Planning

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*Helping people live healthier lives by integrating and coordinating services and supports to treat the "whole-person" across the lifespan.*

### Session goals




- Outline the requirements for quality measurement in OneCare Kansas (OCK)
- Collect member-level data to compare the effect of the model across Medicaid populations and against other models of service delivery
- Early warning system vs retrospective system to monitor and guide service delivery
- Expectations of Lead Entity and OCK partners tied to the data points will be designed by the State

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### OneCare Core Measures

- Federally required by CMS
- Align with other initiatives including:
  - HEDIS (Healthcare Effectiveness Data and Information Set)
  - CMS Adult Core Measures
  - AHRQ (Agency for Healthcare Research and Quality)
  - NQF (National Quality Forum)
- Technical Specifications and Resource Manual



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### 2019 Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set)

NQF #	Measure Steward	Measure Name
<b>Core Set Measures</b>		
0004	NCOA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)
0018	NCOA	Controlling High Blood Pressure (CBP-HH)
0418/0418e	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)
0576	NCOA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)
1768	NCOA	Plan All-Cause Readmissions (PCR-HH)
NA	NCOA	Adult Body Mass Index Assessment (ABA-HH)
NA	AHRQ	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)
<b>Utilization Measures</b>		
NA	CMS	Admission to an institution from the Community (AIF-HH) <sup>a</sup>
NA	NCOA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)
NA	CMS	Inpatient Utilization (IU-HH)

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; NA = Measure is not NQF endorsed; NCOA = National Committee for Quality Assurance; NQF = National Quality Forum.  
<sup>a</sup> For the 2019 Health Home Core Set, NFU-HH was revised and renamed Admission to an institution from the Community (AIF-HH).

### CMS Guidance

#### Technical Specifications

- Original - 2013
- Updated as needed (every year or two)
- Built on previous year
- Few changes from year to year
- Latest Version – 2019

<https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/quality-reporting/index.html>

Google: Health Homes Quality Reporting

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### Technical Specifications Example

**MEASURE ABA-HH ADULT BODY MASS INDEX ASSESSMENT**

**A. DESCRIPTION**

Percentage of health home enrollees ages 18 to 74 who had an updated BMI and waist measurement during the measurement year or the year prior to the measurement year.

**Criteria for Reporting:**

- The measure applies to health home enrollees ages 18 to 74 for the current or the prior measurement year.
- Health home data reporting dates should include and report the measure for the age group on regularly scheduled dates for the measurement year or the year prior to the measurement year.
- The height, weight, and BMI should be from the same data source.
- The participant must be measured and/or seen during the measurement year or the year prior to the measurement year.
- If using health home data, documentation in the medical record should include the date and time of the measurement year or the year prior to the measurement year.
- Include all paid, suspended, pending, and denied claims.
- Enrollees in plans are excluded from the eligible population. A state reports this measure using the HEDIS method, and an enrollee is listed as a member or only member currently residing in the state. An enrollee is removed from the eligible population if the enrollee is not a member of the health home.

The following coding systems are used in this measure: CPT, ICD-9-CM, ICD-10-CM, ICD-10-PCS, and ICD-9-CM.

**B. DEFINITIONS**

**BMI** – Body mass index, a statistical measure of the weight of a person relative to their height.

**Waist** – The perimeter, taken based on the Centers for Disease Control and Prevention's (CDC) 2007 Adult Anthropometric Survey of the waist and hip.

**C. ELIGIBLE POPULATION**

Age: 18 to 74 (January 1 of the year prior to the measurement year to July 31 of the measurement year)

Enrollment: Enrolled in a health home (HH) program for the measurement year and the year prior to the measurement year.

**MEASURE ABA-HH ADULT BODY MASS INDEX ASSESSMENT**

**Administrative Data**

Measure ID: NA

Measure Name: Adult Body Mass Index Assessment

Author: NA

Author Date: December 31 of the measurement year.

Start Date: NA

End Date: NA

**D. ADMINISTRATIVE SPECIFICATION**

**Denominator**

The eligible population.

**Numerator**

For health home enrollees age 18 to 74 on the date of service, BMI (BMI (kg/m<sup>2</sup>)) during the measurement year or the year prior to the measurement year.

For health home enrollees younger than age 18 or the date of service, BMI percentiles (BMI Percentiles) during the measurement year or the year prior to the measurement year.

**Exclusions (optional)**

Enrollees in health home enrollees who have a diagnosis of pregnancy (gestational diabetes) during the measurement year or the year prior to the measurement year.

**E. HYBRID SPECIFICATION**

**Denominator**

A systematic sample drawn from the eligible population.

