MEASURE APPLICATIONS PARTNERSHIP

CONVENED BY THE NATIONAL QUALITY FORUM

MEETING MATERIALS

for

IN-PERSON MEETING OF THE DUAL ELIGIBLE BENEFICIARIES WORKGROUP

JUNE 2 -3, 2011

CHAPTER 5

Coordinating the care of dual-eligible beneficiaries

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Chapter summary

Dual-eligible beneficiaries (those enrolled in both Medicare and Medicaid) have higher medical expenses than other beneficiaries. While they make up disproportionate shares of Medicare and Medicaid spending relative to their enrollment, neither program assumes full responsibility for coordinating all of their care. The Medicare and Medicaid programs often work at cross-purposes in ways that impede the coordination of care for dual-eligible beneficiaries. Conflicting program incentives encourage providers to avoid costs rather than coordinate care, and poor coordination can raise spending and lower quality.

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. Care coordination activities, and the need for them, should reflect these differences, tailoring specific activities to each beneficiary.

In this chapter

- Characteristics of dual-eligible beneficiaries
- Conflicting incentives of Medicare and Medicaid
- Approaches to integrate the care of dual-eligible beneficiaries
- Challenges to expanding enrollment in integrated care
- Concluding observations

Improving the care for dual-eligible beneficiaries requires two fundamental changes in financing and delivering care to them. First, the financing streams need to be more integrated so that the current conflicting incentives between Medicaid and Medicare no longer undermine care coordination. Second, an integrated approach to care delivery is needed to ensure quality care for this complex population. An integrated approach could involve a single entity at financial risk for the care furnished to beneficiaries with the responsibility for coordination of all care furnished to dual-eligible beneficiaries.

In integrated approaches, beneficiaries are regularly assessed for their risk for hospitalization or institutionalization and a multidisciplinary team manages a beneficiary's care according to an individualized care plan. Entities that furnish integrated care need to be evaluated by using outcome measures such as risk-adjusted per capita costs, potentially avoidable hospitalization rates, rates of institutionalization, and emergency room use. In addition, condition-specific quality measures and indicators that reflect the level and success of care integration need to be gathered so that the success of care integration for different subgroups of duals can be assessed.

Two approaches currently in use—managed care programs implemented through Medicare Advantage special needs plans that contract with states and the Program of All-Inclusive Care for the Elderly—offer more fully integrated care. These programs combine funding streams so that the conflicting financial incentives of Medicare and Medicaid are mitigated. Entities are also at full financial risk for all (or most) services, including long-term care, and provide care management services. Given the diversity of the care needs of the dual-eligible population, a common approach to full integration and care coordination may not be best suited for all beneficiaries.

While integrated approaches have the potential to be successful, they are few in number and enrollment in some programs is low. Numerous challenges inhibit expanding their numbers and enrollment. Challenges include a lack of experience managing long-term care, stakeholder resistance (from beneficiaries and their advocates, and from providers), the costly initial program investments and uncertain financial viability, and the separate Medicare and Medicaid administrative rules and procedures. Also, by statute Medicare beneficiaries must have the freedom to choose their providers and cannot be required to enroll in a health plan that could integrate care. However, several states have successfully implemented fully integrated care programs, illustrating that it is possible to overcome these obstacles. ■

Dual-eligible beneficiaries (those enrolled in both Medicare and Medicaid) have, on average, higher medical expenses than other beneficiaries and the care they receive is likely to be uncoordinated. They make up 16 percent of Medicare's enrollment but one-quarter of its spending (Medicare Payment Advisory Commission 2009a). On the Medicaid side, they make up 18 percent of Medicaid enrollment but almost half (46 percent) of its spending (Lyons and O'Malley 2009). However, there are distinct groups of beneficiaries with widely different care needs. Given the multiple chronic conditions of many dual-eligible beneficiaries, care coordination is paramount but often lacking.

The Medicare and Medicaid programs often work at cross-purposes in ways that impede the coordination of care for dual-eligible beneficiaries. Conflicting program incentives in Medicare and Medicaid encourage providers to avoid costs rather than coordinate care, and poor coordination can raise total federal spending and lower quality. Neither program assumes full responsibility for coordinating the care furnished to dual-eligible beneficiaries.

This chapter describes the dual-eligible beneficiaries and spending on them. It then describes examples of fully integrated programs in which an entity receives revenue from Medicaid and Medicare, assumes full (or most of the) financial risk for the enrollees, and manages all the services furnished to them. It discusses performance measures that would be relevant to the dual-eligible population, which are particularly important if enrollment in integrated plans is to expand.

The chapter discusses approaches being used to coordinate the care for dual-eligible beneficiaries—Medicare Advantage (MA) special needs plans (SNPs) that contract with the state Medicaid agencies to provide integrated managed care programs, and the Program of All-Inclusive Care for the Elderly (PACE). These programs make two fundamental changes to the financing and delivery of care to dual-eligible beneficiaries. First, entities are at financial risk for all (or most) of the care furnished to duals, so that the current conflicting incentives no longer undermine care coordination. Second, a single entity takes responsibility for care coordination. Few beneficiaries are enrolled in these programs and the last section discusses the challenges to expanding their enrollment.

Background

Dual-eligible beneficiaries are people who receive health care coverage through both Medicare and Medicaid. In 2005, approximately 16 percent of Medicare beneficiaries were also enrolled in Medicaid. Of these dual-eligible beneficiaries, almost two-thirds were aged 65 or older and one-third were disabled and under age 65 (Medicare Payment Advisory Commission 2008). Many beneficiaries who would otherwise qualify for Medicaid do not enroll in the program.[1] Most dual-eligible beneficiaries remain eligible for state coverage over time because they typically do not experience large changes in assets or income. About 5 percent of dual-eligible beneficiaries lose their eligibility each year; about 40 percent of them reenroll within a year (Stuart and Singhal 2006).

Within the dual-eligible population, there are different levels of assistance through what are called Medicare Savings Programs. Most "duals" (almost 80 percent) qualify for full Medicaid benefits, including long-term care (often referred to as "full benefit duals"). Medicaid also pays their Medicare premiums and cost-sharing expenses. Medicare beneficiaries with higher incomes (often referred to as "partial duals") do not receive Medicaid benefits other than assistance with Medicare premiums and cost sharing.[2]

Medicare is considered the primary payer for dual-eligible beneficiaries and pays for all Medicare-covered services (such as hospital and physician services; see Table 5-1, p. 132). For Medicaid, all states are required to cover certain services, including nursing home care, Medicare cost sharing (the Part A and Part B deductibles, the Part B premiums, and the Part B coinsurance), coverage for inpatient hospital and skilled nursing facility services when Part A coverage is exhausted, and home health care for those dual-eligible beneficiaries who would otherwise qualify for nursing home services. States have the option to cover other services—such as dental, vision, and hearing; home- and community-based services; personal care services; and home health care (for those duals who do not qualify as needing nursing home services). Not surprisingly, there is considerable variation across states in the services covered and in eligibility rules, resulting in different benefits for duals, depending on where they live. States can cap their payments for Part B cost sharing to what they would pay for the service if the beneficiary had only Medicaid coverage.[3] As a result, most states do

TABLE 5–1

Services paid for by Medicare and Medicaid for dual-eligible beneficiaries

Medicare	Medicaid
• Acute care (hospital) services • Outpatient, physician, and other supplier services • Skilled nursing facility services • Home health care • Dialysis • Prescription drugs • Durable medical equipment • Hospice	• Medicare cost sharing (Part A and Part B deductibles, Part B premiums and coinsurance) • Coverage for hospital and skilled nursing facility services if Part A benefits are exhausted • A portion of the cost of prescription drugs • Nursing home care • Home health care not covered by Medicare when the beneficiary qualifies as needing nursing home care • Transportation to medical appointments • Optional services: dental, vision, hearing, home- and community-based services, personal care, and home health care (when the beneficiary does not qualify for Medicare and does not need nursing home care) • Durable medical equipment not covered by Medicare

not, in effect, pay for cost-sharing expenses (Mitchell and Haber 2004).

Over the last three decades, programs delivering home- and community-based services (HCBS) such as home health care and personal care have become an attractive alternative to institutional care for persons who require long-term care. Between 1995 and 2007, Medicaid spending on HCBS as a percentage of its total long-term care obligations has more than doubled from 19 percent to 41 percent (Kaiser Family Foundation 2009b). Demand is high because many beneficiaries prefer to remain at home and receive support services that allow them to avoid being institutionalized. States fund such programs because they believe the services will reduce facility-based expenditures on long-term care, which is the single largest spending item for Medicaid, constituting a third of its total spending (Kaiser Family Foundation 2009a). Differences in state policies to fund these services contribute to the considerable variation in average per capita HCBS spending. In 2006, per capita spending on HCBS ranged from $5,407 in Texas to $33,862 in Rhode Island (Kaiser Family Foundation 2009b).

Although Medicaid is a state-run program, there is considerable federal support. The federal government contributes to each state's Medicaid program based on a formula that yields higher matching funds for poorer states. The average "match rate" is 57 percent, but it ranges from 50 to 76 percent. To provide short-term fiscal relief to states, the Congress included a provision in the American Recovery and Reinvestment Act of 2009 that temporarily (through 2010) raised the minimum match rate to 65 percent and the maximum to 83 percent (Department of Health and Human Services 2009).

Characteristics of dual-eligible beneficiaries

On average, dual-eligible beneficiaries differ from other beneficiaries. They are more likely to be young and disabled and to have multiple chronic conditions. But the dual-eligible population is not homogeneous. Duals differ considerably in their physical and cognitive impairments, their abilities to perform activities of daily living, and whether they are institutionalized. Some duals have multiple chronic conditions that will raise their spending year after year. Others—the essentially well duals—have minimal care needs. These factors will shape the amount and type of services that need to be coordinated and the opportunities and benefits of integration.

Dual-eligible beneficiaries differ from other beneficiaries

To qualify for Medicaid, dual-eligible beneficiaries must have low incomes. More than half of duals have incomes below the poverty line (in 2006, poverty was defined as $10,294 for an individual and $13,167 for married couples) compared with 8 percent of non-dual-eligible beneficiaries. Their poverty shapes their basic living needs. If they have inadequate housing or cannot afford heat and food, they cannot focus on and manage their health care

TABLE 5–2

Demographic differences between dual-eligible beneficiaries and non-dual-eligible beneficiaries

	Percent of beneficiaries	
Characteristic	**Dual eligible**	**Non-dual eligible**
Disabled	41%	11%
Report poor health status	20	7
Race		
White, non-Hispanic	58	82
African American	18	7
Hispanic	15	6
Other	9	4
Limitations in ADLs		
No ADLs	49	71
1–2 ADLs	23	19
3–6 ADLs	29	10
Living arrangement		
In an institution	19	3
With a spouse	17	55
Education		
No high school diploma	54	22
High school diploma only	24	31
Some college or more	18	45

Note: ADLs (activities of daily living). Totals may not sum to 100 percent due to rounding and the exclusion of an "other"category.

