Kentucky Medicaid's Movement to Quality Measure Alignment and Value Based Payments

CHFS
Cabinet for Health and Family Services

DEPARTMENT FOR MEDICAID SERVICES

Managed Care Oversight – Quality Branch

Kentucky
UNBRIDLED SPIRIT

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Conclusion-Kentucky Medicaid's Goals

- Develop set of common measures by collaboration with the Kentuckian Health Collaborative work group
- Reduce administrative burden for Providers reporting quality measures
- Compare measures across different payer sources
- Stratify data measures across the state
- Discuss provider perspective on value-based payment barriers
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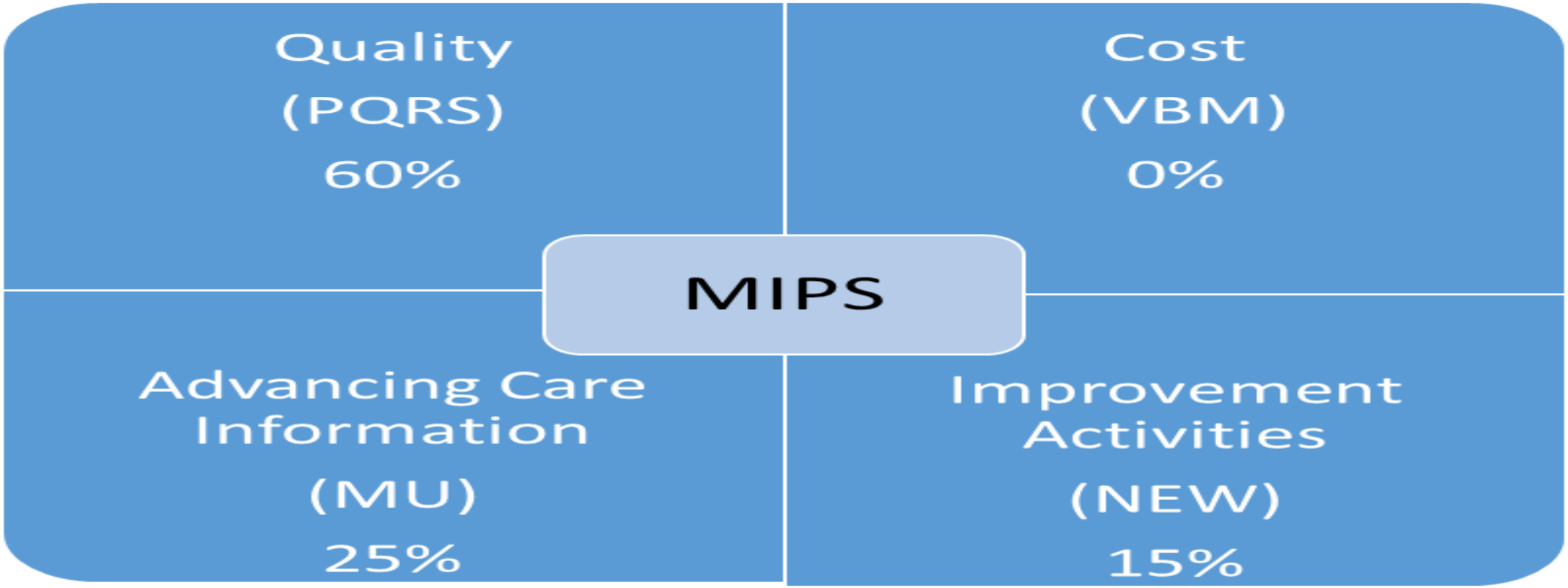
MIPS KEY POINTS

- MIPS starts affecting payments in 2019, but 2017 performance measures will be used to calculate the 2019 payment.

MIPS Categories and Scoring Percentages



atom Alliance, the QIN-QIO and Qsource. (2017). Which Quality Measures Should I Report for the Quality Payment Program. Retrieved 2017

Quality (PQRS)

- Most clinicians report 6 measures or a specialty measure set.
- Must include one outcome measure. If no outcome measure available, one high-priority measure must be reported.
- Six Domains:
  1. Patient Safety
  2. Person and Caregiver-Centered Experience and Outcomes
  3. Communication and Care Coordination
  4. Effective Clinical Care
  5. Community and Population Health
  6. Efficiency and Cost Reduction

Center for Medicare and Medicaid Services (CMS). (2017). Quality Measures. Retrieved from Quality Payment Program : https://qpp.cms.gov/mips/quality-measures

Reporting Requirement Changes

- Quality Reporting will be 365 days
- Improvement Activities will be 90 consecutive days per year
- Cost will be 365 days
- Advancing Care Information will be 90 consecutive days per year

Center for Medicare and Medicaid Services (CMS). (n.d.). Quality Payments Program Overview Fact Sheet. Retrieved from Quality Payment Program: https://qpp.cms.gov.doc/quality_Payments_Program_Overview_Fact_sheet_pdf

Cost (VBM)

- Medicare uses claims to score Cost based on total spending per Medicare patient or total spending per patient for episode-based measures.
- **Cost: Zero % of scoring for Calendar Year 2019, 10% for Calendar Year 2020 and 30% for Calendar Year 2021**
- No data submission required. CMS calculates cost measures using claims data.
- Uses same measures as the Physician Value-Based Modifier program, only the scoring is different.
- Three types of episode groups: Chronic Condition, Acute Inpatient Medical Condition and Procedural Episodes.
- Goal is to align value based cost with better quality outcomes.

