

OneCare Kansas Quality: Goals and Performance Measures

Tim Meier | MCO Operations Data Analyst - KDHE DHCF

Amy Swanson | Quality Program Manager - KDHE DHCF

Shaune Parker | Health Care Data Analyst - KDHE DHCF

Kristian Farmer | Program Evaluation Data Analyst - KDHE DHCF



Legislative Proviso

- Mental Health - Serious Mental Illness
- Substance Use Disorder - Add 2 quarters
- Chronic Conditions
- Adults and Children
- Limited funds (2.5 million this fiscal year)
- Tentative implementation date - Jan. 2020

- Meet requirements
- Learn from other States
 - Keep it simple
 - No “new” measures
- Leverage existing metrics
 - Existing requirements for providers
 - HEDIS metrics
 - Core Measures
- Appropriate for target population



Quality Sub-Group



- Currently:
 - Working with current consultants
 - KDHE and KDADS
 - KUMC Partners
- Adding later:
 - Stakeholders
 - Kansas EQRO
 - KanCare Health Plan Representatives

- The requirements for quality measurement in OneCare Kansas (OCK)
- Provide data to CMS for interim report to Congress
- Collect member-level data to compare the effect of the model across Medicaid populations and against other models of service delivery
- Early warning 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.



CMS Requirements

- Released “recommended” core measures - January 2013
- States must report on Core measures in addition to state-specified goals and measures
- Core measures align with other CMS initiatives
- Technical specifications released in 2013 followed by several revisions
- <https://www.medicare.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/quality-reporting/index.html>

MEASURE ABA-HH: ADULT BODY MASS INDEX ASSESSMENT

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Health Home enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure applies to Health Home enrollees ages 18 to 74. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable) and a total rate: ages 18 to 64 and ages 65 to 74.
- The height, weight, and BMI should be from the same data source.
- The height and weight measurement should be taken during the measurement year or the year prior to the measurement year.
- If using hybrid specifications, documentation in the medical record should indicate the weight and BMI value, dated during the measurement year or the year prior to the measurement year.
- Include all paid, suspended, pending, and denied claims.
- Enrollees in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and an enrollee is found to be in hospice or using hospice services during medical record review, the enrollee is removed from the sample and replaced by a member from the oversample.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9-CM, ICD-10-CM, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

BMI	Body mass index. A statistical measure of the weight of a person scaled according to height.
BMI percentile	The percentile ranking based on the Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts, which indicate the relative position of a patient's BMI number among those of the same sex and age.

C. ELIGIBLE POPULATION

Age	Age 18 as of January 1 of the year prior to the measurement year to age 74 as of December 31 of the measurement year.
Continuous enrollment	Enrolled in a Medicaid Health Home program for the measurement year and the year prior to the measurement year.

Version of Specification: HEDIS 2018



Measure ABA-HH: Adult Body Mass Index Assessment

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Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Health Home enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/ diagnosis	Health Home enrollees who had an outpatient visit (<u>Outpatient Value Set</u>) during the measurement year or the year prior to the measurement year.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

For Health Home enrollees age 20 or older on the date of service, BMI (BMI Value Set) during the measurement year or the year prior to the measurement year.

For Health Home enrollees younger than age 20 on the date of service, BMI percentile (BMI Percentile Value Set) during the measurement year or the year prior to the measurement year.

Exclusions (optional)

Female Health Home enrollees who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NQQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

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

Administrative Data

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

Technical Specifications Example

Medical Record Review

For Health Home enrollees age 20 and older on the date of service, documentation in the medical record must indicate the weight 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.