Using a sample size of 1,000, unless special circumstances apply. States may reduce the sample size (using guidance from the quality improvement plan) based on the state's prior experience with the measure. The sample size may be reduced to 500 if the state's prior experience with the measure is limited to the year prior to the measurement year. For additional information on using a reduced sample size, see the Hybrid Specification for Reporting Sample Size (SS) in the measure manual.

**Numerator**

BMI during the measurement year or the year prior to the measurement year, as determined through administrative data or medical record review.

**Administrative Data**


Apply the Administrative Specification to identify positive numerator hits from the administrative data.

Measure ABA-HH: Adult Body Mass Index Assessment 13

**Medical Record Review**  
 For Health Home enrollees age 20 and older on the date of service, documentation in the medical record must indicate the height and BMI value, dated during the measurement year or year prior to the measurement year. The weight and BMI value must be from the same data source.  
 For Health Home enrollees younger than age 20 on the date of service, documentation in the medical record must indicate the height, weight, and BMI percentile, dated during the measurement year or year prior to the measurement year. The height, weight, and BMI percentile must be from the same data source.  
 For BMI percentile, either of the following meets criteria:  
 • BMI percentile documented as a value (e.g., 85th percentile)  
 • BMI percentile plotted on an age-growth chart  
 Ranges and thresholds do not meet the criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).  
**Exclusions (optional)**  
 Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the measurement year or the year prior to the measurement year.

**F. ADDITIONAL NOTES**  
 The following notations or examples of documentation are considered "negative findings" and do not count as numerator compliance:  
 • No BMI or BMI percentile documented in medical record or plotted on age-growth chart  
 • Notation of weight only


Technical Specifications Example (cont.)



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**Technical Specifications Example: Emergency Department Visits**


- **Data Collection Method:** Administrative
- **Denominator:** Number of enrollee months.
- **Numerator:** Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.
- **Calculation:** Divide the number of ED visits by the number of enrollee months and multiply by 1,000.



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**Data Source for Measures**



	Admin	Hybrid/ Medical Record	EHR
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	X		X
Controlling High Blood Pressure	X	X	X
Screening for Depression and Follow-Up Plan	X		X
Follow-Up After Hospitalization for Mental Illness	X		
Plan All-Cause Readmissions	X		
Adult Body Mass Index Assessment	X	X	
Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite	X		
Admission to an Institution from the Community	X		
Ambulatory Care: Emergency Department Visits	X		
Inpatient Utilization	X		



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**What did we measure for the previous program? (CMS Required)**



1. Initiation & Engagement - Alcohol & Drug Dependence Treatment
  - Adolescents
  - Adults
2. Controlling High Blood Pressure
  - Adequately controlled (<140/90)
3. Screening for Clinical Depression and Follow-up Plan
  - Screen using standardized tool
  - Follow-up documented

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**What did we measure for the previous program? (CMS Required)**



4. Follow-up After Hospitalization for Mental Illness
  - Outpatient visit/encounter/partial hospitalization w/ MH Practitioner
5. Plan All-Cause Readmissions
  - Hospital stays with readmission within 30 days
6. Adult BMI
  - Documented

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**What did we measure for the previous program? (CMS Required)**


7. Inpatient Utilization
  - General hospital/acute
8. Ambulatory Care Sensitive Condition Admission (No longer req.)
  - Acute care admissions for conditions avoidable by primary care

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## What's new? (CMS Required)

9. Prevention Quality Indicator: Chronic Conditions Composite
  - Inpatient hospital admission
  - Based on qualifying event
10. Ambulatory Care: Emergency Department (ED) Visits
  - ED visits for conditions manageable by PCP visits
11. Admission to an Institution from the Community
  - Institutional Facility Admissions
  - Short, Medium and Long-term

