ALASKA MEDICAID REDESIGN + EXPANSION TECHNICAL ASSISTANCE

MENU OF EVALUATION MEASURES FOR IMPLEMENTATION

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to the Alaska Department of Health and Social Services

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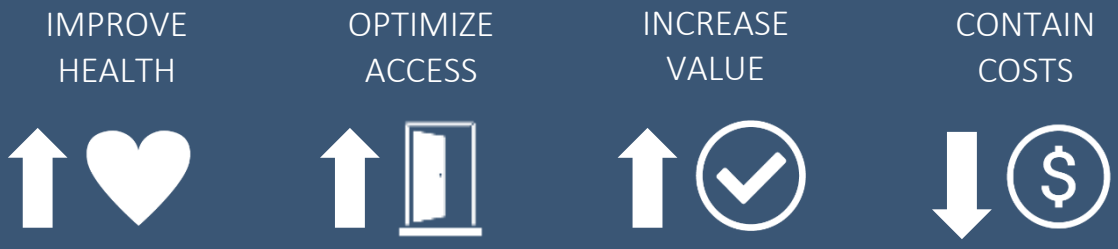
GOALS FOR MEDICAID REDESIGN + EXPANSION



INTRODUCTION

For the final deliverable of the Alaska Medicaid Redesign and Expansion Technical Assistance contract, we are providing a list of potential evaluation measures. While we originally planned to identify measures for each of the recommendations in our final report, following the introduction and passage of Senate Bill 74, we determined that it would be more useful to categorize the evaluation measures to align with sections of the bill, which will now become state statute. We have organized it in this manner to be most useful for the Department of Health and Social Services (DHSS) as it implements the various provisions in the bill. The table includes notes on potential issues or additional considerations for the evaluation measures.

CONSIDERATIONS

In identifying measures to evaluate Alaska's planned Medicaid program changes, it is vital to ensure clarity and consistency in definitions, identify reliable and available data sources, and establish an evaluation plan that can be supported with existing resources. We recommend:

1. **Utilize data from currently available, consistently collected and updated sources whenever possible**. This minimizes costs, effort and burden on all parties. Many of the measures recommended in the proposed measures table can be found in the Medicaid claims data currently available to DHSS. Utilizing data already collected is especially important when requesting data from providers, care management organizations and other entities that regularly receive data requests from multiple sources (see recommendation 3). The Centers for Medicaid and Medicare Services (CMS) has been working to develop and improve its measurement program for Medicare for several years, as part of an effort to tie payments to quality. This could be a good starting point for coordination.[1]

2. **Limit the total number of measures included**. Including too many performance measures increases burden on providers and other reporting entities, as well as on DHSS, without improving the utility of the information. While various stakeholders may advocate for specific measures in specific areas, it is more effective to identify high level measures that act as indicators of overall system change. There are many more measures included in this table than should be included in a final measure set. The set used for a dashboard should be even more limited.

3. **Clearly define and document each data measure, including the specific data to be used in numerators and denominators, and any calculations used to derive the final measure**. Defining the population included, services, costs and other parameters will ensure consistency over time and will make it easier to interpret results and track trends. This clarity will support DHSS's ability to clearly communicate parameters and data sources to legislators and other stakeholders who may not be familiar with the Medicaid program or the data sources being presented. Ideally, DHSS should use the same data sources and parameters over time; where this is not possible, DHSS should clearly

[1] CMS provides a guide for quality measurement in FFS Medicare: *Roadmap for Quality Measurement in the Traditional Medicare Fee-For-Service Program*. The U.S. Department of Health and Human Services (DHHS) collected an inventory of quality measures across DHHS divisions (including CMS). This can be found at: http://www.qualitymeasures.ahrq.gov/hhs/hhsmeasures.aspx. Earlier this year CMS, America's Health Insurance Plans, the American Academy of Family Physicians, and the National Partnership for Women and Families, with technical assistance from the National Quality Forum, announced an agreement to adopt a core set of quality measures for physicians across payers.

document which data sources, measures and calculations have changed, and the reason(s) for the change. This will help all users of the data, particularly those who wish to analyze multi-year trends, accurately interpret the data over time and understand any discrepancies or anomalies that may result from a change in measurement.