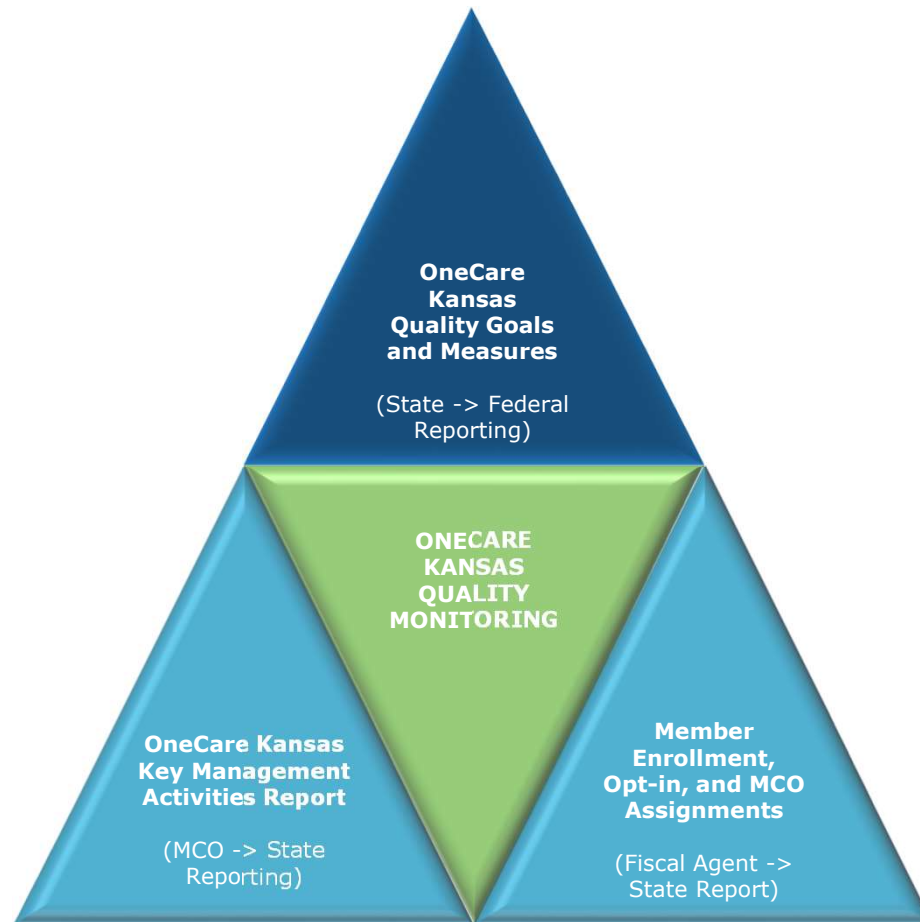
F. ADDITIONAL NOTES

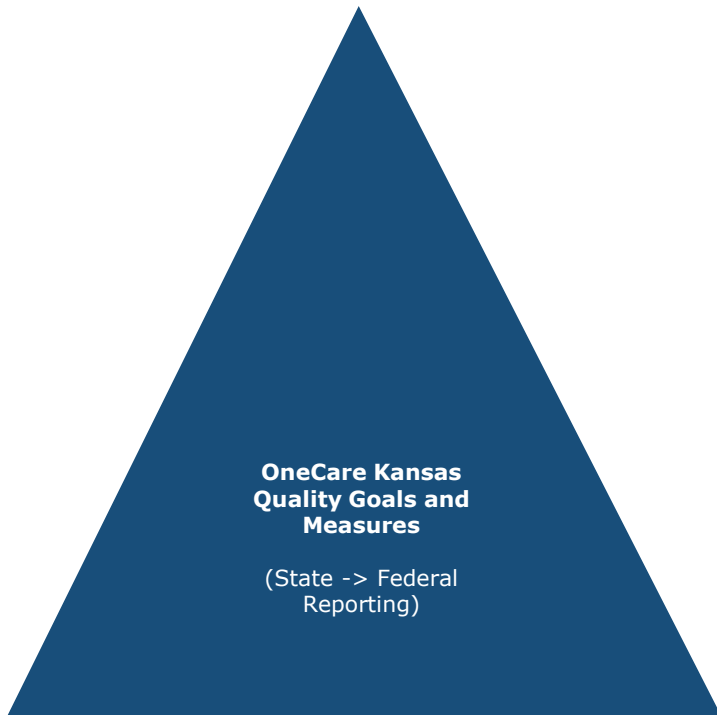
The following notations or examples of documentation are considered "negative findings" and do not count as numerator compliant:

- No BMI or BMI percentile documented in medical record or plotted on age-growth chart
- Notation of weight only

Technical Specifications Example for 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.