Source MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2006.

needs. For example, the lack of adequate heating can delay recovery from illness.

Compared with other Medicare beneficiaries, dual-eligible beneficiaries are, on average, more likely to be young and disabled, report poor health status, and be a member of a racial or ethnic minority group (Table 5-2). Dual-eligible beneficiaries are almost three times more likely than other beneficiaries to have three or more limitations in their activities of daily living (such as dressing, bathing, and eating), with 29 percent reporting this level of physical impairment. Dual-eligible beneficiaries are more than six times more likely to be living in an institution, with 19 percent living in one compared with 3 percent of other beneficiaries. Compared with other beneficiaries, duals are much less likely to live with a spouse. More than half of dual-eligible beneficiaries did not complete high school, compared with fewer than one-quarter of other beneficiaries.

The disabled group make up about one-third of dual-eligible beneficiaries. Among them, 44 percent are mentally ill, one-third have one or no physical impairment, and 18 percent are developmentally disabled (Table 5-3). A small share have dementia, reflecting their younger age.

The group of beneficiaries entitled based on their age make up about two-thirds of dual-eligible beneficiaries. Among them, more than half have one or no physical impairment, 26 percent are mentally ill, and 16 percent have dementia. A small fraction of the aged dual-eligible beneficiaries have two or more physical impairments.

Beneficiaries in these impairment groups vary considerably in what share are institutionalized, which will have a large impact on per capita spending. High proportions of aged duals with dementia or with at least two physical impairments are institutionalized (Figure 5-1, p. 134).[4] But only a small fraction (2 percent) of those with no or one physical impairment are institutionalized. The rates of institutionalization among the other groups—the mentally ill, the developmentally disabled, and the disabled with

TABLE 5–3

Physical and cognitive impairments vary considerably among dual-eligible beneficiaries

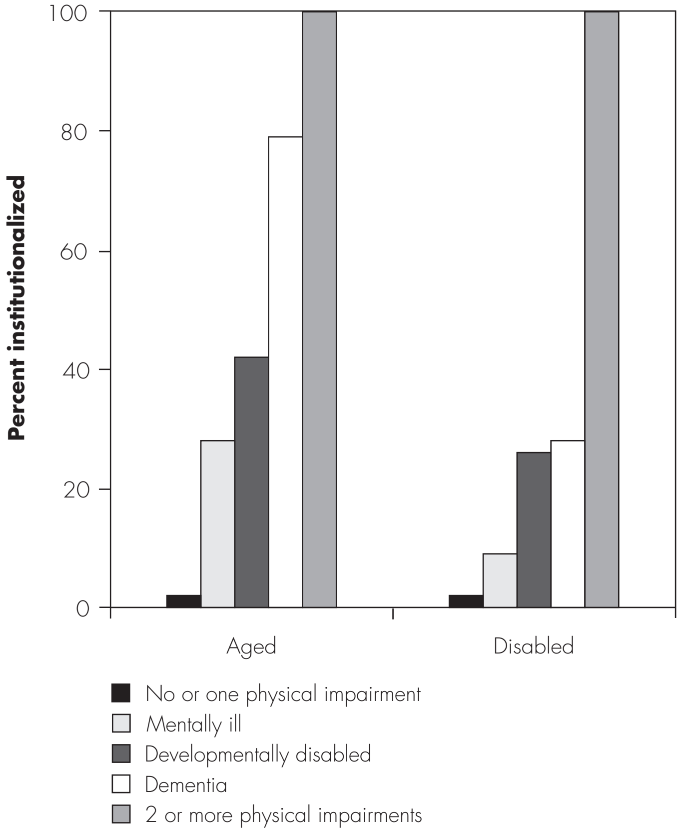
Dual-eligible group	Aged	Disabled
Mentally ill	26%	44%
Dementia	16	3
Developmentally disabled	2	18
One or no physical impairments	54	33
Two or more physical impairments	3	3

Note: Beneficiaries were grouped into the "aged" and "disabled" groups based on how they qualified for Medicare coverage. The grouping uses a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Beneficiaries are then assigned to a cognitive impairment group and, if none, are assigned to a physical impairment group (a beneficiary with both would be assigned to a cognitive impairment group). Physical impairment refers to a limitation to perform activities of daily living such as bathing, dressing, or eating. Beneficiaries with end-stage renal disease were excluded.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2004–2006.

FIGURE 5–1

Rate of institutionalization varies by group of dual-eligible beneficiaries



Note: Beneficiaries were grouped into the "aged" and "disabled" groups based on how they qualified for Medicare coverage. The grouping uses a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Beneficiaries are then assigned to a cognitive impairment group and, if none, are assigned to a physical impairment group (a beneficiary with both would be assigned to a cognitive impairment group). Physical impairment refers to a limitation to perform activities of daily living such as bathing, dressing, or eating. Beneficiaries with end-stage renal disease were excluded.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2004–2006.

dementia—are more variable, ranging from 9 percent to 42 percent. In general, aged duals are more likely to be institutionalized than disabled duals.

Using CMS's chronic conditions warehouse data, we found that many dual-eligible beneficiaries have three or more chronic conditions—41 percent of duals who do not have end-stage renal disease (ESRD) and 74 percent of those who do. The most common chronic conditions include cardiovascular, diabetes, Alzheimer's and related disorders, rheumatoid arthritis or osteoarthritis, and depression (Mathematica Policy Research 2010).

The frequency of chronic conditions varied considerably among the disabled and the aged groups (Table 5-4). More than one-quarter of the aged dual-eligible beneficiaries had the five most frequent chronic conditions—ischemic heart disease, heart failure, Alzheimer's and related conditions, diabetes, and rheumatoid arthritis or osteoarthritis. Except for diabetes, many fewer of the under 65 and disabled dual-eligible population had these conditions. For example, only 17 percent had ischemic heart disease, compared with 43 percent of the aged dual-eligible beneficiaries. Among those under 65 and disabled, only two conditions—depression and diabetes—were as prevalent (at least 20 percent of duals had the condition). It is likely that the under 65 and disabled population has other conditions not included in the Chronic Conditions Warehouse (CCW), such as schizophrenia, other psychosis, serious neurosis, and substance abuse, which are not captured in the data. The vast majority of dual-eligible beneficiaries admitted to inpatient psychiatric hospitals had a diagnosis of psychosis (see Chapter 6). The unreported conditions will understate the prevalence of mental illness among duals.

TABLE 5–4

Five most frequent chronic conditions vary among the aged and the under 65 and disabled dual-eligible beneficiaries

	Percent of group with the condition	
Chronic condition	**Aged**	**Under 65 and disabled**
Alzheimer's and related conditions	30%	5%
Chronic obstructive pulmonary disease	18	10
Depression	18	28
Diabetes	36	23
Heart failure	33	11
Ischemic heart disease	43	17
Rheumatoid arthritis/osteoarthritis	31	13

Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

Duals also vary in the number of chronic conditions they have (Figure 5-2). While 19 percent had five or more chronic conditions, a large share (38 percent) had none or one. Half of the 22 percent with dementia also had four other chronic conditions.

Dual-eligible beneficiaries' health status characteristics—whether they are aged or disabled, their physical and cognitive impairments, and their chronic conditions—shape the amount of care coordination they require, the mix of providers serving them, and their inclination and ability to seek timely care. Those with minimal physical impairments are likely to require much less support than dual-eligible beneficiaries with serious impairments. Care needs will also vary according to the chronic condition. Beneficiaries with conditions particularly at risk for hospitalization, such as heart failure and chronic obstructive pulmonary disease, should be closely monitored to avert unnecessary hospitalization. Beneficiaries who live alone are at risk for institutionalization, which HCBS may be able to delay or avoid.

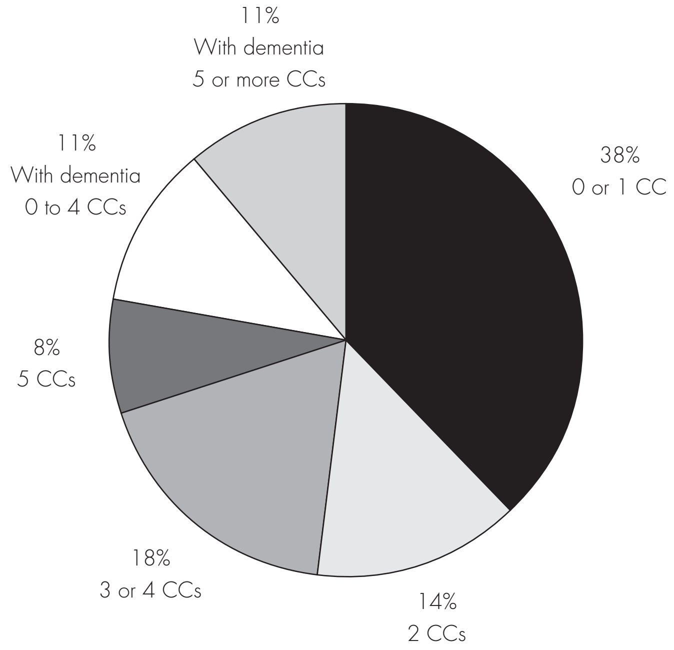
Mentally ill and cognitively impaired dual-eligible beneficiaries are typically limited in their abilities to understand instructions and adhere to them. In addition, although mental health care providers often serve as the central health care resource for mentally ill beneficiaries, they may not routinely screen their patients for general health problems or adequately monitor health effects of medications that are frequently prescribed. Furthermore, the network of mental health care providers treating a dual-eligible beneficiary is often separate from that furnishing general health care, requiring mentally ill duals to navigate yet another system of care. This landscape should shape care coordination activities for this group of dual-eligible beneficiaries.