4. **Limit and consolidate provider surveys and data requests**. As noted above, it is important to be mindful of the many demands on entities who collect health and other types of data. To avoid respondent fatigue and/or poor response rates, DHSS should, where possible, limit and consolidate provider surveys and data requests. For example, providers with patients in the commercial, Medicare and Medicaid sectors may be subject to multiple data requirements from each program, so ensuring consistency with other programs can reduce provider burden. To ensure consistent responses, it may also be effective to include data requests in mandatory processes such as certification, grant or program reporting, and other requirements on entities who will be supplying data.

PERFORMANCE DASHBOARD

In the table in the following section, we have denoted measures that we recommend for inclusion in a performance metrics dashboard. Measures appropriate for a dashboard are high-level indicators that provide a snapshot of the system overall, can communicate directional change, and demonstrate measurable outcomes over time. Dashboards are most effective when the data presented and tracked is limited to a small number of measures. A dashboard can be a simple numerical table with key indicators, or it can be displayed graphically using charts, illustrations and other graphic elements. Using graphics to convey complex information is an effective way to communicate with legislators and other policy makers, as well as with a variety of stakeholders and the general public.

As a guide for implementation and how to visually and effectively communicate data going forward, we have included some examples of existing dashboards from other Alaska organizations and other states' health programs. Please use the hyperlinks below to access the example graphics:

ALASKA DASHBOARDS + HEALTH-RELATED GRAPHICS

1. *Healthy Alaskans 2020*: Scorecard FY16 of 25 leading indicators and status in July 2015. http://agnewbeck.com/wp-content/uploads/2016/05/HealthyAlaskans2020_Scorecard_FY16.pdf
2. *Alaska Statewide Independent Living Council (SILC)*: Dashboard graphic of SILC's FY15 highlights. http://agnewbeck.com/wp-content/uploads/2016/05/AK-SILC_graphic_March_2016.pdf
3. *Alaska Mental Health Trust Authority*: Behavioral Health Systems Assessment, "Alaska's Tribal Behavioral Health System," organizational graphic. http://agnewbeck.com/wp-content/uploads/2016/05/AMHTA_TribalBehavioralHealthSystem.pdf
4. *Alaska DHSS, Section of Chronic Disease Prevention and Health Promotion, Chronic Disease Collaborative*: "Web of Chronic Disease," causes and prevention strategies graphic. http://agnewbeck.com/wp-content/uploads/2016/05/AK-ChronicDiseaseCollaborative_Strategies.pdf

DASHBOARD EXAMPLES FROM OTHER STATES

5. *CMS*: "Geographic Variation in Standardized Medicare Spending" online dashboard. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/GeoVar-State/GeoVar_State.html
6. *California HealthCare Foundation*: "Monitoring Performance: A Dashboard of Medi0Cal Managed Care," including a variety of financial and outcome-oriented performance measures. http://agnewbeck.com/wp-content/uploads/2016/05/MediCal_ManagedCarePerformance_2013.pdf
7. *Health Policy Institute of Ohio*: Health Value Dashboard (2014)
    a. Brief summary of disparities, challenges and Ohio's performance in health value. http://agnewbeck.com/wp-content/uploads/2016/05/HPIO_OhioHealthValue_Summary-Challenges_2014.pdf
    b. Full dashboard of Ohio's health performance. http://agnewbeck.com/wp-content/uploads/2016/05/HPIO_OhioHealthValue_Dashboard_2014.pdf
8. *Oregon Health Authority (OHA) Office of Health Analysis*: Oregon Medicaid Metrics
    a. Summary of the Oregon Metrics and Scoring Committee, tasked with developing and updating incentive measures for Medicaid Coordinated Care Organizations (CCOs). http://agnewbeck.com/wp-content/uploads/2016/05/OHA_Oregon-Metrics-and-Scoring-Committee.pdf
    b. Measurement Strategy outlining OHA's methodology for data collection, analysis and reporting. Includes list of indicators by category, crosswalk with national indicators. http://agnewbeck.com/wp-content/uploads/2016/05/OHA_Oregon-Medicaid-CCO-Measurement-Strategy.pdf
    c. Summary report, "Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update," including summary and reports by data indicator, geography, demographics and performance. Includes progress toward current year's benchmarks. http://agnewbeck.com/wp-content/uploads/2016/05/OHA_2015-Mid-Year-Report-Jan-2016.pdf

