Statewide Medicaid Managed Care Frequently Asked Questions – Performance Measures

Long-term Care

Question:

For Care for Older Adults (COA), the specifications for the denominator require a member to have received home and community based services (HCBS) for at least one month during the measurement year. Does this mean 30 consecutive days or a collective total of 30 days during the measurement year?

Answer:

The member must have received HCBS for 30 consecutive days.

Question:

While COA is a HEDIS measure for Medicare, it cannot be effectively applied to LTC in the administrative sense. LTC is not a medical line of business so we would not essentially receive claims or encounters which would be aligned with the HEDIS specs. More specifically, there are no codes/values in Advanced Care Value Set, Medication Review Value Set, Medication List Value Set, and Functional Assessment Value Set that are submitted or are available to LTC Plans. Again, the HEDIS requirement for Admin hits for COA is misaligned with the LTC program and its scope of services.

Historically, we have addressed the COA submeasures via medical record review since the HEDIS Hybrid Specifications are more inclusive and supportive of LTC programs. However, we believe that our processes for COA would also count administratively if the HEDIS Administrative Specifications would be relaxed for LTC. Would the Agency consider removing the HEDIS Administrative Specification requirement for COA, or relaxing the admin requirements to be more aligned with LTC programs which are not medical in nature?

Answer:

Plans may choose to use the administrative or hybrid methodology for this measure. They are not required to use the administrative specifications.

Question:

What are the benchmarks for Care for Older Adults?

Answer:

Until the National Committee for Quality Assurance (NCQA) publishes means and percentiles for this measure, there are no benchmarks.

Question:

There were three new Long-term Care measures in the November 2016 SMMC contract amendment. What are the benchmarks associated with these measures?

Answer:

Prevalence of antipsychotic drug use in long-stay dementia residents is not a new measure. As stated in the February 20, 2014 Policy Transmittal, plans are not required to report on this measure until there are specifications available. Benchmarks have not been set for the two new Required Record Documentation numerators, Plan of Care/LTC Service Authorizations and Plan of Care/Availability and Amount of Family/Informal Support Systems. Liquidated damages will not be imposed for the first year of reporting these measures.

Question:

Can we count the 701B assessments completed in December 2015 for enrollees effective January 1, 2016 as compliant within the 2016 measurement year?

Answer:

Plans should count whichever assessment was completed during the measurement year. If the initial assessment was completed in December 2015 for an enrollee effective January 1, 2016, the annual re-assessment should occur in December 2016. In this case, the re-assessment would count for this measure since that assessment occurred during the 2016 measurement year.

Question:

For Numerator Two: Plan of Care/Enrollee Participation of the Required Record Documentation (RRD) measure, what happens when the member can't sign (i.e. dementia) and the enrollee's representative is out of state and unresponsive to requests for signature? Will the agency accept proof of trying to reach representative? Will Agency accept an "x" as signature from enrollee? Anything else the Agency will accept to meet this requirement?

Answer:

For this performance measure, an enrollee or the enrollee's representative must have signed the Plan of Care to count in the numerator.

Question:

For Numerator Five: Plan of Care/LTC Service Authorizations of RRD, can you clarify what time span for the care plan the measure looks at? Since we complete care plans on a quarterly basis, does the measure consider these quarterly care plans, or annual?

Answer:

The measure looks at annual care plans.

Question:

For Numerator Five: Plan of Care/LTC Service Authorizations of RRD, what type of services does the measure look at? There are numerous items that are short-term interventions or one time interventions that remain on the plan of care. Examples include DMEs, Chore, Respite Care, short-term PT, etc. Also there can be temporary suspensions when inpatient or visiting family. Should these be exclusions for this measure?

Answer:

This has been clarified in the updated version of the LTC Performance Measure Specifications Manual for July 1, 2017 Reporting.

Question:

For Numerator Five: Plan of Care/LTC Service Authorizations of RRD, would this measure exclude enrollees residing in a facility setting?

Answer:

This measure should include only those enrollees in the community (including ALFs and AFCHs), and exclude enrollees in nursing facilities.

