

MEASURE APPLICATIONS PARTNERSHIP

Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries

INTERIM REPORT TO HHS

NQF

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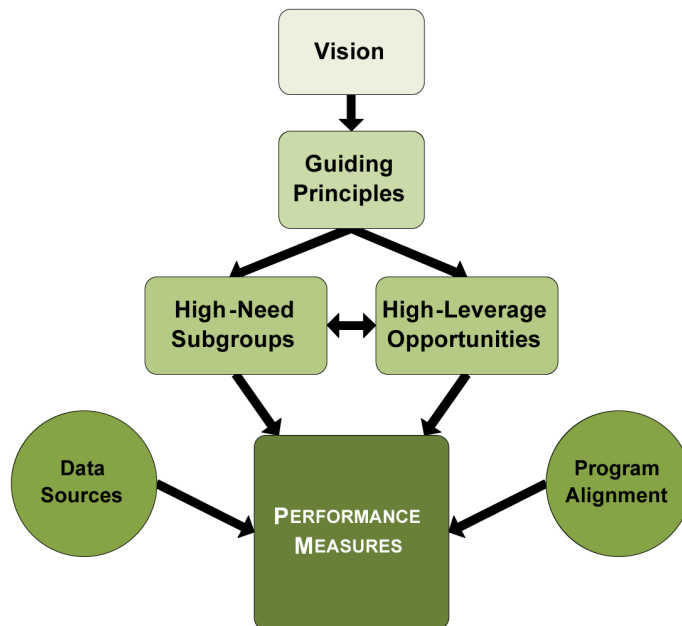
SUMMARY

The Department of Health and Human Services (HHS) has requested that the Measure Applications Partnership (MAP) provide multi-stakeholder input on performance measures to assess and improve the quality of care delivered to individuals who are eligible for both Medicare and Medicaid. To purposefully identify measures that are appropriate for use with the unique dual eligible population, MAP has developed a strategic approach to performance measurement and identified opportunities to promote significant improvement in the quality of care. As depicted in the following graphic, the core of the strategic approach is composed of:

- a vision for high-quality care;
- guiding principles;
- discussion of high-need subgroups; and
- high-leverage opportunities for improvement through measurement.

In addition to the four primary elements, MAP also considered issues related to data sources and program alignment as inputs to the strategic approach.

Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries



MAP's task to identify performance measures appropriate for use with the dual eligible beneficiary population is divided into two phases. This interim report describes the activities of the first phase, which focused on understanding the unique qualities of the population, identifying deficits in quality that affect the group, defining a strategic approach to measurement, and characterizing appropriate measures. The second phase of the work will consider gaps in available measures and propose potential modifications to existing performance measures or new concepts for measure development. MAP will submit its final report on this topic to HHS in June 2012.

MAP BACKGROUND

Purpose

MAP is a public-private partnership convened by the National Quality Forum (NQF) for providing input to HHS on selecting performance measures for public reporting, performance-based payment programs, and other purposes. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to “convene multi-stakeholder groups to provide input on the selection of quality measures” for various uses¹.

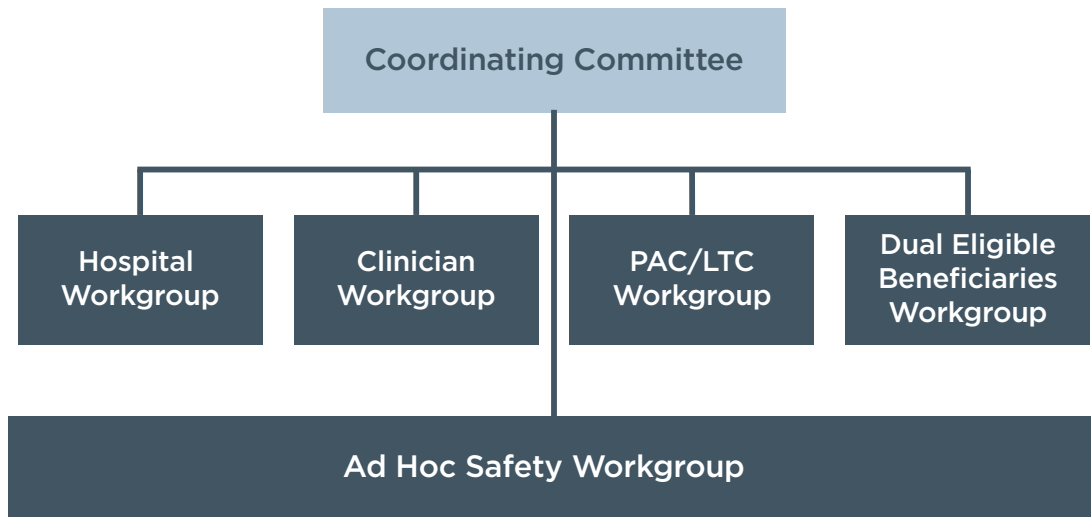
Through MAP activities, a wide variety of stakeholders will provide their input into HHS’s selection of performance measures for public reporting, performance-based payment programs, and other purposes. MAP’s careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures that HHS will receive varied and thoughtful input on performance measure selection.

MAP is designed to facilitate alignment of public- and private-sector uses of performance measures to further the National Quality Strategy’s (NQS) three-part aim of creating better, more affordable care and healthier people.² Anticipated outcomes from MAP’s work include:

- a more cohesive system of care delivery;
- better and more information for consumer decision making;
- heightened accountability for clinicians and providers;
- higher value for spending by aligning payment with performance;
- reduced data collection burden through harmonizing measurement activities across public and private sectors; and
- improvement in the consistent provision of evidence-based care.

Function

Composed of a two-tiered structure, MAP’s overall strategy is set by the Coordinating Committee, which provides final input to HHS. Working directly under the Coordinating Committee are five advisory workgroups responsible for advising the Committee on using measures to encourage performance improvement in specific care settings, providers, and patient populations. More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies (*ex officio* members) are represented in the Coordinating Committee and workgroups.



The NQF Board oversees MAP. The Board will review any procedural questions and periodically evaluate MAP's structure, function, and effectiveness but will not review the Coordinating Committee's input to HHS. The Coordinating Committee and workgroups were selected by the Board, based on Board-adopted selection criteria. Balance among stakeholder groups was paramount. Because MAP's tasks are so complex, including individual subject matter experts in the groups also was imperative.

MAP operates in a transparent manner. The appointment process included open nominations and a public commenting period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

MAP decision making is based on a foundation of established guiding frameworks. The HHS National Quality Strategy is the primary basis for the overall MAP strategy. Additional frameworks include the High-Impact Conditions list determined by the NQF Measure Prioritization Advisory Committee, the NQF-endorsed Patient-Focused Episodes of Care framework, the HHS Partnership for Patients safety initiative³ the HHS Prevention and Health Promotion Strategy⁴, the HHS Disparities Strategy⁵, and the HHS Multiple Chronic Conditions Framework.⁶

One of MAP's early activities has been the development of measure selection criteria. The selection criteria are intended to build on, not duplicate, the NQF endorsement criteria. The measure selection criteria characterize the fitness of a measure set for use in a specific program by, among other things, how closely the measures align with the NQS's priority areas and address the High-Impact Conditions, and by the extent to which the measure set advances the purpose of the specific program without creating undesirable consequences.

NQF has engaged two subcontractors to support MAP's work. The Stanford Clinical Excellence Research Center has provided input into developing measure selection criteria. Avalere Health

has been subcontracted to prepare an analysis of quality issues, strategies for improvement, and measure gaps to support the selection of measures for hospitals, physician offices, and post-acute care/long-term care settings. In addition, Avalere will conduct a similar analysis for dual eligible beneficiaries as a distinct population that crosses all care settings.

Timeline and Deliverables

MAP's initial work includes performance measurement coordination strategies and pre-rulemaking input on the selection of measures for public reporting and payment programs (see Appendix A for schedule of deliverables). Each of the coordination strategies will address:

- measures and measurement issues, including measure gaps;
- data sources and health information technology (health IT) implications, including the need for a common data platform;
- alignment across settings and across public- and private-sector programs;
- special considerations for dual eligible beneficiaries; and
- the path forward for improving measure applications.

MAP began its work in the spring of 2011 (see Appendix B for timeline). The Coordinating Committee set charges for the workgroups in May and continued to convene regularly to review progress and provide guidance to the workgroups. Four of the workgroups—Dual Eligible Beneficiaries, Clinician, Safety, and Post-Acute Care/Long-Term Care—met during June and July and provided reports to the Coordinating Committee in August. Per its schedule of deliverables, MAP is providing this and two other reports to HHS by October 1. Appendix C discusses MAP's approach to this particular task, including a discussion of terminology, rosters for the MAP Dual Eligible Beneficiaries Workgroup and the MAP Coordinating Committee, and links to background materials from the Dual Eligible Beneficiaries Workgroup's earlier meetings.