MENU OF EVALUATION MEASURES FOR IMPLEMENTATION OF HEALTH REFORM EFFORTS IN ALASKA

This table is organized by SB 74 section, the state legislation that enacts or enables the specific recommendations for Medicaid redesign and other health reforms. An asterisk (*) indicates that the measure is recommended for inclusion in the performance dashboard.

SB 74 SECTION	EVALUATION MEASURES	NOTES

Sections 1-4, 6-9, 13-15, 38, 43
 	
Telehealth + Telemedicine
	• Total number of (and change in) telehealth providers (pre/post, over time)*
	  ○ Rate of telehealth by region, service type
	  ○ In areas where telehealth visits have increased, change in other utilization, total costs
	• Total number of (and change in) telehealth visits*
	  ○ Overall
	  ○ For specific uses (primary care, urgent care, behavioral health)
	• Percentage of telehealth vs in person visits for same type of condition/issue (total and change over time)
	• Total use of and change in non-emergency medical transportation (NEMT) – number of trips, reasons for use
	  ○ Average cost of specific services, post-implementation of telehealth option (especially for services identified as having an increase in use of telehealth)
	• Change in spending on NEMT
	• General access to care measure
		• Number of providers is an early stage measure, could be dashboard initially and later retired
		• Commonly used source for access to care measure is Consumer Assessment of Healthcare Providers and Systems (CAHPS)
		• *Sec 47.05.270 (c)*

Sections 5, 7, 10-12, 21-34, 52, 58 **Prescription Drug Monitoring Program (PDMP)[2]**	• Level of integration of PDMP into Health Information Exchange (HIE) • Provider take up/use of HIE • Provider take up/use of PDMP* • Number/rate of emergency departments connected via HIE • Measure of improved data analytic capacity by DHSS • Pharmacist participation in required reporting on dispensing of controlled substances (% participating as required, total number participating)* • Change in use of prescription drugs monitored in PDMP • Change in arrests related to monitored prescription drugs	• Improved data analytic capacity can initially be shown by having a dashboard or other regular reporting, with addition steps later • Collecting information on pharmacist participation is a task for the licensing board

[2] Section 28 also covers Civil Penalties; Seizure of Property. Evaluation recommendations are focused on Medicaid Reform provisions.

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SB 74 SECTION	EVALUATION MEASURES	NOTES

Sections 5, 7, 10-12, 21-34, 52, 58
Prescription Drug Monitoring Program (PDMP)
	• Measures that may be included in report to legislature annually (Section 33):
	  ○ Outcomes related to Board of Pharmacy's education efforts to reduce inappropriate prescription use
	  ○ Outcomes related to reduction in controlled substances by individuals attempting to engage in fraud and deceit
	  ○ Outcomes related to increased coordination among PDMP partners
	  ○ Outcomes related to stakeholder involvement in the planning process
	• Measures that must be included in annual report (Section 33):
	  ○ information about the security of the database
	• reductions in inappropriate use of controlled substances	

Sections 16-20, 36-37 **False Claims/ Fraud**	• Total fraud claims • Number of penalties assessed • Total $ amount of penalties assessed • Return on investment: money returned to the state for every dollar spent to prevent and prosecute fraud and abuse	• Change over time • The meaning of increased or decreased claims, penalties, etc. will depend on what is happening with enforcement, regulations, and other environmental factors
Section 35 **Medicaid for Hospitalized Corrections Population**	• Change in number of applications processed related to new requirement	