Per capita spending on dual-eligible beneficiaries varies by subgroup

The variation in health status, cognitive and physical impairments, and living arrangements across dual-eligible beneficiaries is reflected in the large differences in per capita spending across these beneficiaries' subgroups. A large factor is whether the beneficiary is institutionalized, which affects Medicaid spending and combined program spending. Chronic conditions also contribute to higher spending levels, particularly for patients with dementia, as do cognitive and physical impairments.[5]

FIGURE 5–2

Number of chronic conditions and presence of dementia vary considerably among dual-eligible beneficiaries



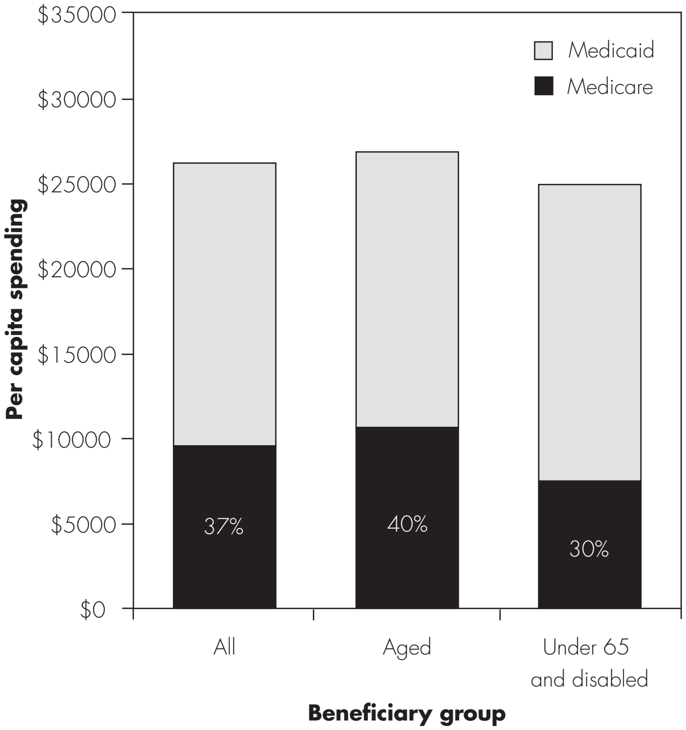
Note: CC (chronic condition). The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

Medicaid and Medicare per capita spending on dual-eligible beneficiaries totaled $26,185 in 2005, with Medicare spending accounting for 37 percent of the total (Figure 5-3, p. 136). Combined per capita spending was slightly higher (3 percent) than average for the aged dual-eligible beneficiaries, while per capita spending for the under 65 and disabled was 5 percent less than the average. Medicare's share of the combined varied from 30 percent (under 65 and disabled) to 40 percent (aged), largely reflecting the share of beneficiaries receiving Medicaid-financed long-term care and prescription drugs. These data predate the implementation of Medicare's drug benefit, so prescription drug spending is included in Medicaid's spending.

FIGURE 5–3

Medicare and Medicaid per capita spending on dual-eligible beneficiaries in 2005



Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans. Spending on prescription drugs is included in Medicaid spending (the data predate Part D). Percents are Medicare share of combined spending.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

Per capita spending varies by nursing home use

The differences in per capita spending for the aged and the under 65 and disabled groups of dual-eligible beneficiaries were more pronounced once we controlled for nursing home use (Table 5-5). For duals with no nursing home spending (i.e., living in the community), combined Medicare and Medicaid per capita spending for the under 65 and disabled was one-third higher ($22,530) than that for the aged ($16,916). For duals with the highest nursing home spending (those in the 20th percentile of nursing home spending), the difference between the groups was smaller. Combined per capita spending was 13 percent higher for the under 65 and disabled group ($84,339) than the spending for the aged group ($74,439).

Nursing home use has a large impact on total combined spending. Combined per capita spending for dual-eligible beneficiaries with the highest per capita nursing home spending was about four times that of duals with no nursing home spending.

Impact of chronic conditions on per capita spending

Considerable differences in combined per capita spending also exist by category of chronic condition (Table 5-6 and online Appendix 5-A, available at http://www.medpac.gov). Among the most frequent conditions, combined per capita spending ranged from 20 percent higher than average for dual-eligible beneficiaries with diabetes or with rheumatoid arthritis or osteoarthritis to 80 percent higher than average for duals with Alzheimer's disease and related conditions. Per capita spending for duals with five or more chronic conditions was almost double the per capita spending for all duals. Because beneficiaries can have more than one chronic condition, the differences reported here are not the additional spending associated with the condition alone. For example, many beneficiaries in the diabetes group have other chronic conditions that raise program spending. Twenty percent of duals had none of the chronic conditions recorded in the CCW.

Dementia plays a key role in per capita spending differences. Across the most prevalent chronic conditions, combined per capita spending for dual-eligible beneficiaries with dementia was 30 percent to 60 percent higher than for duals without it.

Spending also varied considerably by the number of chronic conditions the beneficiary had (Figure 5-4, p. 138). Combined per capita spending for duals with one chronic condition was just over $16,000 but with dementia it increased to more than $31,000. Spending for duals with five or more chronic conditions was $43,000; combined spending on those with dementia was more than $55,000.

Physical and mental impairments influence per capita spending

To examine spending differences by physical and mental impairments, we examined Medicare Current Beneficiary Survey data and used a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Then, it assigned beneficiaries first into cognitive impairment groups and then, if not already

TABLE 5–5

Controlling for nursing home use, per capita spending for under 65 and disabled duals is higher than for aged duals, 2005

	Total	No nursing home spending	Top nursing home spending
All dual eligibles	$26,185	$19,171	$75,469
Aged	26,841	16,916	74,439
Under 65 and disabled	24,924	22,530	84,339

Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans. Top nursing home spending includes the top 20th percentile of spending for beneficiaries who used nursing home services.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

assigned, into physical impairment groups. A beneficiary with both types of impairments is assigned to a mental impairment group.[6]

Within the aged and disabled groups, Medicare and Medicaid per capita spending ranged by a factor of four (Figure 5-5). In both the disabled and aged groups, spending on duals with no or one impairment was about half of the average; in contrast, the highest spending groups (those with two or more physical impairments and those with dementia) were about double the average. Other differences were difficult to discern. Groups with high rates of institutionalization tended to have high spending, but not always. For example, while spending was about twice the average for duals with two or more physical impairments (groups with high institutionalization rates, see Figure 5-1), spending was about 20 percent above average for the developmentally disabled aged group (a group in which fewer than half were institutionalized). For any given impairment group, spending for the aged groups

TABLE 5–6

Total Medicare and Medicaid per capita spending for dual-eligible beneficiaries varied for most frequent chronic conditions

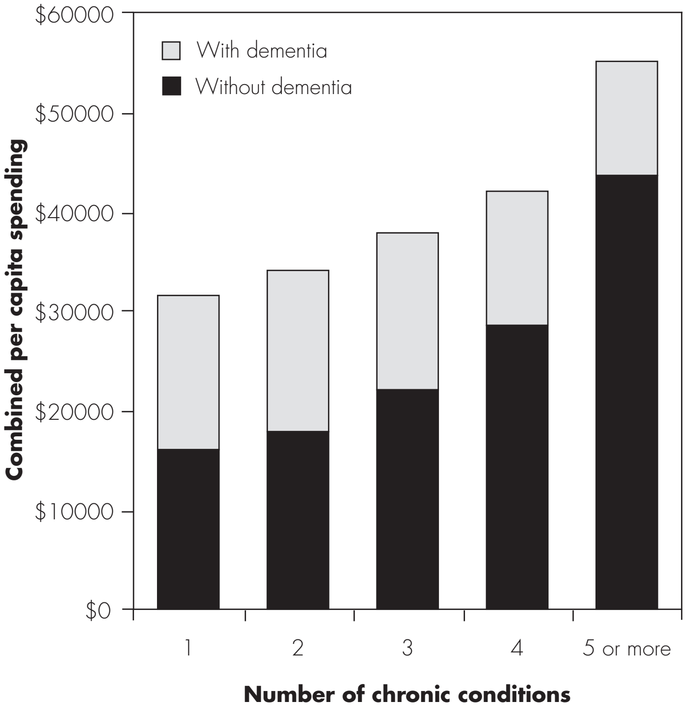
Select chronic condition	Share of all duals with condition	Medicare and Medicaid spending	Spending relative to average
All dual-eligible beneficiaries	100%	$26,185	1.0
Alzheimer's and related conditions	22	46,578	1.8
COPD	15	40,645	1.6
Depression	21	38,829	1.5
Diabetes	32	32,188	1.2
Heart failure	26	40,632	1.6
Ischemic heart disease	34	34,568	1.3
Rheumatoid arthritis & osteoarthritis	25	31,864	1.2
4 or more chronic conditions	30	43,986	1.7
5 or more chronic conditions	19	50,278	1.9

Note: COPD (chronic obstructive pulmonary disease). The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

FIGURE 5–4

Combined per capita spending increases with dementia and number of chronic conditions



Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

tended to be higher than for the disabled groups, but not always. Spending was higher for the aged groups with cognitive impairments, but the disabled group with two or more physical impairments had higher spending than its aged counterpart.

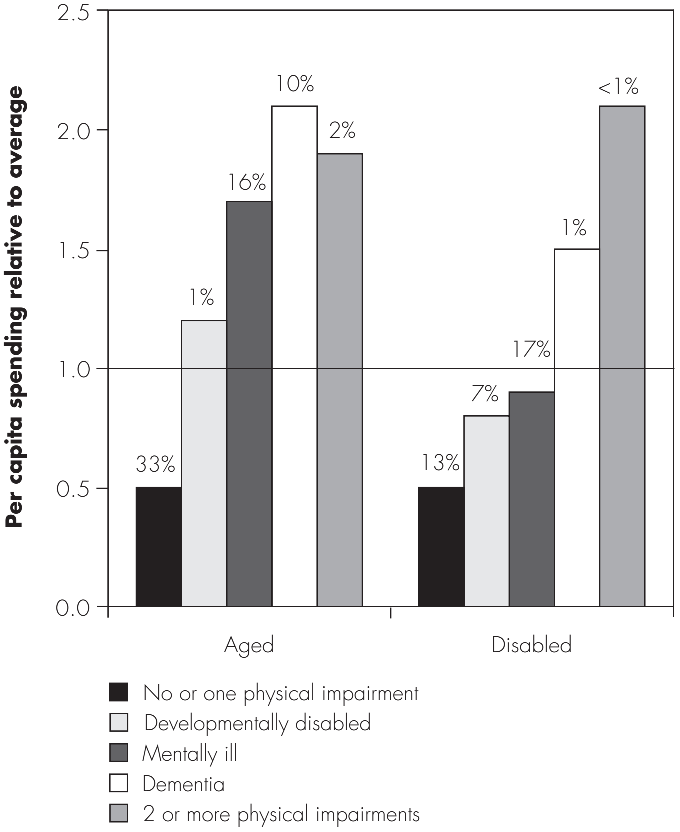
Mix of service spending varies by clinical condition

The impairments and chronic conditions shape the mix of services beneficiaries use. Dual-eligible beneficiaries who are institutionalized have a high proportion of combined per capita spending on nursing home services. Those with minimal impairments, living at home, and without a hospitalization are likely to have a greater share of combined program spending on physician and other community-based services. Those with conditions that are susceptible to frequent hospitalizations, such as chronic obstructive pulmonary disease (COPD) and heart failure, have a high share of combined spending on hospital services.