Previous SMI HH Measures:

- I. Reduce utilization associated with inpatient stays
 - A.) **Decrease in Institutional Care Utilization**
 - B.) Inpatient Utilization- General hospital/Acute
 - C.) Plan- All Cause Readmission
 - D.) **Ambulatory Care- Sensitive Condition Admission**

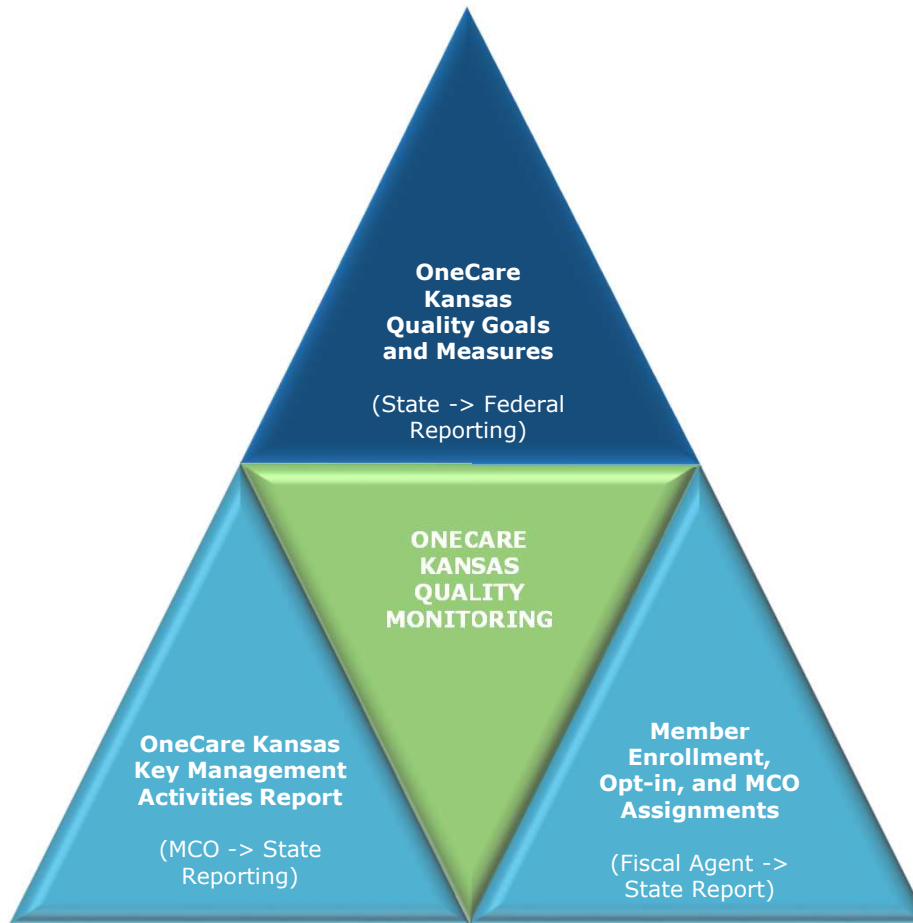
- II. Improve management of chronic conditions
 - A.) **HbA1C Testing**
 - B.) **LDL-C Screening**
 - C.) Follow-up after Hospitalization for Mental Illness
 - D.) Adult BMI Assessment
 - E.) Screening for Clinical Depression and Follow-up Plan
 - F.) Controlling High Blood Pressure

- III. Improve Care Coordination
 - A.) **Increased Integration of Care**
 - B.) Initiations and Engagement of Alcohol and Other Drug Treatment
 - C.) **Tobacco Use Assessment**

- IV. Improve transitions of care among PCP and community providers and inpatient facilities
 - A.) Inpatient Utilization – General hospital/Acute Care (HEDIS)
 - B.) **Care Transition- Transition Record Transmitted to Health Care Professional**
 - C.) Follow-up after Hospitalization for Mental Illness

New CMS Required Measures:

- Prevention Quality Indicator: Chronic Condition Composite
- Nursing Facility Utilization