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SB 74 SECTION	EVALUATION MEASURES	NOTES
Section 39 **Enhanced Eligibility Verification System**	• Comparison of approval rate pre/post as a percentage of total applications, applicants* • Rate of denied applicants who are eventually enrolled • Change in appeals rate (for cases related to verification)* • Return on investment: annual or 5 year cost to implement and administer vs. savings resulting from the use of the system	• Vendor contract should include vendor performance evaluation criteria (e.g., error rate, time it takes to verify applicant eligibility) • Denial rate for eventual enrollees is intended to measure appropriate vs. excessive verification procedures. Define time period for approval after denial (e.g., 6 months)

Section 43
 	
Medicaid Reform Program: Process Redesign
	Payment Process Redesign
	• Premium payments for centers of excellence (COE)
	  ○ Number of agreements established with COE*
	  ○ Percent of payments affected
	  ○ Change over time
	• Penalties for hospital acquired-infection, avoidable readmission, outcome failures*
	  ○ Percent of hospitals penalized (and how many times)
	  ○ Percent of Medicaid claims/encounters affected
	  ○ Relationship between Medicaid payments and penalties
	• Bundled payments
	  ○ Percent of payments for a service bundle that are paid this way
	  ○ Impact on overall Medicaid costs for affected services (change)
	  ○ Impact on utilization for affected services
	• Global payments
	  ○ Change in volume, costs for primary care visits, services by covered recipients
	  ○ Change in volume, utilization mix, costs by providers engaged under this model
	  ○ Compare similar recipients in/out of model
		• Sec 47.05.270 (a)(8)
		• Reporting on penalties requires establishment of standards
		• Reporting on alternative payments should tie back to payment types implemented
		• Throughout Section 43, elements could be part of annual report, using elements identified in this section of the bill, Sec 47.05.270 (b)

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SB 74 SECTION	EVALUATION MEASURES	NOTES
Section 43 **Medicaid Reform Program: Stakeholder Involvement in Target Setting**	*Stakeholder involvement in quality, cost effectiveness target setting* • Number of stakeholders, range of entities involved • Stakeholder survey on level of engagement, satisfaction with process, satisfaction with outcome • Number of quality targets set • Number of cost effectiveness targets set	• Sec 47.05.270 (a)(9) • Provider survey can be used to assess provider awareness, behavior change, opinions[3]

Section 43
Medicaid Reform Program: Prioritizing Care in Home Community
	• Change in use of NEMT*
	  ○ Percent of population using
	  ○ Number of trips per 1,000 enrollees, etc.
		• Sec 47.05.270 (a)(10)

Section 43 **Medicaid Reform Program: Evidence Based Guidelines**	• Which guidelines were established? • Are providers aware of guidelines? • Have guidelines impacted providers' development of new models? • Have guidelines supported change in delivery of care?	• Sec 47.05.270 (a)(11) • Guidelines for providers to develop evidence based models supporting wellness, disease prevention

[3] To minimize provider burden and maximize the utility and comparability of data collected by a survey, the provider survey should be a single combined survey for the various programs and divisions within DHSS and should be tied to required periodic re-certification. In addition, to ensure that results can be used to assess change over time, the survey content and format must be consistent over time.

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SB 74 SECTION	EVALUATION MEASURES	NOTES