Among the most prevalent chronic conditions, the share of total per capita spending devoted to nursing home services ranged from 20 percent for dual beneficiaries with heart failure or COPD to 45 percent for duals with Alzheimer's disease and related conditions (Figure 5-6 and online Appendix 5-A, available at http://www.medpac.gov). Per

FIGURE 5–5

Per capita spending by cognitive and physical impairment group

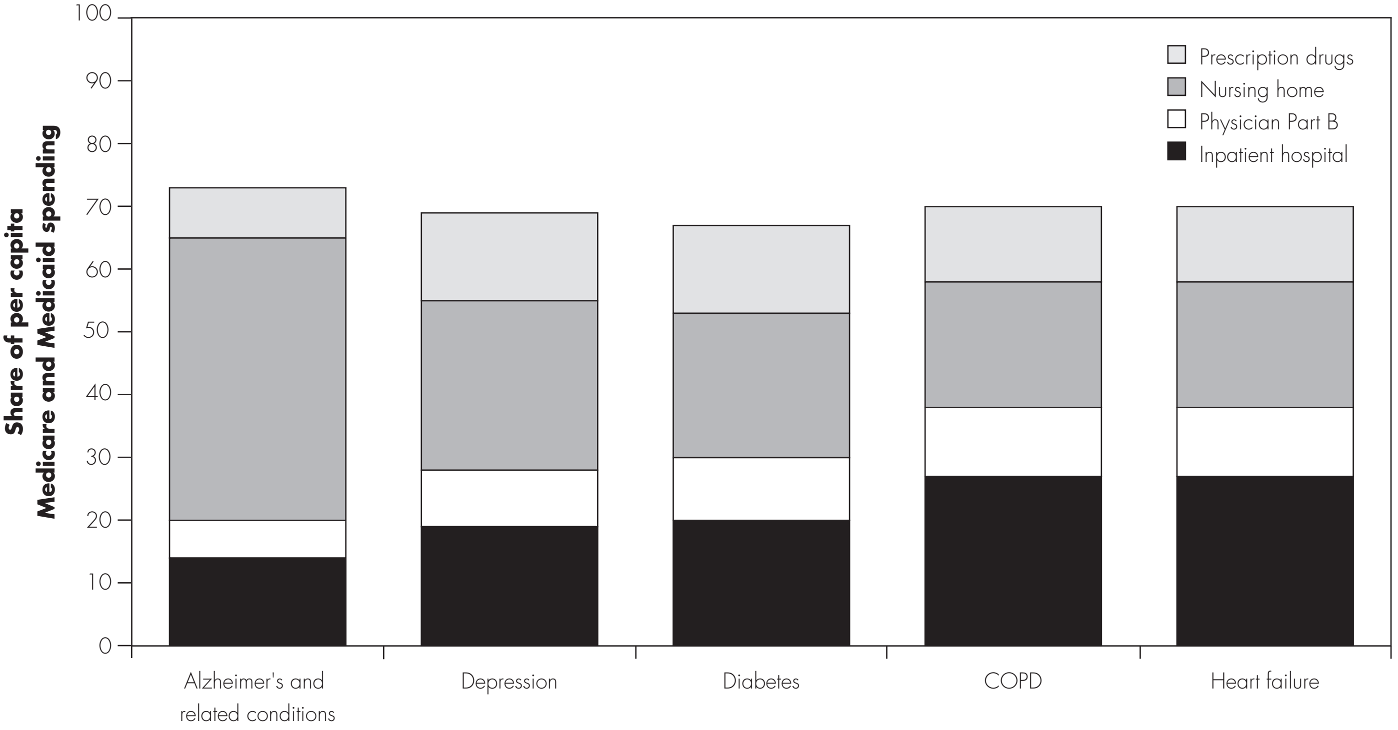


Note: Beneficiaries were grouped into the "aged" and "disabled" groups based on how they qualified for Medicare coverage. The grouping uses a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Beneficiaries are then assigned to a mental impairment group and, if none, are assigned to a physical impairment group (a beneficiary with both would be assigned to a mental impairment group). Physical impairment refers to a limitation to perform activities of daily living such as bathing, dressing, or eating. The percentages represent the share of all duals included in the group. Beneficiaries with end-stage renal disease were excluded.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2004–2006.

FIGURE 5–6

Differences in per capita spending by select chronic condition



Note: COPD (chronic obstructive pulmonary disease). The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

capita spending for inpatient services was more concentrated (27 percent of per capita spending) for duals with heart failure or COPD compared with duals with any chronic condition (17 percent of per capita spending). Across the most common chronic conditions, per capita spending on prescription drugs ranged from 8 percent (Alzheimer's disease and related conditions) to 14 percent (depression and diabetes). Per capita spending on physician and other Part B services ranged from 6 percent (Alzheimer's disease and related conditions) to 11 percent (COPD, heart failure, ischemic heart disease, and rheumatoid arthritis and osteoarthritis).

Implications for coordinating care

The design and targeting of care coordination approaches could be tailored to match the care needs of different groups of dual-eligible beneficiaries. Given the variation in the level and mix of spending, a uniform way to coordinate care for all dual-eligible beneficiaries is unlikely to be as effective as more targeted approaches for individual subgroups. For example, coordinating the care for dual-eligible beneficiaries living in the community will require managing services across a wide array of providers, especially for beneficiaries with multiple chronic conditions. In contrast, for beneficiaries residing in nursing homes, care coordination might be best based at the facility. It might be possible to avoid premature institutionalization of some dual-eligible beneficiaries with minimal care needs if they are managed appropriately.

Beneficiaries with certain clinical conditions are at greater risk of hospitalization than others. Care management approaches that emphasize preventing unnecessary hospitalizations would avoid the unnecessary spending and care transitions that undermine good quality of care. Such techniques would differ for community-dwelling and institutionalized beneficiaries. In addition, specific medication management approaches could be used for beneficiaries with high spending on prescription drugs or with certain diagnoses, similar to the medication therapy management programs that prescription drug plans and Medicare Advantage–Prescription Drug plans are required to implement for high-risk beneficiaries. There has been considerable variation in how these programs were implemented and CMS strengthened plan requirements for 2010 (Medicare Payment Advisory Commission 2009b, Medicare Payment Advisory Commission 2010).

Conflicting incentives of Medicare and Medicaid

Care coordination is hampered by the conflicting incentives of Medicare and Medicaid. The two programs can work at cross-purposes that undermine cost control and good patient care. At the payer level, Medicaid and Medicare have incentives to minimize their financial liability by avoiding costs through coverage rules. Medicare covers services that are restorative or improve a beneficiary's functional status, denying payment for services that are considered "maintenance." In contrast, Medicaid may pay for services that prevent further deterioration. At times there is ambiguity about whether a service helps maintain the status quo or is restorative.

Examples of these conflicting incentives include the financial incentive to hospitalize nursing home residents, shift costs to the next provider ("downstream") in an episode of care, and shift coverage for home health care from one program to another (see text box on conflicting incentives). States' longstanding use of "Medicare maximization" strategies—raising a state's federal match dollars through illusory financial arrangements—underlines the importance of designing financially integrated approaches that successfully balance state flexibility with adequate fiscal controls and the need for carefully specified policies.

Fee-for-service payment methods discourage care coordination

Medicare and Medicaid pay for post-acute care (PAC) by using fee-for-service (FFS) payment methods that typically limit spending per visit, day, or episode. These payment methods create incentives to hospitalize patients with above-average costs rather than invest in the resources (such as skilled nursing staff) to manage patients in-house. Estimates of the rates of potentially avoidable rehospitalizations vary from 18 percent to 40 percent, depending on the PAC setting, the risk adjustment method, and the clinical conditions considered (Grabowski et al. 2007, Medicare Payment Advisory Commission 2010, Saliba et al. 2000).

Hospitalization rates appear to be sensitive to the level of payments. One study of nursing homes found that for every additional $10 in Medicaid daily payment above the mean, the likelihood of hospitalization declined 5 percent (Intrator et al. 2007). Another nursing home study found that Medicaid residents were more likely than other higher payment patients to be rehospitalized, with risk-adjusted hospitalization rates that were 15 percent lower for Medicare and private pay patients (Konetzka et al. 2004).

As a result of the FFS payment methods, providers typically have no incentive to take into account the impacts of their own practices on total spending over time. What may be in a provider's own financial interest in the short term may result in higher federal spending over the longer term. Medicare's PAC transfer policy under the hospital inpatient prospective payment system counters the financial incentive to prematurely discharge inpatients to PAC settings. However, PAC settings do not have transfer penalties. PAC providers can lower their own costs by shifting patients to other PAC settings or to the community. Although bundling Medicare payments for hospital and PAC services could encourage more efficient use of Medicare resources, it would not address the incentive to shift costs to another program.

Further discouraging care coordination is the lack of a care coordination benefit in Medicare. Although care coordination per se is not covered, certain providers are required to conduct some of these activities, such as discharge planning by hospitals. Because MA plans are required to provide only those services covered in FFS, they are not required to furnish care coordination. However, these activities may improve a plan's quality indicators and its financial performance, particularly plans that enroll high-cost beneficiaries. Plans enrolling an essentially well mix of beneficiaries may have little financial incentive to offer care coordination activities.

Conflicting incentives may lower quality of care

Because Medicaid and Medicare have no incentive to improve overall efficiency and care coordination for duals, each program focuses on minimizing its own payments instead of investing in initiatives that would lower overall

Examples of conflicting incentives

Three examples illustrate how providers and states can shift the responsibility for beneficiaries from one program to another and, at the same time, raise total federal spending (Grabowski 2007).

- *Nursing home transfer to hospitals*—Transferring dual-eligible beneficiaries receiving long-term care in nursing homes to hospitals is financially advantageous to facilities and states but raises Medicare spending. A nursing home benefits first by avoiding the high costs associated with care the hospital had to provide. State bed-hold policies that pay nursing homes a daily amount while a resident is in the hospital can also affect hospitalization rates. States with bed-hold policies had hospitalization rates that were 36 percent higher than states without them (Intrator et al. 2007). Second, the facility may qualify for a higher payment under Medicare when the beneficiary is readmitted and requires skilled nursing facility (SNF) services.[7] The state also benefits when beneficiaries qualify for Medicare-covered SNF stays because its financial liability is to pay only for the copayments and deductibles for Medicare-covered services.
- *Hospital transfer to nursing home*—Hospitals do not have a financial incentive to consider the "downstream" costs of long-term care. Rather, their financial incentive is to lower their own costs by transferring patients to nursing facilities, which increases state and federal spending.
- *Home health care*—As a result of a 1988 U.S. Supreme Court decision, Medicare broadened the coverage guidelines for home health care.[8] Medicare's home health benefit expanded from covering mostly short-term, post-acute care to one that can cover patients over longer periods of time (Government Accountability Office 2000). Because Medicare and Medicaid home health care coverage can be ambiguous (does the patient qualify for skilled care, is the patient homebound), Medicare and Medicaid can jockey to avoid paying for care by asserting the beneficiary does or does not meet Medicare's criteria for coverage (being homebound, requiring skilled care, or receiving part-time or intermittent services).[9] ■

spending and improve quality. States are more inclined to invest in programs to lower their long-term care spending than in programs that avoid unnecessary hospitalizations because these benefits accrue to Medicare. Reflecting the ambivalence to lower rehospitalization rates, none of the four state nursing home pay-for-performance programs (Iowa, Kansas, Minnesota, and Ohio) uses hospital readmissions as a performance measure (Grabowski 2007).