STRATEGIC APPROACH TO PERFORMANCE MEASUREMENT

Characterizing the Dual Eligible Population

An accurate understanding of the unique characteristics of the dual eligible population is fundamental to designing an appropriate approach to measurement. MAP examined a range of data and drew upon the wealth of expertise offered by the stakeholder groups to elicit the population's most relevant features. MAP discussion highlighted the heterogeneity of the population, the particularly intense service needs and vulnerabilities of some sub-groups, and the fragmented nature of healthcare and supportive services they receive. A detailed characterization of the population is provided in Appendix D.

Vision for High-Quality Care

MAP established a vision for high-quality care for dual eligible beneficiaries to provide the foundation for the strategic approach to performance measurement.

In order to promote a system that is both sustainable and person- and family-centered, individuals eligible for both Medicare and Medicaid should have timely access to appropriate, coordinated healthcare services and community resources that enable them to attain or maintain personal health goals.

As a part of the vision and the strategic approach to performance measurement, MAP espouses a definition of health that broadly accounts for health outcomes, determinants of health, and personal wellness. For example, one of the National Quality Strategy's aims is to "improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care."⁷

The far-reaching nature of the vision and its multi-factorial view of health are both fundamental to MAP's overall approach to quality measurement for the dual eligible population. The vision aspires to high-value care that is centered on the needs and preferences of an individual and his or her loved ones and that relies on holistic supports to maximize function and quality of life. These themes and others are reflected throughout the approach to measurement.

Guiding Principles

In considering how to achieve the desired vision, MAP established guiding principles for the approach to measurement. Numerous, largely setting-specific, performance measurement programs already exist in Medicare and, to a lesser extent, Medicaid. HHS may establish a new, more comprehensive measurement initiative that would connect Medicaid and Medicare services to evaluate the quality of care provided to dual eligible beneficiaries. The guiding principles, coupled with MAP's emerging measure selection criteria, will assist in evaluating the appropriateness of potential measures to meet the goals of such an initiative.

The guiding principles fall into three general categories: desired effects, measurement design, and data:

Desired Effects:

Promoting Integrated Care: Measurement has the ability to drive clinical practice and provision of community supports toward desired models of integrated, collaborative, and coordinated care. Improving the health of dual eligible beneficiaries will require wide-scale cooperation, systematic communication, and shared accountability.

Ensuring Cultural Competence: The measurement approach also should promote culturally competent care that is responsive to dimensions of race, ethnicity, age, functional status, language, level of health literacy, environmental factors, and accessibility of the environment for people with different types of disability.

Health Equity: Stratifying measures by such factors as race, ethnicity, or socioeconomic status allows for identification of potential healthcare disparities and related opportunities to address them. Moreover, it is important to measure dual eligible beneficiaries in contrast to Medicare-only and Medicaid-only beneficiaries in order to assess any differences in program access.

Measurement Design:

Cascading Levels of Analysis: Person-level measures may be coupled with harmonized population-level measures at increasingly broad levels of analysis, such as a health system or a state, to form a “cascade” of aligned measures. This provides a full picture of a particular issue while providing information that is actionable and meaningful to stakeholders at each level.

Assessing Outcomes Relative to Goals: The measurement approach should evaluate person-level outcomes relative to goals that are defined in the process of developing a person- and family-centered plan of care. Such goals might include maintaining or improving function, longevity, palliative care, or a combination of factors. It also is vital to include outcome measures related to the individual’s or family’s assessment of the care and supports received.

Parsimony: To minimize the resources required to conduct performance measurement and reporting, a core measure set should be parsimonious. The set should include the smallest possible number of measures to achieve the intended purpose of the measurement program.

Cross-Cutting Measures: The heterogeneity of the dual-eligible population complicates efforts to select a small number of measures that would accurately reflect their care experience. Thus, a parsimonious measure set should rely primarily on cross-cutting measures and use condition-specific measures only to the extent they address critical issues for high-need subpopulations.

Inclusivity: The measurement strategy should span the continuum of care and include both Medicare and Medicaid services. It should include measures that are broadly applicable across age groups, disease groups, or other cohorts, as opposed to measures with narrowly defined denominator populations.

Avoiding Undesirable Consequences: The methodology should anticipate and mitigate potential undesirable consequences of measurement. This might include overuse or underuse of services as well as adverse selection. For example, the measurement approach could use strategies such as stratification or risk adjustment to account for the increased difficulty of caring for complex patients and to ensure that such individuals would have access to providers willing to treat them.

Data:

Data Sharing: The measurement strategy should encourage dynamic data exchange and shared accountability. Interoperable health records that enable portability of information across providers can assist greatly in delivering timely, appropriate services that are aligned with a shared plan of care.

Using Data Dynamically: A robust data exchange platform also would assist providers in gathering information from the individual receiving care or his or her caregivers, and circulating feedback, as appropriate, to improve quality. Tracking data over time also enables longitudinal measurement and tracking “delta measures” of change in outcomes of interest.

Making the Best Use of Available Data: While health IT infrastructure develops, the measurement strategy must make the best use of all available data sources, including administrative claims, registries, and community-level information.

High-Need Subgroups

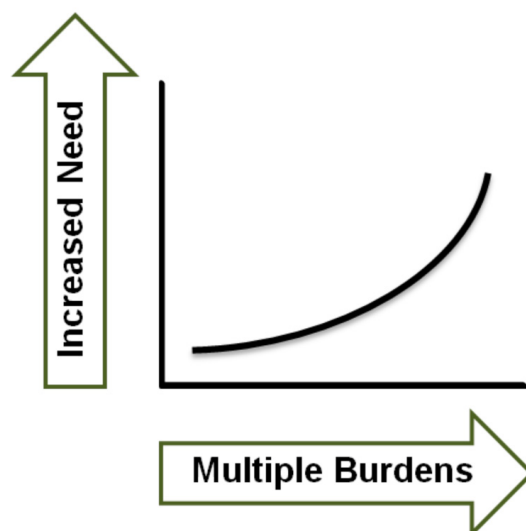
In considering the performance measurement approach with the largest potential impact on the dual eligible population, MAP considered the population's heterogeneity and the particularly intense service needs of some subgroups. In its June 2010 *Report to the Congress*, the Medicare Payment Advisory Commission wrote:

Within the dual-eligible population, there are distinct groups of beneficiaries with widely different care needs. They vary considerably in the prevalence of chronic conditions, their physical and cognitive impairments, and whether they are institutionalized. Many have multiple chronic conditions that make care coordination especially important. Other duals have no or one physical impairment and no chronic conditions. Reflecting this wide range in care needs, spending varies by a factor of four according to physical and cognitive impairment. Likewise, spending on specific types of services differs by subgroup, with some having higher spending on nursing home or hospital services than others.⁸

While there is a need to monitor the quality of care broadly, targeting the care of high-need, high-cost individuals for improvement can yield large gains. Promising practices gleaned from stabilizing and streamlining the care of individuals who are high-need, high-cost outliers may be tailored to match the less-intense care needs of other subgroups of dual eligible beneficiaries.

MAP deliberations suggested that there is not yet an established taxonomy for classifying subgroups of the dual eligible population. Members considered organizational schemata based on functional status, clinical diagnoses, age, and other characteristics but did not identify a satisfactory approach. Instead, MAP members proposed that combinations of particular risk factors lead to high levels of need in an additive or synergistic manner. These risk factors, which exist in myriad combinations, include attributes of comorbidity, function, disability, and vulnerability, such as:

- **limitations in one or more activities of daily living (ADLs) resulting from sensory and/or physical impairments;**
- **mental health/substance use disorder;**
- **cognitive impairment;**
- **intellectual disability/developmental disability;**
- **heavy disease burden or pain from one condition (e.g., end-stage renal disease) or multiple chronic conditions;**
- **residential care setting;**
- **frail elderly;**
- **recipient of home and community-based services (HCBS); and**
- **social factors (e.g., low socioeconomic status, homelessness, low education level, social isolation, or lack of social capital).**



As depicted in the figure above, service needs generally tend to increase along with the number of risk factors or categories that apply to an individual. Some factors may more strongly predict service needs than others. The exact mathematical relationship is not known and would vary by combination of factors, but evidence demonstrates it is not linear.⁹

If particular risk factors are shown to be strongly predictive of increased service needs or receiving care of questionable quality, performance measures may be stratified by those factors to better understand and target certain subgroups. The current ability to perform such an analysis is limited by several barriers. First, appropriate strata have not yet been defined. Second, meaningful strata would likely differ across measures. Third, there may be insufficient numbers of individuals in each band to enable analysis at that level of specificity. Fourth, linked Medicare and Medicaid encounter data would be required to identify duals with certain risk factors, specifically mental health or substance use disorders, cognitive impairment, intellectual or developmental disability, or those who live in a residential care setting or who receive HCBS. Finally, providers must routinely screen and document these factors for them to be a part of the medical record and subsequently available for analysis.