Section 43
 	
Medicaid Reform Program: Comprehensive Integrated Behavioral Health Program
	• Extent to which the plan developed includes required elements
	• The implemented State Plan Amendment (SPA), statutory, regulatory and other changes
	  ○ New credentialed/licensed providers that can bill Medicaid
	  ○ Change in behavioral health services billed to Medicaid
	  ○ Contract with Administrative Services Organization (ASO) that utilizes a performance based component
	• Visits with behavioral health code associated (primary or secondary)
	  ○ Emergency Department (ED)*
	  ○ Ambulatory* (especially primary care setting, though this can be hard to accurately track)
	  ○ Inpatient admission*
	• Screening measures
	  ○ Referrals to behavioral health provider
	  ○ Rate of Screening, Brief Intervention, Referral and Treatment (SBIRT)
	• Other
	  ○ Outpatient/primary care follow up visits after behavioral health emergency department or hospital visits
	  ○ Rate of services such as peer support, telehealth, medication assisted treatment, intensive outpatient substance use disorder (SUD) treatment
	  ○ Use of crisis services (census of Alaska Psychiatric Institute)
	  ○ Detox services
	• Measures of improved functioning*, such as
	  ○ Sustained housing for 12 months
	  ○ Income
	  ○ Employment
	  ○ Number of poor mental health days
	• Change in medical services utilization and total cost
		• Sec 47.05.270 (b)
		• These measures include assessment of the effort to develop and implement system change
		• In conjunction with measures of improved functioning, change in service use and cost can be used as markers of overall system change
		• Change in in-person utilization in areas where telehealth use goes up can help show correlation, not necessarily causation
		• Data (especially utilization, cost information) for a given calendar year are likely not available by November of that year, so use data on process measures at first, then use prior calendar year data for November report.
		• Mental health self-report data is available from the Alaska Behavioral Risk Factor Surveillance System (AK BRFSS), a survey of health-related risk behaviors, chronic health conditions, and use of preventive services
		• Identified elements could be part of annual report, with elements identified in this section of the bill

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SB 74 SECTION	EVALUATION MEASURES	NOTES

Sections 43, 44
 	
Primary Care Case Management (PCCM) to Improve Appropriate Primary and Preventive Care Use
	Primary care utilization: participation in care management
	• Beneficiary assignment to a Primary Care Provider (PCP)* (total, by sub-population)
	  ○ Total, by sub-population including individuals with multiple hospitalizations
	• Beneficiary enrollment in PCCM*
	  ○ Overall
	  ○ Individuals with multiple hospitalizations per year
	• Provider participation as PCP (total, regionally, by provider type, % relative to number of providers permitted to participate)*
	• Beneficiary enrollment in Health Home as % of eligible*
	• Provider participation in PCCM, Health Home as percent of eligible *
	
	Primary care utilization: Visits/screenings
	• Completion rates of health risk assessment within 120 days, annually
	• Completion/updating of a care plan (percent of eligible)*
	• Developmental screenings, well child
	• Prevention and well care visits (child, adult)
	• Screenings for targeted health issues (e.g., asthma, diabetes, COPD, cancer, BH)
	• Referrals for positive screens
	• New members with primary care visit in first 120 days post-enrollment
		• In this section and throughout the document, suggested measures are not exclusive; they are intended as examples based on other state measurement programs
		• Assignment to a PCP, enrollment in PCCM or Health Home could be used early on, before utilization or outcomes measures are available.
		• For measures of control, see list from Section 43 [Sec 47.05.270 (a)(7) Enhanced Care Management]
		• CAHPS is a source of access to care measures, health status, patient satisfaction
		• Alcohol and substance use screening via SBIRT (Screening, Brief Intervention, and Referral to Treatment)
		• Section 43 elements from Sec 47.05.270 (a)(7), Enhanced Care Management

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SB 74 SECTION	EVALUATION MEASURES	NOTES

Sections 43, 44
 	
Primary Care Case Management (PCCM) To Improve Appropriate Primary and Preventive Care Use
	• Measures of access for PCCM users,* for example:
	  ○ Well child and adolescent visits
	  ○ Alcohol, substance use screening
	  ○ Ambulatory care use (emergency department, outpatient)
	  ○ Developmental screening for children under 36 months
	  ○ Follow up after hospitalization for mental illness
	  ○ Child health assessments (mental, physical, dental)
	  ○ All cause readmissions
	  ○ Cervical cancer screening
	  ○ Chlamydia screening
	• Measures of control identified in Section 28 discussion*
	• Prevalence of key conditions identified as priority in state*
	• Longer term measures of population health, overall and for specific populations* such as:
	  ○ Asthma inpatient admissions
	  ○ Diabetes short term complication inpatient admissions
	  ○ COPD inpatient admissions
	  ○ Tobacco use
	  ○ Obesity prevalence
	  ○ Effective contraceptive use among women at risk for unintended pregnancy
	  ○ Childhood immunization status
	• Appropriate care measures,* for example:
	  ○ Diabetes screening, testing and care
	  ○ Follow up care for children prescribed ADHD medication
	• Patient satisfaction measures*
		• Section 43 elements from Sec 47.05.270 (a)(7), Enhanced Care Management