KanCare Key Management Activities Report - OneCare

Lead Entity Name
Service Issues/Concerns

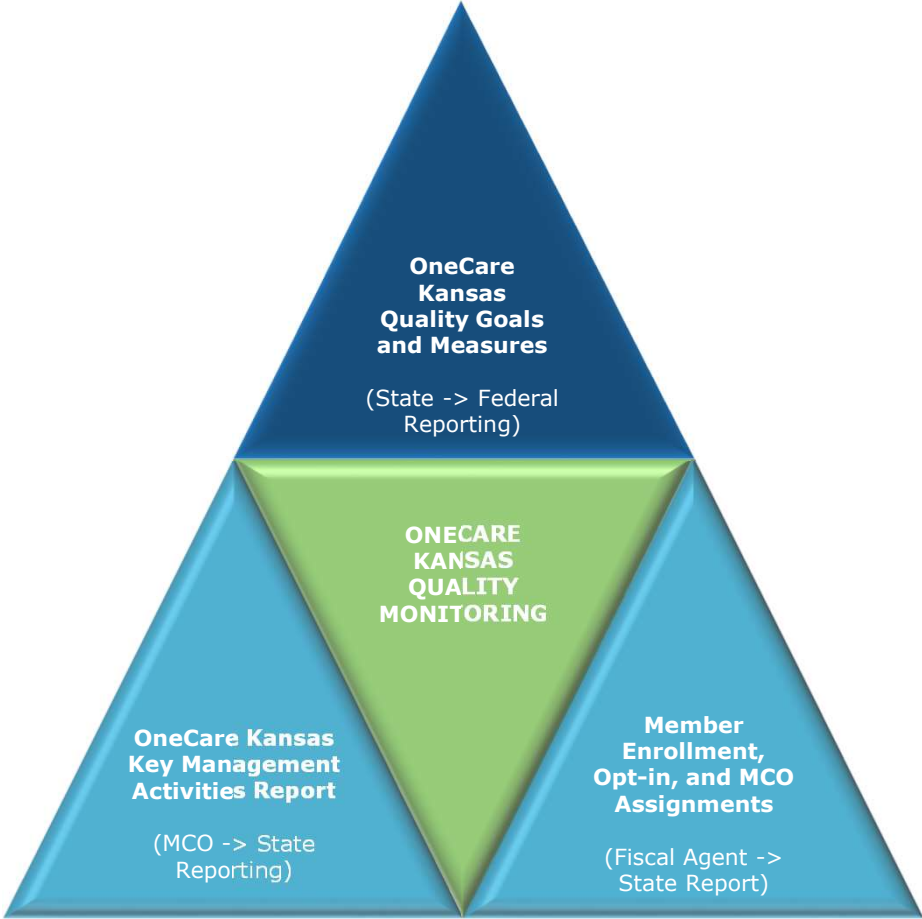
1. Member Services Issues/Concerns	
2. OneCare Partner or Other Provider Services Issues/Concerns	
3. Monthly Member Re-assignments	
# Re-assigned from one OneCare Partner to another - Total	#
4. Implementation of OneCare Goals and Measures	
5. General Other Areas of Activity	

Definitions

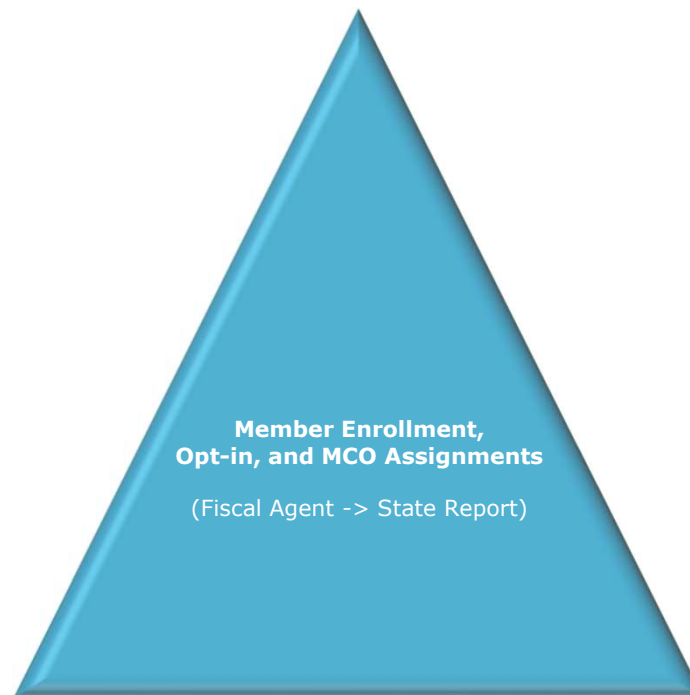
Issues/Concerns: Complaints from members, providers, OneCare partners, care coordinators, member/provider service representatives that the State should be aware of or can assist in