Clipart Panda. (2017). Gold Dollar Sign Clip Art. Retrieved from Clipart Panda.com: http://www.clipartpanda.com/clipart_images/gold-star-clip-art-images-15422939

KDMS Activities to Assist Providers

Kentucky Medicaid's Measurement Crosswalk

- The Quality Measure Crosswalk was prepared by Kentucky Medicaid Managed Care Oversight-Quality Branch in collaboration with Qsource.

- Medicaid's Crosswalk of Quality Measures includes 23 HEDIS© measures that meet the quality reporting standards for MIPS.

- The Crosswalk identifies:
  a. Measure names and descriptions *,
  b. Measure NQF and PQRS identification numbers,
  c. Measures meeting crosscutting and high-priority requirements of MIPS,
  d. Measures that are included in the reporting for ACO MIPS measures, Meaningful Use II measures and the CMS Adult and Child Core Measure Sets, and
  e. Measure domains.

*Measure description is hidden in the next slide for presentation view. It is included on the printed materials and the electronic spreadsheets

Quality Measure Crosswalk*

MIPS and HEDIS© Measure Title	NQF#	PQRS #	Measure Type	High Priority	MIPS Reporting Methods	Crosscutting Measures	ACO Measure	MU II Measure	CMS Core Measure
ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	0108	366	Process	No	Electronic Health Registry			X	Child
Breast Cancer Screening	2372	112	Process	No	Claims, Electronic Health Record, GPRO Web Interface, Registry	X	X	X	Adult

Atom Alliance, the QIN-QIO and Qsource. (2017) Which Quality Measures Should I Report for the Quality Payment Program. Retrieved 2017

Kentucky Performance Measures Alignment Committee (PMAC)

- Collaborating with the Kentuckiana Health Collaborative to align quality measure reporting across all payer sources in Kentucky.

- PMAC is a public-private partnership working to create a core healthcare measurement set that aligns the priorities of healthcare stakeholders across Kentucky.

- The Kentucky Core Healthcare Measures Set (KCHMS) will be for primary care and pediatric providers with goals of:
  a) Improving the quality and value of care,
  b) Reducing provider reporting burdens, and
  c) Align Kentucky's healthcare reporting across all payers.

- Work group for all payer quality measure alignment projected timeline is 12 months. Currently more than half way to completion. All four work groups have submitted their final 40 measures for final review.

PMAC Subcommittees

- There are 4 subcommittees in PMAC:

  a) Preventive Care
  b) Pediatric Care
  c) Chronic & Acute Care
  d) Behavioral Health

- These subcommittees critique quality measures based on the primary care and pediatric providers support, reporting capability of providers and importance to the health of Kentuckians.

- Preference is given to measures that are nationally accepted and align with MIPS measures.

Questions

Any Questions

Google. (2017). Royalty Free Question Mark Images. Retrieved from Google Royalty Free Images: https://www.google.com/search?q=royalty+free+question+mark+images&tbm=isch&tbo=u&source=univ&sa=X&ved=0ahUKEwii_e2ayIHWAhWMzIMKHbiCC9AQsAQIWQ&biw=1600&bih=805

Kentucky Medicaid Movement to Value Based Payments and Contracting

Medicaid Innovation Accelerator Program (IAP) Value-Based Payment and Financial Simulations

The IAP is a new technical assistance program launched by the Center for Medicare & Medicaid Services (CMS). The IAP is supporting Kentucky Medicaid in exploring new payment and service delivery reforms to improve health and improve care for Medicaid beneficiaries.

Kentucky Medicaid and IAP Work Plan

- Providing research support to help align Kentucky's Managed Care Incentive Program with MACRA/QPP.
- Work to include more value-based incentives and contracting.
- In compliance with the 1115 Waiver, develop a withhold plan for MCOs featuring aligned quality measures along with MCO value based contracting and payments to providers.
- Estimated project duration is 12 months.

Washington Medicaid's Model

- Kentucky Medicaid is using Washington Medicaid's model for value based contracting with MCOs to develop the new MCO withhold/incentive plan.
- In Washington's model, MCOs earn the withhold back by meeting the benchmarked goals:

1. 12.5% earned for value based contracting
2. 12.5% earned for value based payments
3. 75% earned for quality measures

Kentucky Medicaid's MCO Withhold and Incentive Program

To earn back the withhold or to gain an incentive, MCOs will be required to meet benchmarks in:

1. Quality measures aligned with MIPS,
2. % of MCO provider contracts value based on the LAN Scale (level and percent to be determined) and
3. % of MCO provider payments includes value based incentive plans (% to be determined).

Provider and MCO Surveys

- Kentucky has developed provider and MCO surveys to assess the current status of value based payments and contracting within the Medicaid provider community
- Surveys sent to Medicaid MCOs have been collected and are in review
- The survey is now available for Kentucky Medicaid providers and non-Medicaid providers on-line. The survey link https://is.gd/kymedicaidVBP_(This is a RedCap Survey conducted and collected by IPRO our EQRO)
- The surveys will be reviewed by DMS Quality, Finance and Innovation Accelerator Program Value Based Payment and Financial Simulation Team. Results from surveys will aid Kentucky Medicaid to set the percentage benchmarks for the MCO withhold/incentive program.

Kentucky Medicaid wants to engage providers to determine current level of value based payments/contracting and to identify the barriers to moving more toward value based payments/contracting.

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Questions

For Additional Questions or Information Contact:

Marydale Coleman, Nurse Consultant/Inspector Managed Care Oversight Quality
275 East Main Street, 6C-C
Frankfort, KY 40601
502-564-9444 x 2089
Marydale.Coleman@ky.gov

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