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SB 74 SECTION	EVALUATION MEASURES	NOTES
Section 45 **Home and Community Based Services Options**	• Primary care visits (especially change over time)* • Other primary care measures, targeting any differences for people enrolled in a demonstration • Comparison of target per member per month (PMPM) and actual cost for demonstration participants* • Measures of control	• Home and Community Based Services options are available under Section 1915(i) and (k) of the Social Security Act
Section 45 **Demonstration Projects under a Federal Waiver**	• Change in utilization or service mix • Change in access and appropriateness of care • Quality measures outlined • Disease prevalence and measures of control	• Section 1115 of the Social Security Act allows states to request a waiver of certain provisions of Medicaid law in order to conduct pilot and demonstration projects. • Specific measures in the areas to the left are identified throughout this document.
Section 46 **Emergency Department (ED) Use Project**	• ED use per 1,000 beneficiaries* • ED use for certain conditions (chronic, ambulatory sensitive, behavioral health) • Change in total visits, spending* • Post-ED referrals to PCPs, primary care* • Number, rate of EDs connected to the HIE • Shared Savings payments* (number of EDs, total payments, payment per participating ED) • Control measures for chronic conditions treatable in primary care setting but seen in ED*	• If used in dashboard, shared savings payment data should be paired with total savings from reduced ED or overall to make shared savings more meaningful (also relevant to Coordinated Care demonstrations) • Compare primary care use by population enrolled in a demo with similar comparison group to look at utilization changes • Control measures (asthma, COPD, etc.) can be used as a longer term measure of population health – is there a change in prevalence of conditions, specific utilization types

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SB 74 SECTION	EVALUATION MEASURES	NOTES
Section 46 **Coordinated Care Demonstration Projects**	• Primary care visits (especially change over time)* • Other primary care measures, targeting any differences for people enrolled in a demo • Comparison of target PMPM and actual cost for demonstration participants* • For a demo with shared savings or losses: percent of members enrolled in a demonstration receiving shared savings payments or subject to shared losses • Measures of control	• Compare primary care use by population enrolled in a demonstration with similar comparison group to look at utilization changes • Control measures (asthma, COPD, etc.) can be used as a longer term measure of population health – is there a change in prevalence of conditions, specific utilization types
Section 50 **Alaska Pioneer Home Applicants Must Apply for Medicaid**	• Impact of Medicaid enrollment on State budget overall for Medicaid eligible Pioneer Home residents prior to and after the change is implemented	• Include both Medicaid and other state general fund costs in calculation
Section 55 **Implement Federal Policy on Tribal Medicaid Reimbursement**	After federal policy on tribal Medicaid reimbursement is implemented: • Impact on costs to state • Number of care coordination agreements implemented between Tribal and non-Tribal providers • Change in number of claims processed compared to prior to implementation	
Section 56 **Health Information Infrastructure Plan**	• Health Information Infrastructure Plan produced • Measure of improved data analytic capacity by DHSS	• See PDMP above (Sections 10-12)

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The following sections of SB 74 have not been included in the table above because there is either not an applicable evaluation measure for that section, or one or more relevant evaluation measures are detailed in other sections:

- Sections 40-42: Provider audits (overpayments)
- Section 43: Civil penalties (this section also includes Medical Assistance Reform Program)
- Section 47: Report to Legislature
- Section 48: Definition of clinic services
- Section 49: Definition of rehabilitative services
- Section 50: Department may require application for state and federal programs in order to get Medicaid
- Section 51-53: Repeal dates for several AS sections
- Section 54: Indirect court rule amendments
- Section 57: Feasibility studies for the provision of specified state services
- Section 59: Direction to apply for needed waivers to implement changes
- Section 60: Authority to implement changes and write regulations
- Section 61: Conditional effect of various provisions
- Sections 62-73: Implementation dates