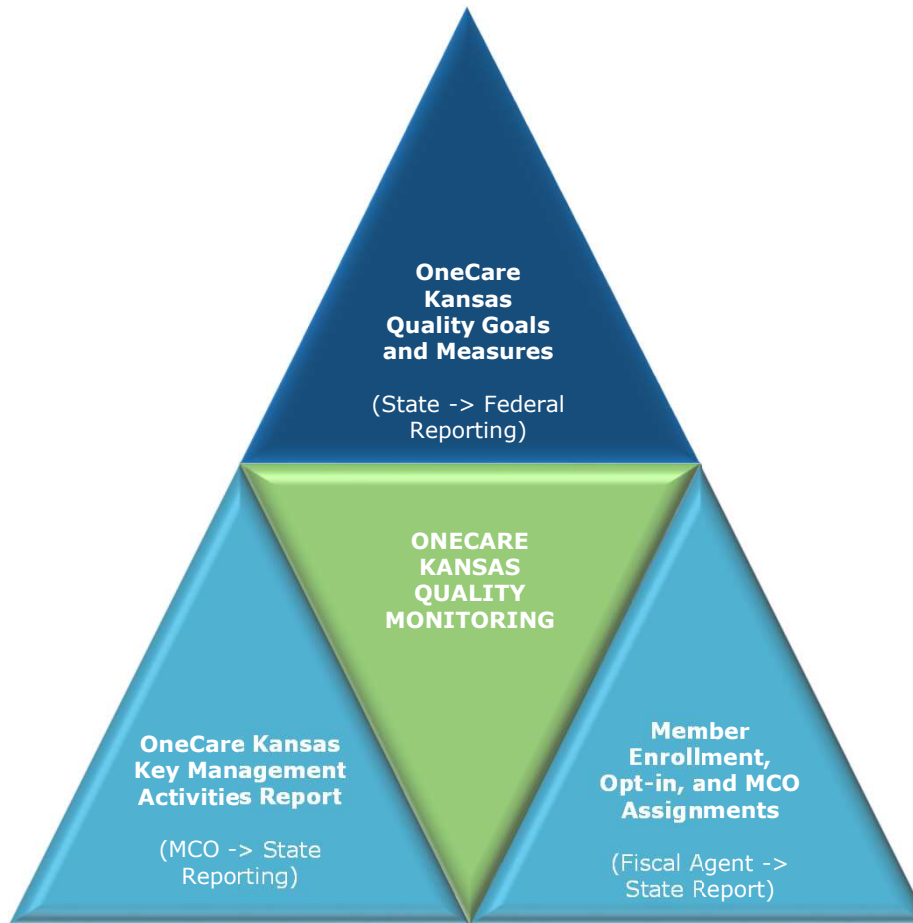


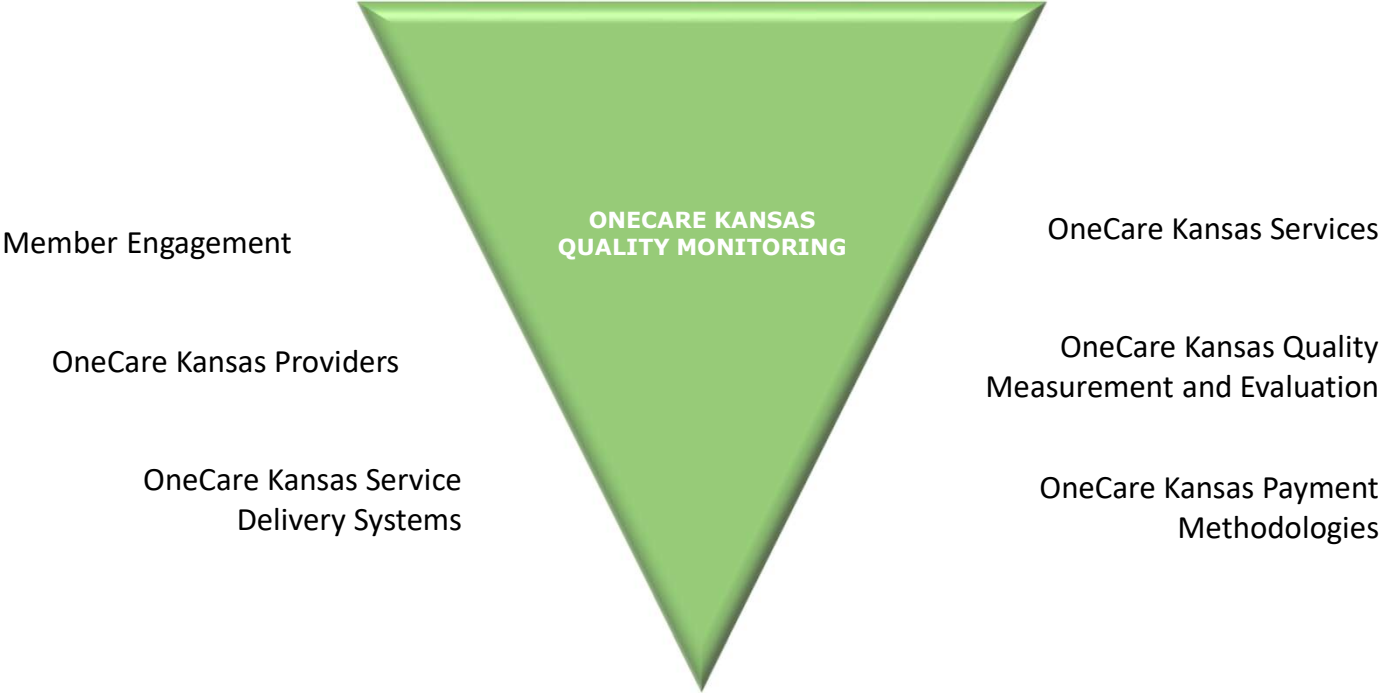
**OneCare Kansas
Key Management Activities Report**
(MCO -> State Reporting)