Question:

To be excluded from Numerator Five: Plan of Care/LTC Service Authorizations, would an enrollee have had to live in a nursing facility for the entire measurement year?

Answer:

Yes.

Question:

Can the Agency further define the documents required to validate compliance for RRD – Plan of Care/LTC Service Authorizations?

Answer:

The Plan of Care and service authorizations are required to validate compliance for this measure.

Question:

For Numerator Five: Plan of Care/LTC Service Authorizations of RRD, will we be penalized for not providing short-term services to all LTC members?

Answer:

This is an inverse measure, so lower rates are better.

Question:

For Case Manager Training (CMT), we understood the specs to mean that any Case Manager not employed with us on 12/31 of the measurement year will not be included in the denominator. If they are employed with us on 12/31, and were with us for at least 90 days during the measurement year, then they need to be included in the denominator. Is this correct?

Answer:

Case managers who were employed with the plan during the measurement year and on their anniversary date for receiving annual training should be included in the denominator. For example, if a case manager is employed with a plan from October 1, 2015 through November 30, 2016 and received their initial training on October 15, 2015, the case manager should be included in the denominator for measurement year 2016 because the training anniversary date is prior to their ending employment with the plan.

Question:

Is December 31st the anchor date for CMT? In other words, if staff is employed with us for more than 90 days during the measurement year but leaves us before December 31st, are they not to be included in the denominator?

Answer:

December 31st is not the anchor date for CMT.

Question:

What is the training requirement for CMT, in terms of time/hours? We conduct 1 hour training sessions every quarter on abuse, neglect, and exploitation with all case managers in LTC. If staff is employed with us approximately 100 days during the measurement year, including December 31st, and they attend at least one of the abuse, neglect, and exploitation training sessions, are they compliant for this measure?

Answer:

According to Exhibit II-B, Section VIII.A.1.c, "All Case Managers shall have at least four (4) hours of in-service training in the identification of abuse, neglect and exploitation and shall complete this training requirement annually." This has been clarified in the updated version of the LTC Performance Measure Specifications Manual for July 1, 2017 Reporting.

Question:

We typically setup services to begin on the first of the month. If the care plan is developed on the 2nd or slightly thereafter, what happens if services begin before this care plan date? The specifications for Timeliness of Service (TOS) indicate that services must begin within 14 days "after" development of the plan of care. We believe services that start between the first of the enrollment month and development of the plan of care (if after the first of the month) should count.

Answer:

If services occur before the plan of care is developed, that would still count for this measure. This has been clarified in the updated version of the LTC Performance Measure Specifications Manual for July 1, 2017 Reporting.

Question:

For the TOS measure, can the Agency define what date should be used if the Plan of Care is developed prior to the first of the enrollment month? Would the Plan of Care development date default to the first day of the enrollment month?

Answer:

In cases where the plan initiates care planning prior to the enrollee's begin date for enrollment, the 14 day timeframe should begin on the first day of enrollment. Plans would need to document their care planning development timeframe carefully in order for this to be represented and accounted for accurately.

Question:

The data collection method for TOS is listed in the LTC performance measure specifications manual as administrative; however, the Plan of Care development date would have to be obtained through document collection and manual review. In the future, will the data collection method be updated from administrative to hybrid?

Answer:

If the Plan of Care development date is not retrievable using electronic data, the plan may need to go to the enrollee's case file to obtain this information.

Question:

Occasionally we receive new members whom we are unable to contact. Do members the plan is unable to locate count as refusing services? If not, can these members be excluded from the Timeliness of Service measure?

Answer:

Members the plan is unable to locate are not considered as refusing services. Please note that the Timeliness of Service measure includes new enrollees for whom a Plan of Care has been developed.

Question:

Because Long-term Care is not a medical benefit product/line of business, our plan will not receive claims for members whom are inpatient in some type of facility. Moreover, close to 90% of the Long-term Care population is 65 years and older and very likely has Medicare, and our plan is not their insurance provider. When members have Medicaid and/or Medicare with another provider, their assigned staff coordinate care with these other providers. They verify hospitalizations and other inpatient related medical benefits (i.e. rehab). The staff also verifies this information directly with the hospitals and facilities where members are receiving the care in question.