The patterns of care that result from shifting patients for financial, rather than clinical, reasons can lead to suboptimal care for beneficiaries. Nursing homes have little incentive to provide preventive care and avoid acute flare-ups of chronic conditions if their efforts raise their costs. Moreover, to the patient's detriment, unnecessary hospitalizations expose beneficiaries to hospital-acquired disease that can delay patients' recovery or erode their health status. We found that dual-eligible beneficiaries make up the majority of beneficiaries with repeat hospitalizations (four or more within two years). Multiple transitions between settings increase the likelihood that a patient will experience fragmented care, medical errors, medication mismanagement, and poor follow-up care. The Health and Human Services Office of Inspector General found that more than one-third of episodes of patients with multiple hospital skilled nursing facility stays were associated with quality-of-care problems (Office of Inspector General 2007).

Care can also be fragmented when dual-eligible beneficiaries are enrolled in multiple plans for their health care coverage. Some dual-eligible beneficiaries are enrolled in different Medicaid and Medicare managed care plans or in a managed care plan under one program and FFS in the other, in addition to a separate plan for prescription drug coverage. Duals in these circumstances do not have a single person or entity taking responsibility for their care. Such fragmentation can lead to medication mismanagement, poor coordination of treatment plans, and low patient adherence to medical instructions.

For cognitively impaired dual-eligible beneficiaries, efforts to effectively coordinate care are further complicated. Focus groups have revealed that dual eligibles often do not understand their benefits and coverage (Ryan and Super 2003). This complexity of coverage can result in discontinuities in care, involuntary disenrollment, and inappropriate charges for cost sharing. These experiences were echoed in focus groups on prescription drug coverage conducted by the Commission in 2009. We found that some low-income beneficiaries were confused about coverage of the various programs they were enrolled in.

Fragmentation can occur even when beneficiaries are enrolled in SNPs, the MA plans that focus on special needs populations, including dual-eligible beneficiaries. Until 2010, SNPs were not required to contract with states to provide Medicaid benefits and most did not. In 2008, the Commission recommended that the Secretary require SNPs to contract with the states of their service areas (Medicare Payment Advisory Commission 2008). The Medicare Improvements for Patients and Providers Act of 2008 required SNPs to contract with states to provide Medicaid benefits (for a summary of the legislative changes to SNP provisions, see online Appendix 5-B, available at http://www.medpac.gov).

Approaches to integrate the care of dual-eligible beneficiaries

There are approaches to coordinate the care for dual-eligible beneficiaries that combine the financing of Medicare and Medicaid and make a single entity (such as a provider or managed care plan) responsible for coordinating all services. Two approaches are being used to integrate the care for dual-eligible beneficiaries: Medicare Advantage special needs plans (SNPs) that contract with the state Medicaid agencies to provide all services and PACE. These approaches shift the current silos of financing and care delivery to one entity that is responsible for all services and at full financial risk. While the models integrate the financing and care coordination, they differ in whether the entity is acting essentially as an insurer (managed care plans) or primarily as a set of providers assuming risk (PACE). They also vary considerably in their target populations and enrollment, the services they manage, and how they organize and integrate services.

Some policy analysts have proposed approaches that integrate the financing of the two programs (but do not coordinate the care) as a way to help overcome the programs' conflicting incentives. Financial integration approaches include giving block grants to the states or shifting the responsibility of dual-eligible beneficiaries to the Medicare program. In block grants, a state would be given a funding allotment each year (a block grant) to pay for all services covered by Medicaid and Medicare.[10] If a state's spending is less than the block grant, the state would keep the difference; if spending exceeds the grant amount, the state would be financially liable. Block grants would require enforcement to ensure that state programs maintained beneficiary access to services and that states funded the intended services.[11] Financial integration could also be achieved if Medicare assumed primary administrative responsibility for the services furnished to the dual-eligible population (Bruen and Holahan 2003, Government Accountability Office 1995, Holahan et al. 2009, Moon 2003). Although approaches to financially integrate Medicaid and Medicare would mitigate the conflicting incentives of the programs, they would not, by themselves, result in coordinated care.

Features of a fully integrated model of care

Fully integrated models of care manage both Medicare and Medicaid services and benefits. Many other efforts manage either Medicaid or Medicare services (but not both), and those that manage only Medicaid services typically exclude long-term care. However, given the incentives to shift costs between the programs, fully integrated models of care should consider including both programs and extend to all services.

Integrated care has the potential to offer enrollees enhanced, patient-centered, and coordinated services that target the unique needs of the dual-eligible enrollees (Table 5-7). 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 care, medication mismanagement, and duplicative care.

Care coordination begins by assessing patients to identify their level of risk and matching coordination efforts to the person's needs. Then, a multidisciplinary team develops a patient-specific plan of care that is regularly updated

TABLE 5–7

Sample activities of an integrated model of care

Feature	Coordinated care activity
Assess patient and assign to a risk group	• Use protocols, service use (e.g., hospital and SNF admissions, ER and specific prescription drugs), referrals from community service and medical care providers, and predictive models to identify high-risk beneficiaries • Care coordination plan reflects the patient's level of risk
Devise and update individualized care plan	• Design a plan of care for each beneficiary; share plan with patient and all providers; update plan periodically to reflect changes in health status or service provision • Educate patients about their prescription drugs and how to manage their disease • Visit at home those patients who are at risk for falls; identify and coordinate installation of safety measures • Socially isolated beneficiaries may be enrolled in adult day care • Adapt patient education and counseling activities for cognitively impaired beneficiaries so that patient/family member recognizes warning signs of the need for prompt medical attention
Assist beneficiary in negotiating health care and community services systems	• Schedule appointments • Arrange for prescriptions, DME, and transportation • Link beneficiary to community services (such as heating assistance programs) that could undermine medical regimen if left unattended
Manage nursing home use	• Visit patients in nursing homes to monitor and treat conditions that if left untreated could result in hospitalization
Coordinate behavioral and primary health care	• Clinical social workers may screen patient population for mental health care needs • Behavioral health providers update primary care physicians on a quarterly basis
Multidisciplinary teams manage care	• Teams may consist of primary care physician, clinical social worker, pharmacist, behavioral health provider, and medical assistant

Note: SNF (skilled nursing facility), ER (emergency room), DME (durable medical equipment).

Source: Lukens et al. 2007.

so that it remains a current map of the care each patient should receive. A comprehensive provider network ensures that patients have access to the full spectrum of services that address the special care needs of dual-eligible patients. Ideally, a beneficiary would have one plan card with one set of rules for Part A, Part B, and Part D coverage. Data are shared across providers so that all participants know the care plan, the services furnished to beneficiaries, and the outcomes and results so that care can be optimally managed.

Performance measures for fully integrated care

Performance measures for fully integrated plans should include outcome-based measures of quality that span all providers over an episode of care as well as metrics specific to the clinical conditions prevalent among the dual-eligible population. In addition, measures should gauge the level and success of care coordination and case management. Tying providers' performance on these types of measures to payments can give them an incentive to collaborate.

One set of outcome measures could be used to gauge the overall performance of all types of fully integrated programs, which would allow for comparison of plans along comparable dimensions of care. Quality measures for managed care plans (such as MA plans) currently assess the extent to which patients receive appropriate preventive care, medication, and acute care and also assess patient satisfaction. In addition, outcome measures could include hospital readmission rates, rates of hospital admissions for ambulatory-care-sensitive conditions, potentially preventable emergency department visits, and mortality rates for specific conditions. Changes over time in functional and cognitive status may also be appropriate measures for the dual-eligible population. For all outcome measures, it is important to use risk adjustment as much as technically feasible to control for patient characteristics that can affect outcomes but are beyond the providers' influence.

Furthermore, some metrics should be tailored to the care needs of the relevant population, defined by specific factors such as diagnoses, cognitive state, disability status, and institutional status. For example:

- *Nursing home residents:* Although publicly reported Nursing Home Compare measures report on many aspects of institutional long-term care, they do not assess the appropriateness of the admission, medication errors, or rates of potentially avoidable hospitalizations. Ideally, quality measures would detect, for example, if patients were prematurely institutionalized or if their medical condition or functioning deteriorated more quickly than expected once they were institutionalized. In addition to measures for the elderly, measures should include those specifically designed to gauge the quality of care furnished to beneficiaries with physical or cognitive disabilities.

- *Beneficiaries living in the community:* Measures could gauge whether beneficiaries who need supportive care and other social services receive them and the degree of care coordination (e.g., does the patient have a primary care physician who is regularly seen and are medications being managed). CMS established a quality framework for HCBS that included the following categories of measures: beneficiary access, patient-centered service planning and delivery, provider capacity and capabilities, beneficiary safeguards, patient rights and responsibilities, outcomes and patient satisfaction, and system performance.[12] Because a large fraction of the disabled live in the community, measures specifically designed for adults with disabilities would need to be able to gauge the quality of care furnished to this population.

- *Duals with significant mental health care needs:* Given the chronic nature of some severe mental illness, outcome measures for many duals will be hard to develop (see Chapter 6). In the interim, process measures could gauge whether the care coordination identifies persons needing mental health services, ensures beneficiaries receive care in a timely manner, checks that patients' medications are reconciled periodically and every time they transition from one care setting to another and that the medications are being taken, and facilitates communication between a beneficiary's mental health professional and his or her primary care physician. Hospitalization rates for selected psychiatric conditions would provide feedback on the success of managing beneficiaries on an outpatient basis.

Fully integrated care programs should also assess the degree of care coordination and care management provided. As of 2009, SNPs are required to report on structure and process measures of case management, care transitions, and dual-eligible integration. For example, one measure looks at how frequently an organization identifies members who need case management services, while another measure counts how many processes focused on reducing unplanned transitions. Regarding Medicare–Medicaid coordination, SNPs must report whether they have, or are working toward, an agreement with the relevant state Medicaid agency. An inherent shortcoming of these structure and process measures is that they do not assess the effectiveness of these care coordination efforts. Patient and physician surveys on care transitions and case management efforts may be helpful in assessing how much managed care programs facilitate patient understanding of postdischarge plans and improve provider collaboration.