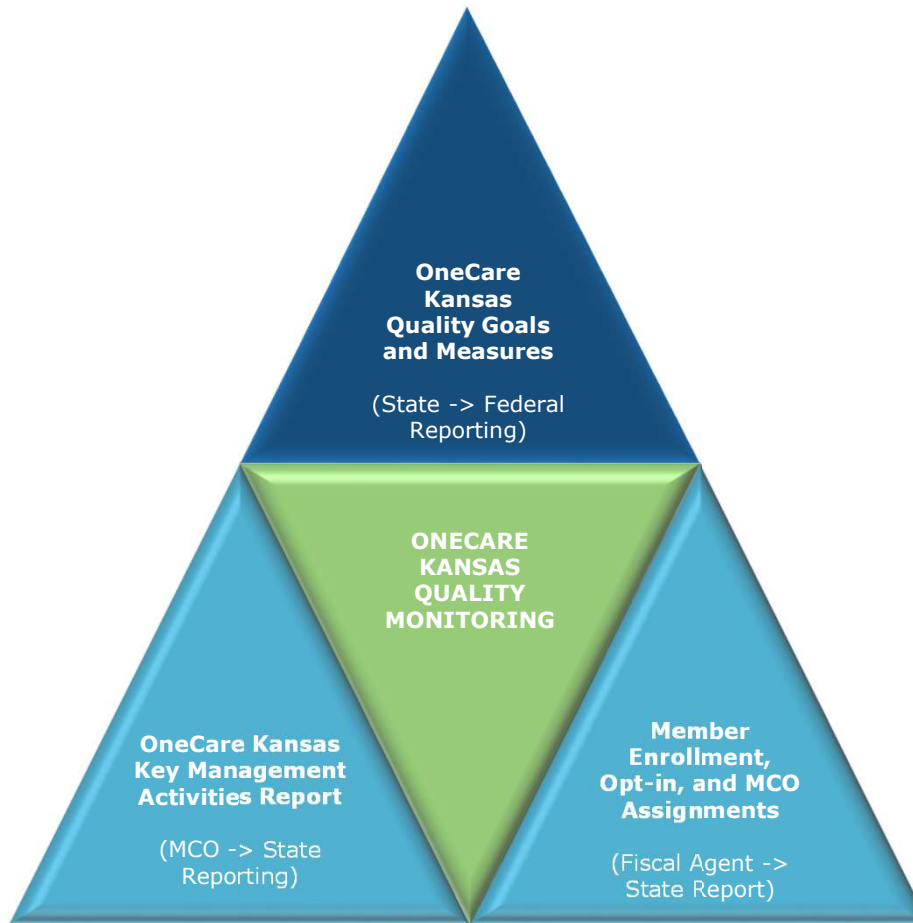


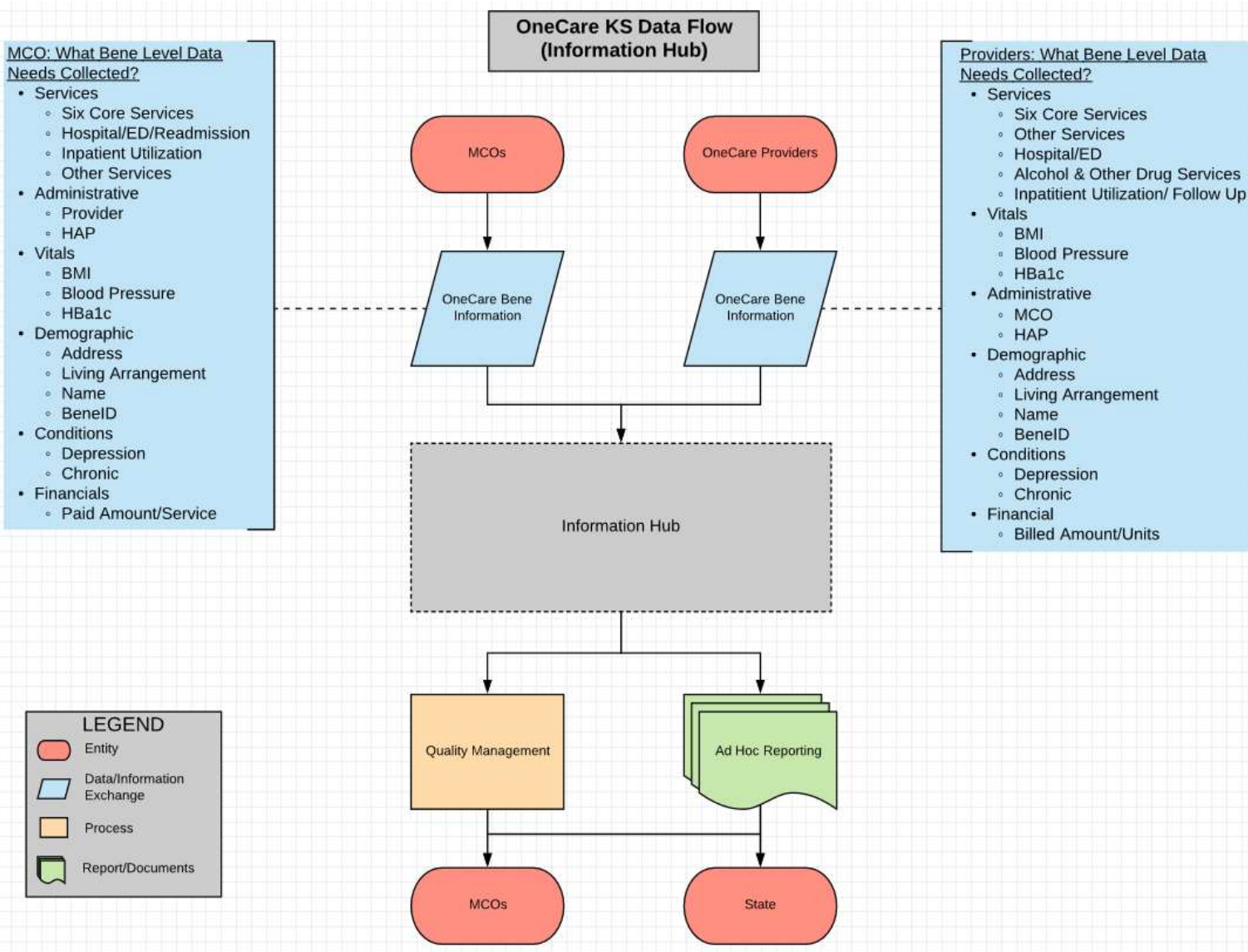
- A separate report will be designed with State Fiscal Agent.
- DXC will receive a file from the MCOs with enrollment information.
- DXC will maintain the number of OneCare Members by MCO.