Because claims data is not present, and the need for excluding these members is necessary, our plan will capture inpatient stay information through a memo created in our claims system. On a monthly basis, a cumulative report listing inpatient members will be generated to ensure these members are properly excluded from the Timeliness of Service denominator. We want to confirm with you that our approach to inpatient exclusions is appropriate considering the circumstances that Long-term Care providers face.

Answer:

It is up to the plan to best determine that someone has had an inpatient stay. Plans may want to check with their HEDIS auditor regarding how this information is captured and used in running the plan's performance measures.

Managed Medical Assistance

Question:

Call Answer Timeliness (CAT) is being retired by NCQA for HEDIS 2017. Do plans need to continue reporting this measure?

Answer:

Plans are required to report on CAT for July 1, 2017 reporting using the HEDIS 2016 Technical Specifications for the measure.

Question:

For Annual Dental Visit (ADV), it is not clear if the new benchmark is 45% for all purposes, including calculation of liquidated damages or if it is only for the corrective action plan purpose, but the liquidated damages will continue to be calculated based on the 50th percentile.

Answer:

If a plan fails to meet the ADV benchmarks listed in Exhibit II-A, Section VII.B.1.f., they may be required to submit a corrective action plan. Liquidated damages for ADV will continue to be calculated based on the 50th percentile. For example, if a plan's ADV rate for calendar year 2016 is 43%, they will be required to submit a CAP and may be assessed liquidated damages if the 50th percentile rate is higher than 43%.

Question:

The required performance measures listed in the November 2016 SMMC contract amendment do not match the ones listed in the December 16, 2016 Policy Transmittal. Which is correct?

Answer:

For July 1, 2017 reporting, please follow the performance measure changes in the December 16, 2016 Policy Transmittal. These changes will be reflected in the next SMMC contract amendment.

Question:

Preventive Dental Services (PDENT), Dental Treatment Services (TDENT), and Sealants (SEA) are no longer listed as performance measures. Does this mean that PDENT and TDENT liquidated damages that were added in the November 2016 SMMC contract amendment do not apply?

Answer:

The Agency will be calculating each plan's PDENT, TDENT, and SEA measures using data that the plans report in their CMS-416/CHCUP reports. Plans do not need to calculate and report on these measures as part of their annual performance measure submission. The PDENT and TDENT benchmarks for liquidated damages and corrective action plans still apply.

Question:

Is Antenatal Steroids (ANT) no longer a required performance measure?

Answer:

Yes, ANT is no longer a required performance measure.

Question:

HPV Vaccine for Female Adolescents (HPV) is not on the December 16, 2016 Policy Transmittal. Are plans not required to report on this measure?

Answer:

HPV is no longer a separate HEDIS measure. As of HEDIS 2017, this measure has been moved under the Immunizations for Adolescents (IMA) HEDIS measure that plans will continue to report.

Question:

For Follow-Up After Hospitalization for Mental Illness (FHM), can the community behavioral health codes listed in the MMA performance measure specifications manual count towards the 7 and 30 day numerators if the code but not the specific modifier was included on the claim?

Answer:

The community behavioral health codes listed in the measure specifications must have the specified 2-letter modifier to count in the numerator for FHM – 7 Day and FHM – 30 Day.

Question:

For Highly Active Anti-Retroviral Treatment (HAART), the measure specifications state that “At least three single-agent antiretroviral medications filled within 10 days of each other” – do we need to ensure that this is three unique medications?

Answer:

There must be three or four different chemical entities filled within the same 10 day period to qualify as HAART therapy. As indicated in the specifications for this measure, this could occur with three separate single-agent claims, one double-agent plus a single-agent claim, one triple-agent claim, or one four-agent claim.

Question:

The HIV/AIDS Performance Measure Attachment for July 1, 2017 reporting has a section with one medication marked as “Single-Agent Medication (Not an antiviral)” but this item doesn’t appear to be reference in the specifications. Is this meant to be included in any of the HIV/AIDS measures?

Answer:

Tybost is not an antiretroviral – please disregard. This was provided for information only.