HHS has opportunities to address these barriers. For example, the agency could consider funding the development of a precise classification system for dual eligible beneficiaries. The risk factors identified above could serve as a starting place for that analysis.

Link to Affordability of Care

The dual eligible beneficiary population generally, and high-need subgroups specifically, use healthcare and support services heavily, incurring a disproportionate share of Medicare and Medicaid expenditures. As discussed above, spending on dual eligible beneficiaries is further concentrated among a small minority of individuals with intense service needs. MedPAC has reported that the most expensive 5 percent of duals account for 27 percent of total spending on duals.¹⁰ The tremendous public expense associated with providing this care makes the population of interest to all stakeholders across the health and human services systems. The opportunity costs such as lost productivity and caregiver burden associated with high-need population subgroups also are significant. For these reasons, any discussion of the quality of duals' care is inextricable from discussion of its affordability.

Systematically capturing the total cost of care for dual eligible beneficiaries across Medicare and Medicaid is currently impossible. Claims data systems for the two programs are operated independently, and each state's Medicaid data are structured differently. Medicaid claims may be incomplete; MAP members reported that some states' Medicaid reimbursement rates are so low that providers do not bother to bill them for services. Moreover, private health plans own large portions of Medicare and Medicaid data. Long delays in the availability of claims data for analysis can further diminish the value of processing the information for certain purposes. Despite these barriers, MAP recognizes that the ability to identify the total cost of care is fundamental to understanding the value of healthcare and supportive services provided to dual eligible beneficiaries. Harmonizing claims systems and data sets will be required to achieve this.

MAP identified several major cost drivers for the population, including emergency services, hospitalization, institutionalization, and fragmentation of care leading to overutilization. Each

of those drivers can be largely avoided with sufficient and properly coordinated upstream care and supports. For example, a CMS-commissioned study found that in 2005, 39 percent of hospitalizations of dual eligible beneficiaries from long-term care or skilled nursing facility settings may have been avoidable, either because the condition might have been prevented or because it might have been treated in a less-intense care setting than a hospital.¹¹ The costs associated with these potentially avoidable hospitalizations totaled more than \$3.2 billion.¹² In a survey conducted by the Commonwealth Fund, 30 percent of adults reported experiencing duplicate tests or care they believed was of little or no value.¹³

Beyond those specific cost drivers, most types of disability also are associated with increased spending. Spending is expected on the conditions directly related to the disability as well as additional spending for services and supports as the disability interacts with other conditions. This spending may be particularly high for individuals born with intellectual or developmental disabilities, as they often require services and supports of varying extent throughout their lifetimes.

Although specific strategies to deliver high-value care should be tailored to individuals' needs, MAP members offered a number of broad suggestions. For example, policies and programs should seek to enhance access to a usual source of primary care, promote team-based care, reduce intensity of services and care settings where appropriate, and mobilize appropriate support resources and coaching for individuals who are less able to navigate the system for themselves.

MAP cautions that any effort to improve the affordability of care should not create further limits to access for dual eligible beneficiaries. For example, cuts to Medicaid reimbursement rates may further damage providers' willingness to treat duals or to provide certain types of specialty services. Instead, improving the affordability of care should be oriented to other cost-saving opportunities identified throughout this report, such as improving coordination across transitions of care and delaying or avoiding institutionalization.

High-Leverage Opportunities for Improvement Through Measurement

Countless opportunities exist to improve the quality of care delivered to dual eligible beneficiaries. In recognition that a measurement strategy should be parsimonious and focused on areas with substantial room for improvement, MAP reached consensus on five domains where measurement could drive significant positive change. Those domains are quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures. MAP concluded that, wherever possible, selection of measures to fit these areas should drive broad improvements in healthcare delivery and community supports by promoting shared accountability, addressing affordability along with quality, encouraging health IT uptake, and pushing toward longitudinal measurement.

Quality of Life

The measurement strategy should promote a broad view of health and wellness, encouraging the development of a person-centered plan of care that establishes goals and preferences for each individual. Ideally, that care plan and its goals would form the basis for measurement. For example, in situations in which an individual who is near the end of life has stated health-related goals

oriented toward palliative care instead of interventions to extend life, the measure strategy should accommodate that choice. In the short term, measurement can focus on discrete opportunities to elicit health-related goals, for example, ensuring assessments include information about wishes for end-of-life care.

Measures in this care domain should focus on outcomes. They also should capture multiple facets of quality of life, such as an individual's ability to determine his or her home environment, participate in the community, develop meaningful relationships, and meet employment and education goals. While some quality-of-life measures may be more difficult to determine for dual eligible beneficiaries who cannot self-report objectively, assessing progress toward treatment and recovery goals remains appropriate.

Incorporating measures of functional status, particularly if they can be reported by the patient, caregiver, or another selected representative and evaluated over time, is vital.

MAP also considered measures related to comfort, pain management, and symptom control under this domain.

Care Coordination

Care coordination is a vital feature of high-quality care for dual eligible beneficiaries. NQF has previously identified preferred practices and performance measures related to care coordination.¹⁴ MAP discussed that measures in this domain should promote coordination across multiple dimensions, such as across care settings, between the healthcare system and community supports, across provider types, and across Medicare and Medicaid program benefit structures.

To ensure adequate care coordination, measures should address desired components of such coordination. MAP emphasized the importance of a shared plan of care developed jointly between providers and beneficiaries, proactive medication management, access to an inter-professional team that spans settings of care, advance care planning, and palliative care. A thorough approach to care coordination would account for patient engagement and relevant factors (e.g., symptom control) in the span between encounters with the health system.

Measurement in this area could be oriented to identifying missed opportunities or breakdowns in care. Some warning signs of poor care coordination are incidents in which patients are transferred across settings without appropriate medical records, a Medicaid case manager has not been notified that an HCBS recipient has been hospitalized, or a clinician has prescribed a medication contraindicated by the plan of care.

Screening and Assessment

Approaches to screening and assessment should be thorough and tailored to address the complex care needs of the dual eligible beneficiary population. MAP regarded the routinely recommended clinical preventive screenings as generally necessary but not sufficient for this group. The measurement approach should encourage providers to screen for factors that particularly affect vulnerable populations, such as food insecurity, drug and alcohol use, housing, falls, underlying mental and cognitive conditions, and HIV/AIDS.

Assessment goes hand in hand with screening but does not have to occur in a single clinical encounter. The ongoing assessment process should use person-centered principles and go beyond the basics to account for the home environment, economic insecurity, availability of family and community supports, capacity of formal and informal caregivers, caregiver stress, access to healthful food, transportation, and consideration of whether the individual is receiving care in the most appropriate, least restrictive setting. After screening and assessment is complete, the results should be incorporated into an individual's person-centered plan of care.

Mental Health and Substance Use

Mental health conditions such as depression are highly prevalent in the dual eligible population. Other serious psychiatric conditions such as schizophrenia are less common but heavily concentrated in the dual eligible population less than 65 years old. Substance use disorders also are commonplace. Addressing the sequelae of mental health and substance use conditions is vital to improving health outcomes in a large portion of dual eligible beneficiaries.

The Institute of Medicine (IOM) has published a strategy for applying the *Quality Chasm* approach to the mental health field and highlighted several related issues.¹⁵ First, mental health and substance use conditions are significant contributors to rising costs of care and are individual and societal burdens. Second, individuals with mental health and substance use disorders are significantly affected by co-occurrence of diabetes, cardiovascular disease, and other general medical conditions. Finally, measured improvements in the clinical quality of behavioral health services have trailed other specialties.

MAP echoed the IOM recommendation that mental health and substance abuse treatment should be more closely coordinated with primary care. MAP also discussed that measures in this domain eventually should be able to evaluate care across the continuum, including screening, treatment, outcomes, and patient experience. Approaches to both treatment and performance measurement should be grounded in the recovery model, as appropriate.¹⁶

Structural Measures

Structural measures are necessary to provide a sense of the capacity, systems, and processes that exist to provide care and supports for dual eligible beneficiaries. In particular, MAP views structural measures as a critical part of a parsimonious measure set and a high-leverage opportunity because they can assess disconnects between Medicare and Medicaid. It will be necessary to identify the extent of current problems and attempt to fix underlying structures and processes before providers and other stakeholders will be comfortable being held accountable to outcome measures.

Structural measures can reflect the presence of elements that relate to other high-leverage opportunities such as quality of life and care coordination. For example, structural elements related to quality of life include the availability of HCBS within a state and an individual's ability to self-direct those services. Additional structural measures related to care coordination might assess the presence of contracts between state Medicaid agencies and Medicare Advantage Special Needs Plans (SNP) to coordinate care, health IT uptake among Medicaid providers in a region, or capacity for information sharing within and across health provider and community support services organizations.

ILLUSTRATIVE MEASURES

The table below presents information about existing performance measures and considerations related to their use in the strategic approach to performance measurement. *MAP did not attempt to assemble a finite set of recommended measures at this stage of its work.* Instead, members discussed the characteristics of desired measures, rationale for their use, and how to identify those that would be most reflective of the unique care experience of dual eligible beneficiaries.