Examples of fully integrated care programs

There are two main types of fully integrated care programs: state–SNP integrated managed care programs and PACE. These programs receive capitated Medicare and Medicaid payments to cover all Medicare and Medicaid services including all or some long-term care services. The programs are at full financial risk for all (or most) of the services they cover. This risk structure gives the programs the incentive to coordinate the Medicare and Medicaid services they offer to reduce unnecessary utilization or high-cost services that programs would otherwise have to pay for.

The type of entity that receives the capitated payments and manages the benefits differs in the two approaches. In the state–SNP programs, the integration is through a managed care plan; under PACE, these functions are carried out by a PACE provider. All the state–SNP programs and PACE target dual-eligible beneficiaries, although the specific subgroups of dual-eligible beneficiaries that are targeted for enrollment differ across programs. In addition, while the intensity of care coordination varies across programs, this variation may reflect the level of needs of the programs' target population. For example, the PACE program offers an intense care management structure with frequent monitoring and management of participants; however, PACE serves the frail elderly living in the community who require this level of care. A program serving a healthier dual-eligible population may require a less intense form of care management than PACE provides.

A number of states are considering other models to improve care coordination for the dual-eligible population. These alternative models include state-administered managed care plans and medical homes. Each has the potential to improve the care coordination for the dual-eligible population but, for different reasons, may have limited success and one model could raise significant concerns about adequate fiscal controls and accountability (see text box, p. 147).

State–SNP integrated managed care programs

To date, at least eight states—Arizona, Massachusetts, Minnesota, New Mexico, New York, Texas, Wisconsin, and Washington—have fully integrated Medicare and Medicaid programs for dual-eligible beneficiaries through SNPs (all of which are MA plans) or through MA plans that are not SNPs (see text box on SNPs, p. 148). Under these programs, a managed care organization, often operating in MA as a SNP, receives capitated payments from both Medicare and Medicaid. The plans are then responsible for establishing provider networks and implementing the model of care, including care coordination or case management services. An estimated 120,000 dual-eligible beneficiaries nationwide are enrolled in fully integrated managed care programs (Center for Health Care Strategies 2009). These individuals represent less than 1.5 percent of the dual-eligible population and about 8 percent of the dual-eligible beneficiaries enrolled in MA plans (SNP and non-SNP MA plans) (Center for Health Care Strategies 2010).[13]

Integrated managed care programs through SNPs could be an option for all subgroups of the dual-eligible beneficiaries—the nonfrail aged, the nursing-home certifiable, the institutionalized, the physically disabled, and the mentally retarded and developmentally disabled. Currently, programs exist to serve these individual subgroups, but few programs serve all subgroups in the same program.

The state programs vary in their eligibility requirements (their target populations), their enrollment, covered services, risk structures, and models of care. There is also variability in results, if any, to date. The key characteristics and differences across state–SNP integrated managed care programs are discussed below (Table 5-8). A brief description of each state–SNP integrated managed care program is provided in a text box (see text box on state–SNP integrated managed care program descriptions, pp. 150-151).

Eligibility While the programs vary in the subgroups of dual-eligible beneficiaries they serve, the two broadest groups of dual-eligible beneficiaries—the aged and disabled—are eligible to enroll in almost all of the programs. Six of the programs (Arizona, New Mexico, New York, Texas, Wisconsin, and Washington) enroll the aged and disabled in the same program. Minnesota has separate programs for the aged and disabled. Some programs exclude large subgroups of duals, such as the non–nursing home certifiable (beneficiaries who are healthy or not frail enough to require a nursing home level of care), institutionalized duals, or the mentally retarded and developmentally disabled. The programs that do not restrict eligibility to the nursing home certifiable can enroll both beneficiaries who are healthy or not frail enough to require nursing home services and frail dual-eligible beneficiaries who require a nursing home level of care.

Fully integrated state–SNP programs appear to more selectively target subgroups of the disabled duals compared with the aged duals. Regarding the disabled populations, some programs exclude the non–nursing home certifiable and institutionalized disabled, while others restrict eligibility to the physically disabled, thus excluding the mentally retarded and developmentally disabled population. Regarding the aged, the non-nursing home certifiable is the most common subgroup of the aged duals that is excluded from these programs, and one program also excludes the institutionalized aged. These restrictions may be indicative of the challenges in designing and implementing multiple models of care in a single program to serve the distinct subgroups of dual-eligible beneficiaries.

Enrollment Most states with strong enrollment in their integrated care programs had statewide Medicaid managed care programs in place before adding the integrated programs. Other states' programs, such as the one in New York, struggled with enrolling large numbers of eligible duals. In New York, voluntary program enrollment and

TABLE 5–8

Characteristics of fully integrated care programs

State	Program name	Eligible population: Aged	Eligible population: Disabled	Mandatory or voluntary enrollment
Arizona	Arizona Long-Term Care System (ALTCS)	Nursing home certifiable only	Nursing home certifiable only	Mandatory enrollment in ALTCS for Medicaid long-term care services, but voluntary enrollment in a Medicare managed care plan
Massachusetts	Massachusetts Senior Care Options	Yes	No	Voluntary
Minnesota	Minnesota Senior Health Options (MSHO)	Yes	No	Voluntary for MSHO, but mandatory for aged Medicaid beneficiaries to enroll in a managed care plan. MSHO is one of the managed care options.
	Special Needs Basic Care	No	Yes	Voluntary; disabled are not required to enroll in a managed care plan
New Mexico	Coordination of Long-Term Services	Yes	Yes, but excludes beneficiaries with developmental disabilities who are enrolled in a 1915(c) waiver	Mandatory
New York	Medicaid Advantage Plus	Nursing home certifiable only	Nursing home certifiable only	Voluntary
Texas	Texas Star+Plus	Yes, except for beneficiaries residing in nursing facilities	Yes, except for beneficiaries residing in intermediate care facilities for the mentally retarded	Mandatory
Washington	Washington Medicaid Integration Partnership	Yes	Yes	Voluntary
Wisconsin	Wisconsin Partnership Program	Nursing home certifiable only	Physically disabled only	Voluntary

Source: Center for Health Care Strategies 2010, Centers for Medicare & Medicaid Services 2007, Edwards et al. 2009, Frye 2007, Korb and McCall 2008, and Osberg 2009.

competition from nonintegrated SNPs contributed to the program's low enrollment (Korb and McCall 2008). In addition, most programs operate in select regions within each state rather than across the entire state, which can also limit enrollment.

Covered services and risk structure The nine state–SNP fully integrated programs cover Medicare acute care benefits, Medicaid acute care wraparound benefits, and Medicaid long-term care services. Most also cover behavioral health services. A few of these programs, however, place limits on the amount or type of long-term care services that are covered. For example, Minnesota's programs, Minnesota Senior Health Options (MSHO) and Special Needs Basic Care, cover nursing home utilization up through 180 days and 100 days, respectively. Any nursing home utilization incurred after these limits is paid through Medicaid FFS although enrollees remain in the program. New York's Medicaid Advantage Plus program also caps

Alternative models may be limited in their ability to effectively control spending and coordinate care

Some states are considering other ways to improve the care coordination for dual-eligible beneficiaries, including state-administered managed care plans and medical homes. In state-administered managed care plans, a state entity would receive special needs plan–like payments from Medicare and Medicaid and would be responsible for all health care benefits for dual-eligible beneficiaries. One model considers state-administered Medicaid Advantage plans in which participating states contract with competing health plans to manage the care for dual-eligible beneficiaries (Turner and Helms 2009). The state would have the option of managing the care itself, if its state capacities were sufficiently developed, or contracting with private health plans. Each state could tailor benefit packages to target specific groups of dual-eligible beneficiaries, use performance-based payments, and encourage plans to engage in active care management.

This model may have potential in some states but may not result in adequate beneficiary access to care and proper use of federal spending in every state. Policymakers should note a long history of state financial strategies to maximize federal support while minimizing the state's own contributions. Such strategies generated considerable controversy because the higher federal spending did not always expand coverage or get used to furnish or improve health care (Coughlin and Zuckerman 2002). The strategies underline the importance of adequate fiscal controls and accountability to ensure that spending remains focused on target populations and services.

A number of states are considering the use of medical homes to manage care for dual-eligible beneficiaries. In this model, primary care practitioners are paid (typically on a per member per month basis) to coordinate care for patients between visits and across providers. In 2008, the Commission recommended that Medicare establish a pilot program for medical homes that pays qualified medical practices to coordinate the care of beneficiaries with multiple chronic conditions.

In January 2010, the North Carolina Community Care Networks, an existing medical home and shared savings program serving the Medicaid population, began providing dual-eligible beneficiaries with care management in return for a portion of the savings that may eventually accrue. Any Medicare savings beyond a certain threshold will be reinvested in other services, including home-based services, health information technology, and coverage expansions (Community Care of North Carolina 2009). According to CMS, at least half of the shared savings payments will be contingent on those providers meeting certain quality goals.

Under current payment policies, because medical homes do not assume full risk for their patients' care, their effectiveness at controlling spending will be limited. Medical homes operate within the context of fee-for-service (FFS) medicine and their ability to control total spending will be limited by the portion of payments attached to performance measures. That said, medical homes represent a potentially effective way to bridge the unmanaged world of FFS and more fully integrated care. ■

covered nursing home utilization at 100 days. Texas's program covers community-based long-term care services but not institutional nursing home care (Center for Health Care Strategies 2010, Edwards et al. 2009, Osberg 2009, Texas Health and Human Services Commission 2010b).

Model of care for state–SNP programs The state–SNP programs manage the Medicare medical services and Medicaid medical and support services for the dual-eligible beneficiaries. For example, in addition to managing the Medicare and Medicaid medical services, care coordinators typically consider the need for nonmedical services and supports that facilitate beneficiaries living in the community. These services include HCBS, transportation, heating, food, and housing-related supports; they can help beneficiaries function at home so they can more effectively seek medical attention and adhere to treatment regimens, resulting in appropriate service use.

Special needs plans

Special needs plans (SNPs) are Medicare Advantage (MA) plans that target enrollment to certain groups of Medicare beneficiaries. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized SNPs to target enrollment to the following types of beneficiaries with special needs: those dually eligible for Medicare and Medicaid services, the institutionalized, and beneficiaries with severe or disabling chronic conditions. SNPs were originally authorized through December 2008; first extended through 2009 by the Medicare, Medicaid, and SCHIP Extension Act of 2007; extended again through 2010 by the Medicare Improvements for Patients and Providers Act of 2008; and again through 2013 by the Patient Protection and Affordable Care Act (H.R. 3590).

SNPs receive capitated payments from Medicare to offer Part A and Part B services as well as prescription drug coverage under Part D. Medicare pays SNPs through the same payment method as other MA plans. Payments are risk adjusted for factors that include dual-eligibility status, health condition, disability status, and residence in an institution. SNP per capita payments tend to be higher than payments to other MA plans in the same geographic area because of the risk-adjustment factors and the populations SNPs enroll.