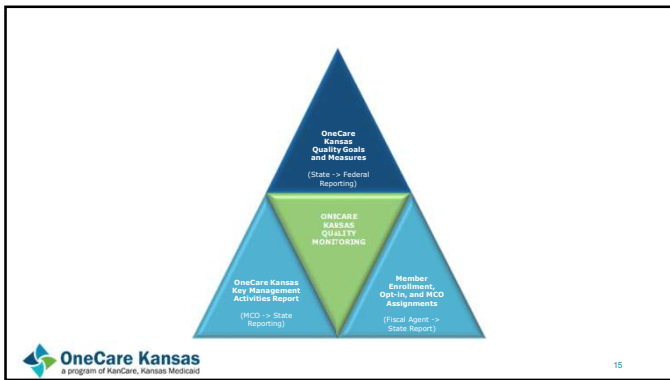


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Code Set	Service Goal	Measure	Measure Category	Description	Guidance for Reporting
PC9-BB	1.1 Babeser utilization associated with inpatient stays	Plus All Care Re-Admissions	Quality of Care	For OCK members ages 18 to 64, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: Count of Acute Hospital Stays (CHS) Count of Expected 30-Day Readmissions	MCOs use to report this measure using the Administrative workflow. This measure applies to OCK members ages 18 to 64. Although the BE200 measure includes modified reporting by number of hospital stay and age for the Health Home Care Set, the rates will calculate and report only the Total rate. Supplemental data may be used for this measure. MCOs should report by Count of Expected 30-Day Readmissions for this measure to four decimal places. This measure requires risk adjustment. Risk adjustment guidelines are provided in the administrative specification. When applying risk adjustment, MCOs should include all services, whether or not the MCO paid for those services or not for their fee (i.e., include dental claims). When identifying all other events, do not include dental services (i.e., only include paid services and services reported to be paid). Other conditions and restrictions apply. See technical specification for additional information.
PC10-BB	1.2 Babeser utilization associated with inpatient stays	Ambulatory Care Services Change Practices Composite	Quality of Care	Number of inpatient hospital admissions for ambulatory care sensitive chronic conditions per 100,000 member months for OCK members age 18 and older. This measure includes acute hospital admissions for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with severe chronic complications, chronic obstructive pulmonary disease, asthma, hypertension, or heart failure without a cardiac procedure. Note: A lower rate indicates better performance.	MCOs use to report this measure using the Administrative workflow. For the purpose of Health Home Care Set reporting, MCOs should calculate and report this measure for two age groups (in applicable) and a total rate: ages 18 to 64, age 65 and older, and total (all ages). MCOs should report this measure as a rate per 100,000 member months as reported to per 100,000 Health Home members. A two-step process should be used to determine whether members should be included in this measure: 1) For each member month included for the denominator, assess the member's age on the 1st of the month (or the 21st of the month if February). If the member is age 18 or older by that date, the member month should be included in the denominator. For example, if a member is over age 18 on the 30th but only has eligibility through the 27th, the month would not count toward the denominator. 2) For each hospital admission representing a qualifying numerator event, assess the member's age on the date of admission. Only admissions for members age 18 or older should be included in the numerator. Include paid claims only. Other conditions and restrictions apply. See technical specification for additional information.
AMB-BB	1.3 Babeser utilization associated with inpatient stays	Emergency Department (ED) Visits	Quality of Care	Rate of emergency department (ED) visits per 1,000 member months using OCK numbers.	MCOs use to report this measure using the Administrative workflow. For the purpose of Health Home Care Set reporting, MCOs should calculate and report this measure for three age groups (in applicable) and a total rate: ages 0 to 17, ages 18 to 64, age 65 and older, and total (all ages). Report all services the MCO paid for or expects to pay for (i.e., claims incurred but not paid). Do not include services and days denied for any reason. Exclude all inpatient stays, regardless of payment status (paid, suspended, pending, denied), when confirming that an ED visit did not result in an inpatient stay.

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## But what about our audit??




Planning Council discussion - June 20

- Previous partner program structures
- What partners excited to share with Planning Council Representatives
- How partners assessed their programs
- How partners overcame challenges

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## Establishing Audit Criteria




- Short-term
- Non-duplicative
- Widely accessible
- Demonstrate value beyond the specific population

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## Question Categories




- Provider programs
- Data sources
- Provider outcomes
- Success

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### Potential Auditing Categories

New partners, focus areas, service expectations, staff	<b>Education/Training</b>
<b>Collaboration</b>	Outreach to new partners, hosted health fairs
Recruitment, position descriptions, roles	<b>Staffing</b>
<b>Engage Clients</b>	In-person visits, HAP completion, cancelled appointments


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### Potential Auditing Categories (cont.)


QOL surveys, health goals, SDOH	<b>Member Outcomes</b>
<b>Program Outcome Monitoring</b>	Referrals, service delivery, personnel tracking
Travel, reimbursement, case logs	<b>Staff Outcomes</b>
<b>Performance Imp. Outcomes</b>	Program evaluation/imp., personnel evaluations, trends

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### Audit tool





- Will incorporate stakeholder feedback
- One consistent audit tool for all 3 MCOs
- Interpretive guidelines for consistency in application
- Well-defined auditing methodology
- State oversight – MCO auditing, partner/member outreach, surveys

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### Next Steps


- Fully integrate the measures into the reporting practices of the Lead Entities and OneCare Partners
- Re-visit measures regularly to identify implementation issues and solutions
- Revise based on achievement and goals for continuous quality improvement
- Celebrate successes!




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### In conclusion

- Building on lessons learned
- This is an iterative process
- Measures will reflect coordinated and cohesive efforts
- Audits will promote and highlight program and member outcomes
- Communication will continue



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