Two illustrative measures are provided for each of the five high-leverage measurement domains. The strengths and weaknesses of these measures were considered by MAP members and are presented as a starting place for discussion of the relevant issues. These and other measures will be more fully vetted in MAP's future work.

Existing Performance Measures	Measure Type	Additional Considerations
<p>Quality of Life Measure:</p> <p><i>Improvement in Ambulation/Locomotion</i></p> <p>Percentage of home health episodes where the value recorded for the OASIS item M0702 on the discharge assessment is numerically less than the value recorded on the start (or resumption) of care assessment, indicating less impairment at discharge compared to start of care.</p> <p><i>NQF Endorsed, #0167</i></p>	<p>Outcome</p>	<ul style="list-style-type: none"> • Uses existing data source (OASIS) • Broadly applicable across clinical conditions • Oriented to outcome and promotes longitudinal view across episode of care • Applies only to beneficiaries receiving home health services
<p>Quality of Life Measure:</p> <p><i>Change in Daily Activity Function as Measured by the AM-PAC</i></p> <p>The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified that consists of functional tasks that cover the following areas: feeding, meal preparation, hygiene, grooming, and dressing.</p> <p><i>NQF Endorsed, #0430</i></p>	<p>Outcome</p>	<ul style="list-style-type: none"> • Broadly applicable across clinical conditions • Functional status is a fundamental aspect of quality of life • Oriented to outcomes and change over time • Data for measure can come from electronic health record (EHR) • AM-PAC may be duplicative of MDS and OASIS instruments that also evaluate function • Narrowly limited to post-acute care patients. Many others in dual eligible population would benefit from regular assessment of daily activity function, particularly individuals receiving HCBS so that an institutional placement might be avoided

Existing Performance Measures	Measure Type	Additional Considerations
<p>Care Coordination Measure: <i>3-Item Care Transition Measure (CTM-3)</i> Uni-dimensional self-reported survey that measures the quality of preparation for a transition in care. <i>NQF Endorsed, #0228</i></p>	<p>Patient Experience of Care</p>	<ul style="list-style-type: none"> • Captures the beneficiary's perspective • Broadly applicable (not condition-specific or age-restricted) • Proposed ACO measure • Some individuals may be unable to complete the survey (because of limited English proficiency, cognitive impairment, etc.) and would require a proxy
<p>Care Coordination Measure: <i>Advance Care Plan</i> Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan <i>NQF Endorsed, #0326</i></p>	<p>Process</p>	<ul style="list-style-type: none"> • Broadly applicable across clinical conditions and all levels of function • Encourages upstream planning and decision-making on the part of the beneficiary and his or her loved ones • Advance directives were noted for their particular importance to the dual eligible population, especially given the high prevalence of cognitive impairment • Limited by age
<p>Screening and Assessment Measure: <i>Screening for Fall Risk</i> Percentage of patients aged 65 years and older who were screened for fall risk (two or more falls in the past year or any fall with injury in the past year) at least once within 12 months <i>NQF Endorsed, #0101</i></p>	<p>Process</p>	<ul style="list-style-type: none"> • Not specific to a clinical condition • Important risk factor in the dual eligible population, particularly among older adults • Proposed ACO measure • Limited by age; others with limitations in mobility may be at risk for a fall • Measure does not push provider to change care plan based on results of the assessment, only to document that one was performed

Existing Performance Measures	Measure Type	Additional Considerations
<p>Screening and Assessment Measure:</p> <p><i>Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention</i></p> <p>Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period.</p> <p>Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.</p> <p><i>NQF Endorsed, #0028</i></p>	<p>Process</p>	<ul style="list-style-type: none"> • Assessment is paired with an intervention but does not measure the success of the intervention • Promotes longitudinal view across the two-year measurement window • Not limited by age or other clinical condition • eMeasure specifications have been developed • Included in Meaningful Use Clinical Quality Measures for Stage 1 • Identified by NQF as a disparities-sensitive measure
<p>Mental Health and Substance Use Measure:</p> <p><i>Depression Remission at Six Months</i></p> <p>Adult patients aged 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate remission at six months defined as a PHQ-9 score less than 5.</p> <p><i>NQF Endorsed, #0711</i></p>	<p>Outcome</p>	<ul style="list-style-type: none"> • PHQ-9 is a standardized tool completed by the patient • Applies to both patients with newly diagnosed and existing depression, a highly prevalent condition in the population • Measure is specified for multiple data sources and eMeasure specifications have been developed • Risk adjustment may be necessary • NQF has endorsed two related measures, a process measure for use of the PHQ-9 and an outcome measure for remission at 9 months • Promotes longitudinal view of care and ongoing contact between patient and provider, but if patient does not receive follow-up care or sees a different provider, he or she will be excluded from the measure denominator

Existing Performance Measures	Measure Type	Additional Considerations
<p>Mental Health and Substance Use Measure: <i>Follow-up After Hospitalization for Mental Illness</i> Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. <i>NQF Endorsed, #0576</i></p>	<p>Process</p>	<ul style="list-style-type: none"> • Crosses mental health conditions but captures only the group of beneficiaries whose mental illness is severe enough to warrant hospitalization • Promotes follow-up care at a vulnerable time; phone follow-up is not sufficient for purposes of this measure • Proposed Medicaid Adult Core measure • Can be reported at many levels (clinician, facility, health plan, integrated delivery system, population) • Measure does not push provider to change care plan based on results of follow-up, only to document the encounter
<p>Structural Measure: <i>SNP Structure and Process Measure #6: Coordination of Medicare and Medicaid Coverage</i> The organization coordinates Medicare and Medicaid benefits and services for members. Element A: Administrative coordination for dual-eligible benefit packages, Element B: Relationship with state Medicaid agency for dual-eligible benefit packages, Element C: Administrative coordination for chronic condition and institutional benefit packages, Element D: Service coordination <i>Not Currently Endorsed by NQF</i></p>	<p>Structure/ Process</p>	<ul style="list-style-type: none"> • Promotes coordination between private Medicare Advantage Special Needs Plans and state Medicaid agencies • Plan-level measure, would have to be modified to assess this concept at a population level • Applies only to Special Needs Plans, which enroll a minority of dual eligible beneficiaries • Focus on documenting that SNPs are working on state relationships rather than directly assessing alignment of Medicare and Medicaid • No measurement of degrees of integration

Existing Performance Measures	Measure Type	Additional Considerations
<p>Structural Measure:</p> <p><i>Medical Home System Survey</i></p> <p>Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with:</p> <ul style="list-style-type: none"> a. Improved access and communication b. Care management using evidence-based guidelines c. Patient tracking and registry functions d. Support for patient self-management e. Test and referral tracking f. Practice performance and improvement functions <p><i>NQF Endorsed, #0494</i></p>	<p>Structure</p>	<ul style="list-style-type: none"> • Access to ongoing, coordinated care is fundamental for the dual eligible population • System-level measure, would have to be modified to assess this concept at a practice and/or population level • A relatively high standard to be applied broadly

Gaps in Available Measures

Current Medicare and Medicaid measurement activities include dual eligible beneficiaries, but the population has not been stratified or separately evaluated in a systematic fashion to date. Appendix E discusses the landscape of current performance measurement activities as it relates to duals. In considering this landscape, MAP identified numerous gaps in measures currently available to evaluate the quality of care provided to dual eligible beneficiaries. Illustrative measures in the table above are among the best available to the field, yet many fail to reflect the complexity of quality problems faced by duals. Needed measures fall into two types of gaps:

Measure Development Gaps: Many concepts one might wish to evaluate have not been developed as standardized performance measures. Data at the patient level may exist in other forms, such as consumer surveys or assessments, but performance measures based on that data would need to be developed and tested. Other concepts may not have an obvious data source at this time. Examples include:

- World Health Organization’s Quality of Life Questionnaire;
- cross-cutting measures of culturally competent care, compassionate care, continuity of care, and consistency of care;
- measures of how well a care team functions together; and
- nontraditional domains of quality: person-centered goals; autonomy, self-efficacy, self-determination; meaning, purpose, and connection; caregiver, household, and community benefits.

Measure Endorsement Gaps: A desired measure or measure set that has been fully developed and tested but not yet endorsed by NQF is considered in an “endorsement gap.” Under certain circumstances, such a measure submitted to NQF for endorsement may be eligible for expedited review. Examples include:

- some measures proposed for Medicaid Adult Core Set;
- some measures proposed in the Substance Abuse and Mental Health Services Administration’s National Framework for Quality Improvement in Behavioral Health Care; and
- outcome indicators for the HCBS population.