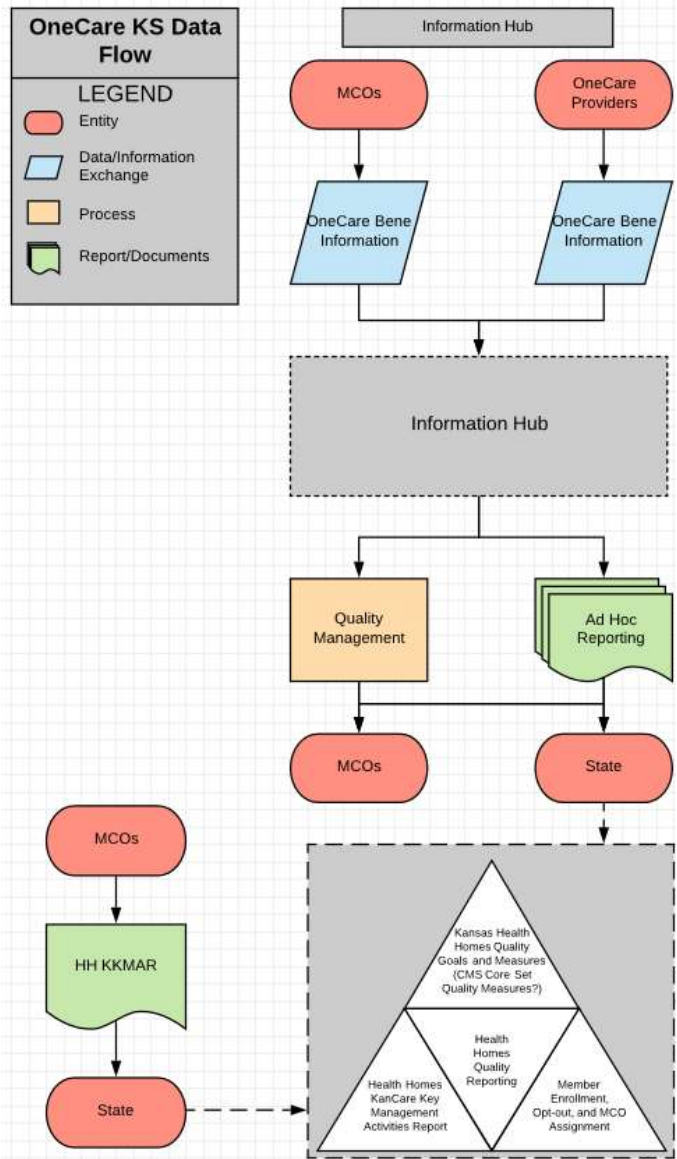












Next Steps



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

Summary

- CMS requirements and reporting updates in technical specifications
- Individual level data - opt-in program
- Outlines data collection points
 - We will demonstrate member outcomes processes
 - Serves as a means to assess our successes for replication

Questions?

**For more information about
OneCare Kansas**

Visit: <https://www.kancare.ks.gov/>

Or email your questions to:

OneCareKansas@ks.gov