SNPs can also contract with states to receive Medicaid payments to offer Medicaid benefits for dual-eligible beneficiaries. Beginning in 2010, new and expanding dual-eligible SNPs are required to have contracts with states; however, existing dual-eligible SNPs that are not expanding have until January 1, 2013, to establish state contracts (see summary of main legislative changes in online Appendix 5-B, available at http://www.medpac.gov). SNPs can offer a range of Medicaid services for the dual-eligible beneficiaries including coverage of Medicare cost sharing, supplemental acute care services that are not offered by Medicare (such as vision, dental, and transportation), and institutional and community-based long-term care services and supports. SNPs that offer all Medicare and Medicaid acute and long-term care services are considered fully integrated programs. More information on SNPs is available in online Appendix 5-B, available at http://www.medpac.gov. ■

Source: Saucier et al. 2009, Verdier 2006

Each program has a single care coordinator or a care management team to oversee the enrollee's care. For example, in Minnesota's MSHO program for the aged, enrollees are assigned a care coordinator who works with the enrollee's primary care physician and coordinates the enrollee's health care and social services. In the Massachusetts Senior Care Options program for the aged, care management teams coordinate the care for enrollees and authorize the services that enrollees can receive. Similarly, in the Wisconsin Partnership Program, which enrolls both the nursing home certifiable aged and physically disabled adults, the managed care plans employ staff who work together as care coordination teams and nurse practitioners who are responsible for overseeing enrollees' care (Centers for Medicare & Medicaid Services 2007).

Programs also include other coordination activities in their models of care. Arizona's program, for example, focuses on rebalancing nursing home– and community-based long-term care. Institutionalized enrollees are reassessed every six months to see if they can be placed in the community (Centers for Medicare & Medicaid Services 2007). Some integrated care programs have adopted elements of the Evercare Nursing Home Program, a model of managing Medicare benefits for long-stay nursing home patients. The goal of the program is to provide better Medicare primary care services in order to lower Medicare spending by reducing hospitalizations and emergency services. The health plans employ nurse practitioners who work with nursing home residents' primary care physicians to provide enhanced primary care, care coordination, and customized care planning.

Results Outcomes research on the integrated programs is limited; however, analyses of some of the programs demonstrate their ability to reduce institutional and inpatient utilization. The Massachusetts Senior Care Options and Minnesota Senior Health Options program reduced nursing home utilization. Specifically, the

Massachusetts program reduced the number of nursing home admissions and nursing home lengths of stay. Under the Minnesota program, nursing facility utilization declined over a recent five-year period by 22 percent and the number of seniors receiving HCBS increased by 48 percent (JEN Associates 2009, Osberg 2009). An analysis of Evercare demonstration sites found that patients had a lower incidence of hospitalizations, fewer preventable hospitalizations, and less emergency room utilization compared with two control groups (Kane et al. 2002).

Program of All-Inclusive Care for the Elderly

PACE is a Medicare benefit and an optional Medicaid benefit that fully integrates care for the frail elderly, most of whom are dual eligible. To qualify for coverage, beneficiaries must be at least 55 years of age, nursing-home certified, and live in a PACE service area. Enrollees attend an adult health day care center where they receive medical attention from an interdisciplinary team of health care and other professionals. States vary in their licensing requirements for PACE entities—as day care centers, home care providers, outpatient clinics, or some combination of them.

Under capitation with both Medicare and Medicaid, the PACE organization is responsible, and at full risk, for providing all medically necessary care and services, including primary care, occupational and recreation therapy, home health care, and hospital and nursing home care. The interdisciplinary team consists of a physician, registered nurse, social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietician, PACE center manager, home care coordinator, personal care attendants, and drivers. PACE sites directly employ the majority of PACE providers and establish contracts with providers such as hospitals and nursing facilities. If an enrollee needs nursing home care, the PACE program pays for it and continues to coordinate his or her care, even though the beneficiary resides in the facility. Beneficiaries are provided transportation to attend the day care center during the week.

Evaluations of this program have been positive. In its demonstration phase, the program demonstrated higher rates of ambulatory service utilization and significantly lower rates of nursing home utilization and hospitalization relative to those of a comparison group (Chatterji et al. 1998). Concurrently, quality measures were good—enrollees reported better health status and quality of life, and mortality rates were lower. The Balanced Budget Act of 1997 authorized the coverage of PACE benefits in the Medicare program, and PACE programs began expanding across the country.

Overall enrollment in PACE programs is low, although the number of PACE organizations has more than doubled since 1999. The number of PACE programs grew from 30 in 1999 to 72 in 2009, and as of February 2010, 18,000 beneficiaries in 30 states were enrolled in PACE (National PACE Association 2010).[14] In a survey of PACE program officers and researchers, one study identified a number of barriers to expansion (Lynch et al. 2008). First, many beneficiaries did not find the program appealing, given that they would have to frequently attend the adult day care center and change their existing provider relationships. Second, the program had significant upfront costs that nonprofit entities often could not afford. Third, it is more difficult to make PACE programs financially viable in rural areas. The distances raise transportation costs and place a greater premium on information technology to integrate the care coordination and centralize medical records. Despite these challenges, officials from the National PACE Association mentioned that 14 programs are operating in rural areas. Some of these programs use teleconferencing for team meetings and information technology to facilitate the sharing of medical charts from multiple locations.

The PACE model is not a match for some beneficiaries. The program targets the frail elderly who live in the community and are eligible for nursing home care. Patients who have modest care needs are not appropriate for this level of care.

Challenges to expanding enrollment in integrated care

States and managed care entities have faced a number of challenges when implementing integrated care programs. While some states and entities have overcome these factors, they still remain as challenges to more wide-scale implementation of these programs.

Lack of experience with long-term care

Most states, Medicare managed care plans, and medical homes do not have experience with managed care for long-term care services. Only 10 states had some form of Medicaid managed long-term care by January 2009 (Edwards et al. 2009). The remaining states either do not have Medicaid managed care programs for the aged

State–special needs plan integrated managed care program descriptions

Arizona Long-Term Care System

The Arizona Long-Term Care System (ALTCS) program is an example of a mandatory Medicaid managed care program in which the state contracts with managed care plans to also offer enrollees Medicare benefits. It is one of the programs within the Arizona Health Care Cost Containment System—a statewide mandatory 1115 waiver demonstration program for Medicaid beneficiaries. ALTCS provides long-term care services. Participation in ALTCS is mandatory for the elderly and disabled who are nursing home certifiable; however, enrollees can choose to enroll in one of the Medicare managed care plans or special needs plans (SNPs) for their Medicare benefits or they can receive their Medicare benefits through fee-for-service (FFS). Most ALTCS members reside in the community and receive home- and community-based services (HCBS) such as home health, attendant care, personal care, transportation, adult day care, and homemaker services. Institutionalized enrollees are reassessed every six months to see if they can be placed in the community (Centers for Medicare & Medicaid Services 2007).

Massachusetts Senior Care Options

The Massachusetts Senior Care Options (SCO) program began in 2004 as a demonstration program and converted to SNP authority. All aged Medicaid beneficiaries, both nursing home certifiable and non–nursing home certifiable, are eligible to enroll in the program on a voluntary basis. The program covers all Medicare and Medicaid benefits, including institutional and community-based long-term care services. Care management teams coordinate the care for enrollees and the teams authorize the services that enrollees can receive. An evaluation of SCO published in 2009 found that the program reduced both the number of nursing home admissions and nursing home length of stay (Centers for Medicare & Medicaid Services 2007, JEN Associates 2009).

Minnesota Senior Health Options

Minnesota's program, Minnesota Senior Health Options (MSHO), originally began in 1997 under Medicare demonstration authority. The managed care plans participating in MSHO are now required to be SNPs. MSHO is a voluntary program for dual-eligible seniors who are nursing home certifiable and non-nursing home certifiable. Although the program is voluntary, it has been mandatory since 1983 for Minnesota's elderly Medicaid population to enroll in a managed care plan for primary and acute Medicaid services, and the elderly Medicaid beneficiaries must choose from MSHO and another plan that offers only Medicaid services. All Medicare and Medicaid acute care services are integrated in MSHO as well as behavioral health and community-based long-term care services and up to 180 days of nursing home care. Nursing home utilization after 180 days is paid for through FFS. Each enrollee has a care coordinator who works closely with the enrollee's primary care physician and coordinates the enrollee's health care and social services. MSHO data show that nursing facility utilization for MSHO members declined by 22 percent from 2004 to 2009 and the number of seniors receiving HCBS increased by 48 percent (Centers for Medicare & Medicaid Services 2007, Edwards et al. 2009, Osberg 2009).

Minnesota Special Needs Basic Care

The Minnesota Special Needs Basic Care program (SNBC), is a voluntary program for all dual-eligible beneficiaries with disabilities. SNBC coordinates all Medicare and Medicaid acute services and Medicaid behavior health services. The program covers the first 100 days of nursing home care, but all other HCBS and long-term care services are FFS (Center for Health Care Strategies 2010, Osberg 2009).

New Mexico Coordination of Long-Term Services

New Mexico's Coordination of Long-Term Services (CoLTS) program began in 2008. CoLTS is a mandatory program for dual-eligible beneficiaries, Medicaid beneficiaries living in nursing facilities, and Medicaid beneficiaries enrolled in New Mexico's disabled and elderly waiver program. The program excludes Medicaid beneficiaries with developmental disabilities who are enrolled in New Mexico's 1915(c) waivers. CoLTS offers all Medicare acute care benefits and

(continued next page)

State–special needs plan integrated managed care program descriptions

Medicaid acute and long-term care services through SNPs (Edwards et al. 2009, Korb and McCall 2008).

New York Medicaid Advantage Plus

The Medicaid Advantage Plus program (MAP) is a Medicare and Medicaid managed care program for dual-eligible beneficiaries who are nursing home certifiable. MAP offers Medicare acute and Medicaid long-term care services, including up to 100 days of care in a nursing home and HCBS such as personal care, case management, adult day care, and social support services. New York contracts with a SNP to offer the program. MAP is voluntary; however, beneficiaries must enroll in the SNP to receive their Medicare benefits before they are permitted to enroll in the SNP for their Medicaid benefits (Edwards et al. 2009).