One endorsement gap measure of particular interest to MAP is related to screening an individual for problematic alcohol use and making a referral for treatment. There is a strong evidence base documenting the benefits of this intervention, its cost-effectiveness, and its relevance to subgroups of dual eligible beneficiaries (e.g., individuals with severe mental illness). This measure is included in the proposed CMS Medicaid adult core measures and is being used widely by the Veterans Health Administration and Indian Health Services systems. NQF anticipates it will be considered for endorsement as a part of an upcoming call for measures in behavioral health.

Measure exclusions also create gaps in the universe of available measures by limiting their applicability. Performance measures have detailed technical specifications that describe which individuals are included in the numerator and denominator of the measure. The specifications often identify particular characteristics that exclude an individual from measurement. Unfortunately, the characteristics that lead to exclusion are highly prevalent in the dual eligible population. For example, when an individual changes providers or transfers between settings of care, he or she is lost to follow-up and excluded from measurement. In addition, individuals with certain types of comorbid conditions or who are of advanced age are commonly excluded from measurement because the evidence underlying the measure has not documented its applicability to that group.

MAP will continue to explore measure gaps in more detail in the second phase of this work. To address identified gaps, MAP also will recommend modifications to existing measures and new measure concepts for development.

DATA SOURCES

MAP proposed that it would be ideal to track individual beneficiaries or cohorts of duals across settings and time for measurement purposes. This concept faces multiple barriers. Data required to calculate performance measures are currently split across myriad sources. Furthermore, the sources vary for each individual based on whether that person is enrolled in fee-for-service, one or more managed care plans, Medicaid waivers, pharmacy benefits, or other carve-out services such as mental health. There is not currently a system in place to link records belonging to the same individual across databases. The system also lacks common standards for inputs, outputs, data processes, structures, procedures, and privacy controls. This fragmentation of information has severely limited the ability of stakeholders to assess quality and performance to date.

The limited and piecemeal data generated by existing approaches is inadequate to inform policy makers and other stakeholders about the quality of healthcare and community supports provided

to dual eligible beneficiaries. The identification of appropriate measures must be accompanied by a data collection strategy identifying one or more specific data sources for each measure to generate the information required to calculate them. MAP anticipates that securing appropriate data sources for an initial set of performance measures may be a significant challenge. While the development of health IT and health information exchange (HIE) infrastructure across the country show tremendous promise for enhancing the availability of information, the measurement strategy may not be able to leverage these activities immediately.

Promise of Health IT and HIE

A data collection strategy should promote adoption of health IT/HIE and the use of electronic data sources to reduce the burden of data collection and make information readily available for multiple purposes. Wherever possible, the strategy should include measures that have been specified for collection via electronic health records (EHR) or personal health records (PHR).

The ability to capture and share clinical information among primary care providers, specialists, hospitals, labs, pharmacies, community supports providers, and other entities is foundational to a successful measurement strategy. Information exchanges, data warehouses, and aggregation tools can be used to bring together clinical and non-clinical information from multiple data sources.

Using a portable EHR to collect information directly from beneficiaries or their caregivers at home or in a clinical setting may prove especially valuable. This would enable assessment of health risks, quality of life, functional status, and patient experience in a timely manner and link the data to an individual's plan of care. When presented to providers with appropriate decision support, this robust data can assist in delivering appropriate care that is responsive to an individual's social and environmental context. In addition, measures could incorporate the results of established and validated data collection instruments such as risk assessment algorithms or functional status questionnaires. Such instruments can be completed directly by patients, caregivers, or clinicians and provide valuable information that can be stored as structured data for reuse in EHRs and PHRs.

Interoperability and rapid information exchange also help to ensure that providers have the ability to access a single, shared, person-centered plan of care and that vulnerable individuals are not forgotten or overlooked. When fully developed, information infrastructure will benefit both measurement and clinical practice by enabling care coordination, reducing duplication of services, and promoting the best possible outcomes for beneficiaries.

This type of data exchange platform requires that information be clearly communicated and understood by both senders and receivers of data. It requires both patient permission and coordination among differently configured health IT systems. The platform must include either the standard use of language or translation at a central hub. Further, a method is needed to identify clearly the individual about whom the information is exchanged. For example, identifying the medications dispensed to a person who is enrolled in two payment programs requires matching at the individual level and merging data at either the end-point or some central hub. Alignment with national standards established for interoperability is essential, and standards must be applied equally regardless of payment program.

Data Elements

It will be important to precisely define the necessary data elements for data collection and reporting. Medicare and Medicaid data currently collected by the Centers for Medicare & Medicaid Services (CMS) could be harmonized to form the initial foundation of the data platform, with additional elements planned to be added over time. CMS administrative data are currently limited in their timeliness, comprehensiveness, and accuracy, but they are nevertheless a vital starting place for constructing the data platform. Data integrity, a problem highlighted by MAP, could be improved through systematic review and feedback loops. It will also be important to include appropriate privacy protections.

MAP suggested that the full range of data elements should include individual characteristics, community/environmental characteristics, clinical characteristics, and health-related experience information. This information is important context for guiding care and interpreting measures; however, providers should not be held accountable for macro-level elements that are beyond their sphere of influence (e.g., presence of an informal caregiver) and for which there is no Medicare or Medicaid benefit (e.g., non-medical transportation).

Data Availability in Current Programs

Two primary challenges related to Medicare data are lack of access to information about duals enrolled in private Medicare Advantage plans and Part D pharmacy benefits. An individual health plan, particularly if it is an integrated SNP, may have all of the data it needs to coordinate care and measure performance, but there is little ability to merge that information with other plans to view trends more broadly.

Medicaid data differs across states, making it difficult to aggregate. These challenges are compounded within states by the limited availability of Medicaid data for duals enrolled in private managed care plans and community-based services waiver programs. For example, some dual eligible beneficiaries receive behavioral health care services through a Medicaid 1915(c) waiver.¹⁷ MAP discussed a measure related to follow-up outpatient care after hospitalization for mental illness; but if states do not have complete, longitudinal mental health claims information tied to dates of service, it is not possible to calculate the measure.

MAP acknowledges and supports ongoing efforts within CMS to make Medicare and Medicaid data more available and useful to states for the purpose of coordination. Lessons learned from the process of exchanging this information should inform the data collection strategy and be applied to the challenges previously mentioned. For information on related efforts that may influence future data availability, see Appendix F.

PROGRAM ALIGNMENT

A small percentage of dual eligible beneficiaries are served through integrated models of care such as the Program of All-Inclusive Care for the Elderly (PACE), but more than 80 percent of dual eligible enrollees are in traditional fee-for-service Medicare, fee-for-service Medicaid, and a “stand-alone” Medicare prescription drug plan.¹⁸ Thus, despite their generally high needs for services, supports, and care coordination, the vast majority of the population receives care that is fragmented by payer source.

Medicare is the primary payer for most acute care services, while Medicaid is the primary payer for most long-term care services. Both Medicare and Medicaid can be delivered through a fee-for-service model or a managed care model. Moreover, some states carve out behavioral health and other services. A single beneficiary may be enrolled in three or more health plans with different benefit structures, provider networks, policies, and procedures. This fragmentation is confusing to beneficiaries and providers, inefficient, and makes it impossible for a single entity to be held accountable for delivering high-quality care.

State and local stakeholders experience particular alignment challenges in trying to meet the needs of dual eligible beneficiaries. The weak economy's twin effects of decreased tax revenue and increased Medicaid enrollment have placed tremendous strain on the resources of states, providers, and other stakeholders. As described above, states have historically lacked access to Medicare data and have experienced significant challenges trying to merge them with Medicaid data. Finally, the system struggles with Medicare and Medicaid's coverage limitations for needed services. For example, factors like nutrition, housing, and transportation have strong effects on health outcomes but generally are not benefits covered by either program.

Stakeholders have noted that the existence of multiple quality reporting programs and those programs' diverse goals have led to an excessive number of measures now being required for reporting. Alignment across programs and a concerted focus on a limited number of realistic, evidence-based measures is vital to reducing the burden of reporting. The core of the measurement approach should leverage other programs' required measures whenever possible and expand to specialized measures for key segments of the dual eligible population. Adding the complexity of many new measures will likely not drive as much improvement as focusing on the specific identified opportunities to improve quality and affordability.

Many stakeholders, including offices within HHS, have proposed that accountability and financial incentives for Medicare and Medicaid should be more purposefully aligned. MAP agrees that those changes are fundamental to addressing root causes of quality shortfalls. To implement MAP's strategic approach to performance measurement, a potential measure set would need to attempt to align many existing programs and reporting requirements. These include setting-specific measurement programs, the Medicare Advantage star rating program, PACE reporting requirements, Meaningful Use incentives, SNP Model of Care requirements, Medicare and Medicaid Conditions of Participation, HEDIS® measures, Medicare Health Outcomes Survey (HOS), CAHPS® surveys, and accreditation and certification standards, among others.

As a part of a larger policy strategy, uniform performance measurement can help to drive alignment across benefit structures and settings of care and begin to bridge the divide between the healthcare delivery system and community-based supports and services. Many of the concepts in MAP's strategic approach to performance measurement go beyond current Medicare and Medicaid reporting requirements. It will be necessary to balance immediate, short-term, and long-term steps to advancing a comprehensive measurement strategy. In the near term, CMS could stratify selected Medicare and Medicaid performance measures and separately report them for dual eligible beneficiaries. Long term steps would include measure development, testing, codification, and implementation.

NEXT PHASE OF WORK

Following submission of these interim findings, MAP will continue its work related to identifying measures appropriate for use with the dual eligible population. MAP will further consider gaps in currently available measures and suggestions for potential modifications to existing measures and may propose new measure concepts for development. A final report with MAP's input on improving the quality of care delivered to individuals who are eligible for both Medicare and Medicaid is due to the Department of Health and Human Services on June 1, 2012.

Beyond the currently assigned tasks, MAP looks forward to continuing its role in promoting quality improvement in caring for and supporting dual eligible beneficiaries. Opportunities for doing so may include further analysis of the unique needs of high-need subgroups and adapting the strategic approach to performance measurement accordingly. Additionally, NQF can add value in supporting states as they assess quality within their CMS-funded demonstrations to redesign delivery systems serving duals. It will also be necessary to determine a methodology for capturing the data required to calculate the performance measures that HHS selects for use.

APPENDIX A: Measure Applications Partnership—Schedule of Deliverables

Task	Task Description	Deliverable	Timeline
15.1: Measures to be implemented through the Federal rulemaking process	Provide input to HHS on measures to be implemented through the Federal rulemaking process, based on an overview of the quality issues in hospital, clinician office, and post-acute/long-term care settings; the manner in which those problems could be improved; and the measures for encouraging improvement.	Final report containing the Coordinating Committee framework for decision making and proposed measures for specific programs	Draft Report: January 2012 Final Report: February 1, 2012
15.2A: Measures for use in the improvement of clinician performance	Provide input to HHS on a coordination strategy for clinician performance measurement across public programs.	Final report containing Coordinating Committee input	Draft Report: September 2011 Final Report: October 1, 2011
15.2B: Measures for use in quality reporting for post-acute and long term care programs	Provide input to HHS on a coordination strategy for performance measurement across post-acute care and long-term care programs.	Final report containing Coordinating Committee input	Draft Report: January 2012 Final Report: February 1, 2012
15.2C: Measures for use in quality reporting for PPS-exempt Cancer Hospitals	Provide input to HHS on the identification of measures for use in performance measurement for PPS-exempt cancer hospitals.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012
15.2 D: Measures for use in quality reporting for hospice care	Provide input to HHS on the identification of measures for use in performance measurement for hospice programs and facilities.	Final report containing Coordinating Committee input	Draft Report: May 2012 Final Report: June 1, 2012

Task	Task Description	Deliverable	Timeline
15.3: Measures that address the quality issues identified for dual eligible beneficiaries	Provide input to HHS on identification of measures that address the quality issues for care provided to Medicare-Medicaid dual eligible beneficiaries.	Interim report from the Coordinating Committee containing a performance measurement framework for dual eligible beneficiaries	Draft Interim Report: September 2011 Final Interim Report: October 1, 2011
		Final report from the Coordinating Committee containing potential new performance measures to fill gaps in measurement for dual eligible beneficiaries	Draft Report: May 2012 Final Report: June 1, 2012
15.4: Measures to be used by public and private payers to reduce readmissions and healthcare-acquired conditions	Provide input to HHS on a coordination strategy for readmission and HAC measurement across public and private payers.	Final report containing Coordinating Committee input regarding a strategy for coordinating readmission and HAC measurement across payers	Draft Report: September 2011 Final Report: October 1, 2011

APPENDIX B: Measure Applications Partnership Timeline

2011				
GROUP	APR	MAY	JUN	JUL
MAP Coordinating Committee Sets charges for all workgroups and centralizes input; provides pre-rulemaking input to CMS (15.1)	Web meeting	In-person meeting: big picture planning, charge for workgroups, framework May 13 ALL MAP optional attendance at group web meeting	June 21-22 In-person meeting, clinician coordination strategy, safety input, duals input, framework	Aug 5 Web meeting
Clinician Workgroup Coordination of measures for physician performance improvement (15.2a), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		May 13 ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	June 7-8 In-person meeting, framework, strategy for coordination of physician measurement, HACs & readmissions June 30 Web meeting	July 13-14 In-person meeting to finalize strategy and themes for report on physician performance measurement
Hospital Workgroup Measures for PPS-exempt cancer hospitals (15.2c), major input on HACs & readmissions (15.4), pre-rulemaking (15.1)		May 13 ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework		
Ad Hoc Safety Workgroup HACs & readmissions (15.4)		May 13 ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	June 9-10 In-person meeting with additional panelists, consider HACs & readmissions, framework	July 11-12 In-person meeting, review other groups' work on HACs and readmissions to finalize report on HACs & readmissions
Dual Eligible Beneficiaries Workgroup Identify quality issues specific to duals and appropriate measures and measure concepts (15.3); some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		May 13 ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	June 2-3 In-person meeting to discuss duals' quality issues, HACs & readmissions, framework	July 6 Web meeting July 25-26 In-person meeting to continue discussion of quality issues, finalize preliminary themes for report
PAC/LTC Workgroup Measures and coordination for Medicare PAC programs (15.2b), measures for hospice care (15.2d), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		May 13 ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	June 28 1 day in-person meeting, consider HACs & readmissions, framework	

Future dates are subject to change

2011						
AUG	SEP	OCT	NOV	MEASURES PUBLISHED BY CMS ON DECEMBER 1	DEC	
Aug 17-18 In-person meeting, HACs and readmissions, finalize WG input for September reports, begin work on quality issues in 11 settings		Oct 19 Web mtg	Nov 1-2 In-person meeting, finalize PAC report, discuss quality issues in 11 settings			Dec 8 ALL MAP groups on web meeting to distribute measures with homework
Aug 1 Web meeting Aug 29-Sept 12 2 week public comment period for physician strategy and HACs/readmissions	Sept 30th REPORT 15.2a					Dec 8 ALL MAP groups on web meeting to distribute measures with homework Dec 12 1 day in-person meeting to react to proposed measures
			Oct 12-13 In-person meeting to discuss hospital coordination framework and finalize measures for cancer hospitals			Dec 8 ALL MAP groups on web meeting to distribute measures with homework Dec 15 In-person meeting to react to proposed measures
Aug 29-Sept 12 2 week public comment period for physician strategy and HACs/readmissions	Sept 30th REPORT 15.4					
	Sept 30th Interim REPORT 15.3	Oct 3-Oct 24 Public comment period	Nov 15 1 day in-person meeting, present public and HHS feedback, begin next phase			Dec 8 ALL groups on web meeting to distribute measures with homework Dec 16 Web meeting to react to proposed measures
	Sept 8-9 In-person meeting to discuss measures for PAC and coordination strategy		Nov 21, Nov 29, or Dec 2 30 day public comment period on PAC report and public webinar to introduce public comment on PAC report			Dec 8 ALL MAP groups on web meeting to distribute measures with homework Dec 14 In-person meeting to react to proposed measures

Future dates are subject to change

2012						
GROUP	JAN	FEB	MAR	APR	MAY	JUNE
MAP Coordinating Committee Sets charges for all workgroups and centralizes input; provides pre-rulemaking input to CMS (15.1)	Jan 5-6 In-person meeting to finalize pre-rulemaking input 1-2 week public comment period	Feb 1st REPORT 15.1 Early Feb - informational public webinar Late Feb - Web meeting	Mid March In-person meeting, finalize input on June reports			
Hospital Workgroup Measures for PPS-exempt cancer hospitals (15.2c), major input on HACs & readmissions (15.4), pre-rulemaking (15.1)				Early April Public webinar and 30 day comment period on draft report		June 1st REPORT 15.2c
Dual Eligible Beneficiaries Workgroup Identify quality issues specific to duals and appropriate measures and measure concepts (15.3); some input on HACs & readmissions (15.4), pre-rulemaking (15.1)	Late Jan Web meeting	Mid Feb In-person meeting to finalize measure concepts and themes for report		Early April Public webinar and 30 day comment period on draft duals report		June 1st REPORT 15.3
PAC/LTC Workgroup Measures and coordination for Medicare PAC programs (15.2b), measures for hospice care (15.2d), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		Feb 1st REPORT 15.2b Mid Feb Web meeting Late Feb In-person meeting to finalize measures for hospice		Early April Public webinar and 30 day comment period on draft hospice report		June 1st REPORT 15.2d

Future dates are subject to change

APPENDIX C: Approach to the Dual Eligible Beneficiaries Task

Terminology

For purposes of this interim report, a *dual eligible beneficiary* is an individual who qualifies for, and is enrolled in, health insurance through both Medicare and Medicaid. As this population receives increased attention from policymakers and other stakeholders, the term *Medicare-Medicaid enrollee* and the shorthand *Medi-Medi* are also emerging to describe these individuals. Lacking a more precise alternative, MAP refers to *dual eligible beneficiaries*, *individuals who are dually eligible*, and *duals* throughout this report to be consistent.

Note that these terms are policy-centric in order to refer to a specific group of people who qualify for a particular array of public benefits. While these benefits fundamentally influence how a dual eligible beneficiary interacts with the health system, most individuals with that status would not readily identify themselves as duals. Furthermore, providers of care and supports may not be aware of individuals' status as dually eligible or the associated implications for service delivery. MAP considered quality measurement for dual eligible beneficiaries specifically, but some findings could be generalized to similar Medicare- or Medicaid-only populations with characteristics such as low income, complex chronic conditions, disability, and advanced age.

MAP also chose other terms purposefully. For example, this report uses the phrase *person-centered care* (or *person- and family-centered care*) instead of *patient-centered care* because many long-term supports and services do not fit the medical model implied by the word *patient*. In addition, MAP refers to an *interprofessional care team* versus a *multi-disciplinary care team* to align with the Health Resources and Services Administration's terminology for that topic.¹⁹

Roster for the MAP Dual Eligible Beneficiaries Workgroup

CHAIR (VOTING)	
Alice Lind, MPH, BSN	
ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
Better Health Greater Cleveland	Patrick Murray, MD, MS
Center for Medicare Advocacy	Patricia Nemore, JD
National Health Law Program	Leonardo Cuello, JD
Humana, Inc.	Thomas James, III, MD
L.A. Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National PACE Association	Adam Burrows, MD
EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Substance Abuse	Mady Chalk, MSW, PhD
Emergency Medical Services	James Dunford, MD
Disability	Lawrence Gottlieb, MD, MPP
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN
FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Medicare-Medicaid Coordination Office	Cheryl Powell
Health Resources and Services Administration	Samantha Wallack Mekliir, MPP
HHS Office on Disability	Henry Claypool
Substance Abuse and Mental Health Services Administration	Rita Vandivort-Warren, MSW
Veterans Health Administration	Daniel Kivlahan, PhD
MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)	
George Isham, MD, MS	
Elizabeth McGlynn, PhD, MPP	

Roster for the MAP Coordinating Committee

CO-CHAIRS (VOTING)	
George Isham, MD, MS	
Elizabeth McGlynn, PhD, MPP	
ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Judith Cahill
AdvaMed	Michael Mussallem
AFL-CIO	Gerald Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Steven Findlay, MPH
Federation of American Hospitals	Chip N. Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Association of Medicaid Directors	Foster Gesten, MD
National Partnership for Women and Families	Christine Bechtel, MA
Pacific Business Group on Health	William Kramer, MBA
EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Joseph Betancourt, MD, MPH
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD MSc
Health Resources and Services Administration (HRSA)	Victor Freeman, MD, MPP
Office of Personnel Management/FEHBP (OPM)	John O'Brien
Office of the National Coordinator for HIT (ONC)	Joshua Seidman
ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
American Board of Medical Specialties	Christine Cassel, MD
National Committee for Quality Assurance	Peggy O'Kane, MPH
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

Background Materials from Dual Eligible Beneficiaries Workgroup Meetings

As part of the National Quality Forum's commitment to transparency, all materials related to the deliberations of the MAP Dual Eligible Beneficiaries Workgroup are available online at www.qualityforum.org/Setting_Priorities/Partnership/Dual_Eligible_Beneficiaries_Workgroup.aspx

All-MAP Orientation Web Meeting

The Coordinating Committee and all the advisory workgroups met via web meeting to introduce the workgroups to the MAP project, build understanding of the workgroup charges, and review the issues related to patient safety.

- Agenda
- PowerPoint Slides
- Meeting Materials
- Online Archive
- Meeting Summary

In-Person Meeting of Dual Eligible Beneficiaries Workgroup: June 2-3, 2011

The Dual Eligible Beneficiaries Workgroup met in person to discuss and prioritize quality issues unique to the population to form the basis for its strategic approach to performance measurement. The workgroup also provided input on patient safety issues specific to dual eligible beneficiaries.

- Agenda
- PowerPoint Slides
- Meeting Materials
- Meeting Summary

Web Meeting of Dual Eligible Beneficiaries Workgroup: July 6, 2011

The Dual Eligible Beneficiaries workgroup met via web meeting to discuss the Coordinating Committee's feedback on its initial progress and MAP's working measure selection criteria, and to refine the strategic approach to performance measurement.

- Agenda
- PowerPoint Slides
- Online Archive
- Meeting Summary

In-Person Meeting of Dual Eligible Beneficiaries Workgroup: July 25-26, 2011

The Dual Eligible Beneficiaries Workgroup met in person to further refine its strategic approach to performance measurement and discuss potential measures. Representatives from across HHS gave presentations and participated in discussion.

- Agenda
- PowerPoint Slides
- Meeting Materials
- Meeting Summary

APPENDIX D: Characterizing the Dual Eligible Population

An accurate understanding of the unique characteristics of the dual eligible population is fundamental to designing an appropriate approach to measurement. MAP examined a range of data and drew upon the wealth of expertise offered by the stakeholder groups to elicit the population's most relevant features. Discussion highlighted the heterogeneity of the population, the particularly intense service needs and vulnerabilities of some subgroups, and the fragmented nature of healthcare and supportive services they receive.

About 9 million people are dually eligible for and enrolled in both the Medicare and Medicaid programs.²⁰ Low-income seniors make up two-thirds of the dual eligible population, and people with disabilities under age 65 account for the remaining third.²¹ The proportion of dual eligible beneficiaries varies across the states due to factors such as Medicaid eligibility criteria and overall demographics. The state of Maine has the highest share of Medicare beneficiaries who are dually eligible (36 percent, compared to a nationwide average of 21 percent).²² California is home to the most dually eligible beneficiaries (1.2 million individuals in 2007) and Wyoming the fewest (9,800 individuals in 2007).²³

The dual eligible beneficiary population includes many of the poorest and sickest individuals covered by either Medicare or Medicaid. Most duals qualify for Supplemental Security Income (SSI) benefits, which require them to have low incomes, limited assets, and a significant disability that impairs their ability to work at a substantial gainful level.²⁴ More than half of dual eligible beneficiaries have incomes below the poverty line, compared with just 8 percent of non-dual Medicare beneficiaries.²⁵ Such low socioeconomic status (SES) limits one's ability to meet basic needs for food and shelter, which in turn influences health status. Health disparities also may be magnified for the 42 percent of duals who are members of a racial or ethnic minority group.²⁶

Some dually eligible beneficiaries have a significant burden of illness. More than 60 percent of dual eligible beneficiaries have three or more multiple chronic conditions (MCCs), with the most common being cardiovascular disease, diabetes, Alzheimer's and related disorders, rheumatoid arthritis or osteoarthritis, and depression.²⁷ In addition, more than three out of five duals are affected by a mental or cognitive impairment.²⁸ Duals are also more likely than others on Medicare to have less than a high school education, to live in an institution, and to require assistance with activities of daily living (ADLs) such as eating and bathing.²⁹

Duals' health and long-term care benefits are split across Medicare and Medicaid, neither of which bears full responsibility or accountability for the delivery of care. Medicare is the primary payer, covering medical care such as hospital, physician, diagnostic tests, post-acute and other services, and prescription drugs.³⁰ For the majority of duals, Medicaid provides assistance with Medicare premiums and cost-sharing while also paying for services that are not covered by Medicare, most notably, long-term care.³¹ The programs were created separately and for different purposes, leaving beneficiaries, providers, health plans, and other stakeholders struggling to navigate differing rules, provider networks, and benefit structures. These misalignments can complicate care coordination, lead to cost-shifting, and severely undermine the quality of care.

Fragmentation of care often compounds the health needs of dual eligible beneficiaries, contributing to overall costs that are roughly five times greater than those incurred for other Medicare beneficiaries.³² Per capita spending averaged more than \$20,000 per dually eligible individual in 2005, for a total of nearly \$200 billion.³³ Spending on duals is disproportionately high in both programs. Duals comprise 15 percent of Medicaid enrollees but 39 percent of total Medicaid spending, and 21 percent of Medicare enrollees but 36 percent of total Medicare expenditures.³⁴ In particular, states' budgets are heavily burdened by the large and growing volume of long-term care spending in Medicaid.

Overall statistics on the dual eligible population are of limited use, however, as the group is highly heterogeneous and better thought of as a collection of distinct subgroups. In its June 2010 *Report to the Congress*, the Medicare Payment Advisory Commission wrote:

Within the dual-eligible population, there are distinct groups of beneficiaries with widely different care needs. They vary considerably in the prevalence of chronic conditions, their physical and cognitive impairments, and whether they are institutionalized. Many have multiple chronic conditions that make care coordination especially important. Other duals have no or one physical impairment and no chronic conditions. Reflecting this wide range in care needs, spending varies by a factor of four according to physical and cognitive impairment. Likewise, spending on specific types of services differs by subgroup, with some having higher spending on nursing home or hospital services than others.

In many ways, the expensive and uncoordinated healthcare and supportive services delivered to dual eligible beneficiaries exemplify the challenges faced by the American health system as a whole. However, the implementation of ACA and the creation of the Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare & Medicaid Services (CMS) present unprecedented opportunities to align federal and state policies more purposefully around the care of the dual eligible population. The goals of the MMCO include more effectively integrating Medicare and Medicaid benefits, eliminating cost-shifting between Medicare and Medicaid, and improving access, quality of care, and beneficiaries' experience of care.³⁵

APPENDIX E: Current Performance Measurement Landscape

One of the challenges before MAP is to identify measures that can appropriately provide an assessment of the quality of care administered to the dual eligible beneficiary population. Current Medicare and Medicaid measurement activities include dual eligible beneficiaries, but the population has not yet been stratified or separately evaluated in a systematic fashion. MAP examined the current landscape of activities to inform its work, focusing on the programs and settings of particular importance to dual eligible beneficiaries.

Existing Medicare Measurement

The Medicare program currently employs quality measures for most settings of care: inpatient hospital care, outpatient hospital care, ambulatory care, dialysis facilities, nursing homes, home health care, and the community. Quality also is monitored at the clinician level and at the health plan level for Medicare Advantage, Special Needs Plans (SNPs), and Part D plans. As of July 2011, 597 total measures were in use. The Affordable Care Act (ACA) also requires the Department of Health and Human Services (HHS) to undertake new activities related to quality monitoring and improvement, such as developing outcome measures, improving the Physician Quality Reporting System, and launching quality reporting in five new settings (e.g., hospice, PPS-exempt cancer hospitals). The experience of dual eligible beneficiaries already is captured in each of the established programs, but it is not assessed separately from the general Medicare population. Of note, SNP participation in quality reporting programs for Medicare Advantage is complicated by the complexity of their patient populations, and the current measures do not necessarily speak to the unique care experience of duals.

Existing Medicaid Measurement

Because the Medicaid program is a federal-state partnership, states administer Medicaid quality monitoring and improvement activities differently. Efforts to measure the quality of some Medicaid program features at the national level are being developed but are not yet complete.

Medicaid Adult Core Measures

ACA requires HHS to identify and publish a list of core quality measures for the adult Medicaid population. The measures are intended for voluntary use by state Medicaid programs as well as health plans and providers serving Medicaid members. Desired attributes of the core set included being reflective of issues that are high priorities for the population, providing state-level information for public reporting, revealing opportunities for quality improvement, applying to all insurance categories, being parsimonious, and fulfilling other regulatory requirements where possible.

Working with experts in an iterative process, a subcommittee of the National Advisory Council of the Agency for Healthcare Research and Quality (AHRQ) selected the draft measures. HHS published a draft list of 51 measures for the initial core set in the Federal Register on December 30, 2010. MAP specifically discussed the draft list to identify the measures that had particular importance for the dual eligible population. MAP suggests that states report the measures related to alcohol misuse, hospital readmissions, follow-up after hospitalization for mental illness,

management of schizophrenia, and patient experience of care in a manner that would allow for identification of dual eligible beneficiaries. The adult core measure set is expected to be finalized by January 1, 2012, and will continue to inform the second phase of the MAP work.

Medicaid HCBS Measures

A portion of dual eligible beneficiaries receive home- and community-based services through Medicaid. These services are increasingly costly to states yet critical for enabling individuals to remain independent and living in the community instead of an institutional setting of care. The Deficit Reduction Act of 2005 specified a series of activities for AHRQ related to quality in the domains of program performance, client functioning, and client satisfaction within Medicaid-funded HCBS.

AHRQ began with an environmental scan of existing Medicaid HCBS measures that identified more than 300 measure sets.³⁶ The scan found that valid and tested measures exist across a wide range of measure domains, but also that many measures the states submitted as a part of the scan lacked rigorous testing. The scan also concluded that national measures do not yet exist, and it is not possible to compare across states or across HCBS subpopulations. AHRQ and CMS are currently developing further capacity to measure the quality of HCBS provided by states.

Other stakeholders are actively working on measuring Medicaid services and supports. Recently, AARP's Public Policy Institute, The Commonwealth Fund, and the SCAN Foundation developed and jointly released the State Long-Term Services and Supports (LTSS) Scorecard. "The Scorecard examines state performance across four key dimensions of LTSS system performance: (1) affordability and access, (2) choice of setting and provider, (3) quality of life and quality of care, and (4) support for family caregivers. It is designed to help states improve the performance of their LTSS systems. It also underscores the need for states to develop better measures of performance over a broader range of services and collect data to more comprehensively assess the adequacy of their LTSS systems."³⁷

Existing Integrated Models

Fully integrated models of care combine financing and care coordination to manage both Medicare and Medicaid services for dual eligible beneficiaries. If provider networks are comprehensive enough to address the unique needs of the population, integrated care has the potential to offer enrollees enhanced, person-centered, and coordinated services. Case management, individualized care plans, assistance with accessing community services, and care transition services are intended to lower total program costs by averting hospitalizations, institutional placements, incidents of medication mismanagement, and duplicative care.³⁸ Furthermore, integrated models have the advantage of being able to access Medicare and Medicaid information needed to calculate performance measures and are therefore best positioned to implement the strategic approach MAP suggested.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a provider-based model of integrated care. Nationally, 76 PACE organizations serve 22,000 participants in 30 states. Under a capitation

arrangement with Medicare and Medicaid, PACE organizations are responsible, and at full risk, for providing all medically necessary care and services to the individuals they serve, including all nursing home costs.³⁹ Working under a team approach, PACE organizations have the most flexibility of any publicly funded program to deliver a range of services and supports that assist older adults in maintaining independence.

PACE programs currently report two levels of basic quality information to CMS for program monitoring purposes. In addition, the National PACE Association is leading its member organizations in the development of model practices for primary care and outcome measures tailored to the vulnerable elderly population they serve. The model practices are based on existing clinical guidelines and stratified by three types of care goals: longevity, function, and palliative. The outcome measures effort will identify existing measures relevant to the PACE population; establish clear definitions, inclusion/exclusion criteria, and benchmarks; and select a common data set. If successful, the emerging quality measurement efforts within PACE can provide insights on how to capture nontraditional domains of quality, such as patient-centered goals, self-determination, social connection, and benefits to caregivers.

Integrated Special Needs Plans

Under state SNP integrated plans, a managed care organization receives capitated payments from both Medicare and Medicaid. The plans are then responsible for establishing provider networks and delivering services and supports that include care coordination or case management.⁴⁰ An estimated 120,000 dual eligible beneficiaries are enrolled in programs that fully integrate Medicare and Medicaid services. Each varies in its eligibility requirements, enrollment, covered services, and risk structures.⁴¹

Current quality measurement activities are focused on applying HEDIS and Structure and Process Measures established by the National Committee for Quality Assurance (NCQA). These measure sets continue to evolve. NCQA is developing new HEDIS measures to address plan all-cause readmissions and potentially avoidable hospitalizations. As the structure and process measures evolve, NCQA will focus on evidence of policy implementation, procedures, processes and programs, and use of systems.⁴² MAP considered challenges in SNP measurement, including mismatches between measures and population needs, mismatches between benchmarks and populations, and measures not being person-centered.

APPENDIX F: Related Data Efforts

Many efforts related to data exchange, aggregation, and analysis are in progress and can potentially offer insights to the ongoing process of developing a data platform for dual eligible beneficiaries. For example, there has been notable progress in several states in creating public/private payer databases. Other initiatives include:

Better Quality Information to Improve Care for Medicare Beneficiaries (BQI) Pilot: In 2006, CMS funded a Quality Improvement Organization (QIO) special project known as the Better Quality Information to Improve Care for Medicare Beneficiaries (BQI) pilot. This effort supported six regional pilot sites to test methods to aggregate Medicare A, B, and D claims data with claims data from commercial health plans, and in some cases Medicaid data, in order to calculate and report quality measures for physicians.⁴³ Though lack of uniform data standards reportedly made aggregation difficult, all sites successfully used Medicare fee-for-service data, four out of six included some Medicaid data, but only the Minnesota site included information on dual eligible beneficiaries.⁴⁴

National Information Exchange Model (NIEM): With its origins in the justice system, the National Information Exchange Model (NIEM) was launched in 2005 to bring together all levels of government to develop and deploy a national model for information sharing and the organizational structure to govern it.⁴⁵ NIEM currently includes 12 data domains and is poised to expand into the areas of health and human services, among others. When complete and more widely adopted, and with the proper privacy and confidentiality protections in place, NIEM could interface with health information exchanges to provide extremely rich information about difficult-to-measure dual eligible beneficiaries.

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