Texas Star+Plus

Texas Star+Plus is a mandatory program for elderly Medicaid recipients and nonelderly Medicaid beneficiaries with a physical or mental disability who reside in the community. Current nursing home residents, beneficiaries in intermediate care facilities for the mentally retarded, and Star+Plus enrollees who spend more than 120 days in a nursing facility are not allowed to participate in the program. The state contracts with some SNPs to offer both Medicare and Medicaid benefits for the dual-eligible enrollees, and by 2010 contractors will be required to be SNPs. The program covers community-based long-term care but does not cover nursing facility care. Star+Plus health plans are still responsible for members who enter a nursing facility and must work with service coordinators to assess the member at 30 days and 90 days after admission to determine whether the individual can return to the community. However, nursing facility services are paid by the state directly to the nursing facility and after four months of nursing facility utilization, Star+Plus members are disenrolled from the program and return to Medicaid fee-for-service (Center for Health Care Strategies 2010, Texas Health and Human Services Commission 2010a, Texas Health and Human Services Commission 2010b).

Washington Medicaid Integration Partnership

The Washington Medicaid Integration Partnership (WMIP) is a voluntary pilot project for elderly and nonelderly disabled dual-eligible beneficiaries. The program began in 2005 and operates in one county through a SNP. WMIP offers both Medicare acute and Medicaid acute and long-term care services (Korb and McCall 2008).

Wisconsin Partnership Program

The Wisconsin Partnership Program (WPP) began in 1999 under Medicare demonstration authority and now operates through SNPs. The program is voluntary and targeted to adults with physical disabilities and the nursing home certifiable elderly. WPP covers all Medicare services and all Medicaid acute services, community-based long-term care services, and nursing home services. The managed care plans employ staff to function as care coordination teams for enrollees, and a nurse practitioner is responsible for overseeing each enrollee’s care. WPP also integrates the services of independent physicians who participate in the program’s network (Centers for Medicare & Medicaid Services 2007, Frye 2007). ■

and disabled or carve long-term care services out of their managed care programs. Although institutional SNPs have relationships with long-term care providers, they offer Medicare benefits to the institutional population and are not required to contract with states for Medicaid long-term care services. All dual-eligible SNPs are required by 2013 to have contracts with states. These contracts are likely to initially cover Medicaid cost-sharing, wraparound, or supplemental services but not long-term care services. Managed care entities also may not be willing to cover institutional or community-based long-term care services if they lack experience establishing a provider network for those services. Some states are considering various risk-sharing agreements to give plans incentives to include long-term care services in their benefits packages.

Stakeholder resistance

Many states faced resistance from stakeholders during the development of integrated care programs for dual-eligible beneficiaries. In some states, stakeholder opposition has derailed implementation of integrated managed care programs or expansion of these programs to additional dual-eligible populations. Resistance has come from provider groups concerned about payment rates, the loss of clients and autonomy, and dealing with managed care organizations.

Beneficiaries and their advocates are concerned with the impact of the programs on enrollee benefits, freedom of choice, and quality of care (Korb and McCall 2008). In addition, beneficiaries often are not interested in selecting managed care options for their care. They prefer seeing their current set of providers and do not want to switch physicians. Furthermore, because Medicaid currently covers the cost-sharing requirements of Medicare, dual-eligible beneficiaries are not likely to benefit financially (i.e., reduced cost-sharing obligations) by joining a managed care option.

Such resistance could be overcome with program designs that accommodate stakeholder concerns and better understanding of the benefits of the program. For example, in Minnesota and New Mexico, support for these programs grew as the states addressed some of the advocates' concerns through the program design and as advocates understood the benefits of the programs, especially the increased access to community-based long-term care. New Mexico asked for input on program design elements such as enrollment and quality from stakeholder groups including advocates, providers, and Native Americans (Edwards et al. 2009).

Initial program investments and program financial viability

Integrated care programs require initial program investments. Managed care plans, for example, have to dedicate resources to managing the care of enrollees and may hire health care professionals to coordinate care. Plans would also have to invest in technology, such as electronic medical record systems. New PACE program sites incur the initial capital costs of establishing a day care and outpatient clinic and of hiring professional staff. Surveys of PACE sites show that lack of start-up capital limited the expansion of existing nonprofit organizations (Lynch et al. 2008).

In addition, there is concern among states about Medicaid program investments generating Medicare program savings. States must secure a waiver from the federal government to implement mandatory Medicaid managed care programs, offer beneficiaries additional services under voluntary or mandatory Medicaid managed care, expand Medicaid eligibility, or test a new payment system. As part of the waiver application, states must demonstrate to the Office of Management and Budget (OMB) that federal Medicaid expenditures under the waiver will be budget neutral. Yet states may incur costs as they invest in care management services designed to lower rehospitalizations, emergency room and skilled nursing facility use, and nursing home placements. Thus, although state Medicaid programs fund care management services (many are not Medicare-covered services), the savings accrue to Medicare. States cannot use expected savings in Medicare to offset any increases in Medicaid spending when demonstrating budget neutrality. These budget-neutrality rules are longstanding OMB policy, not statutory or regulatory requirements (Rosenbaum et al. 2009).

Waiver rules also require that budget neutrality be achieved within two to five years, depending on the waiver. Savings are likely to accrue more quickly from lower hospital, emergency room, and skilled nursing facility use than from averted nursing home admissions. However, under current policies as noted, savings from one program cannot be used to underwrite costs from the other in an integrated managed care program.

Separate Medicare and Medicaid administrative rules and procedures

Medicare and Medicaid have separate and often different procedures for administrative tasks, such as enrollment, disenrollment, eligibility, marketing, appeals, and performance reporting. Navigating and trying to align the two programs' administrative rules and processes is challenging for states, managed care entities, and dual-eligible individuals with limited resources. In addition, states can take many years to obtain federal approval for a Medicare and Medicaid managed care program. Further, each program cannot access health care claims from the other, and lack of data sharing in real time can inhibit care management and coordination between SNPs and states on covered services. SNPs and states can address some of the administrative barriers through close collaboration. For example, all but one of the SNPs participating in Minnesota's integrated care program contract with the state to be responsible for the plans' Medicare enrollment (Edwards et al. 2009).

The Patient Protection and Affordable Care Act established the Federal Coordinated Health Care Office within CMS. The Federal Coordinated Health Care Office goals include simplifying processes for dual-eligible beneficiaries and eliminating regulatory conflicts between Medicare and Medicaid and may help alleviate the administrative burdens of integrated care programs.

Low program enrollment

States can obtain waivers from CMS to mandate enrollment into Medicaid managed care; however, in contrast to states' authority over Medicaid benefits, states cannot require dual-eligible beneficiaries to enroll in a SNP to receive Medicare benefits. Under Medicare, beneficiaries have freedom of choice to select providers. Dual-eligible beneficiaries are permitted to receive their Medicare benefits through any MA plan (and can change plans monthly) or through any FFS provider. Duals may not recognize the advantages of an integrated care program (such as enhanced care coordination) and therefore may not choose to enroll in integrated care programs for their Medicare benefits.

Concluding observations

Approaches to better care coordination for dual-eligible beneficiaries need to combine financing streams and actively manage the care that beneficiaries receive. Without combined finances, an approach will not fully align provider and program incentives. A strategy to coordinate care is also needed. Likewise, care coordination alone would not align financial interests across providers and programs. Conflicting financial incentives could continue to result in unnecessary and fragmented care. Excluding long-term care from any approach will make it difficult to control federal spending for these services and result in less optimal coordinated care.

This review has not concluded whether one or more approaches to care integration are more or less likely to be successful. We have not assessed whether provider-based models (such as PACE) or health plan-based models (such as a state–SNP approach) will have better results. State–SNP arrangements appear to be successful at coordinating care for dual-eligible beneficiaries, but such arrangements were often initiated by states with a history of Medicaid managed care. States vary in their experience with and aversion to managed care and this model will not be equally replicable in all states. Future work will consider the characteristics of successful fully integrated programs and how enrollment might be expanded.

Care coordination activities should be tailored to patients' characteristics and their relative risk for costly undermanagement—potentially avoidable hospitalizations, medication mismanagement, and premature institutionalization. Beneficiaries at risk for institutionalization will need to be more closely monitored than the essentially well dual-eligible beneficiaries. Approaches for dual-eligible beneficiaries with several chronic conditions will need to emphasize communication and data sharing across the multiple providers and appropriate primary care to avert unnecessary facility-based care. Care management activities for cognitively impaired beneficiaries (a high-spending group) will need to be tailored to their ability to understand and adhere to care plans.

Integrated models of care should, like all beneficiary care, be evaluated with measures that gauge their relative efficiency—such as risk-adjusted hospitalization rates, nursing home use, emergency use, and per capita costs. Other measures should capture the extent to which and how well programs integrate the care dual-eligible beneficiaries receive using measures of care coordination and care transitions. Tying provider payment to these measures will put them at risk for achieving good patient outcomes.

Even if best models are identified, implementing full care integration for all dual-eligible beneficiaries will require a transition from the essentially uncoordinated world to one with active care management. There are multiple ways it could be accomplished. Integration could begin with certain services, such as cost sharing and optional Medicaid services. After successfully integrating these services, the models could be expanded to take on the more difficult (but more important, given the dollars at stake) set of long-term care services. Integration could also start with certain subgroups—either the high cost, those most at risk for costly undermanagement, or those with the most beneficiaries. Partial integration efforts need to be designed with enough flexibility so that other services and groups of beneficiaries can be folded in over time. ■

Endnotes

1 One study found that fewer than half of all Medicare beneficiaries with incomes at or below 100 percent of the federal poverty level were enrolled in Medicaid (Pezzin and Kasper 2002). Reasons for low participation rates include welfare stigma, a lack of information about program and eligibility criteria, and cumbersome enrollment processes.

2 There are four ways to be eligible for the Medicare Savings Program (MSP). Beneficiaries whose income is less than 100 percent of the federal poverty level (FPL) qualify for the qualified Medicare beneficiaries (QMBs) benefit, and Medicaid pays for their Medicare premiums and cost sharing. Some QMBs do not qualify for full Medicaid benefits (and are referred to as "QMB only"). In some states, higher income beneficiaries do not qualify for cost-sharing benefits but they do qualify for other Medicaid benefits. If their income is between 100 and 120 percent of FPL, then they qualify for the specified low-income Medicare beneficiaries benefit, and Medicaid pays for their Medicare Part B premiums. If their income is between 120 and 135 percent of FPL, then they qualify for the qualifying individuals benefit, and Medicaid pays for their Medicare Part B premium. If beneficiaries are working, disabled individuals with an income up to 200 percent of FPL, then they qualify for the qualified working disabled individuals benefit, and Medicaid pays their Medicare Part A premium. Under the provisions of the Medicare Improvements for Patients and Providers Act of 2008, for all these programs, beneficiary assets cannot exceed twice the Supplemental Security Income limit—$6,600 for individuals and $9,910 for couples (Centers for Medicare & Medicaid Services 2009). In 2008, the Commission recommended that the Congress raise the MSP income and asset criteria to those of the low-income drug subsidy criteria, which the Congress adopted beginning in 2010. This alignment updated the criteria (they were last revised in 1989) and will simplify the application process for beneficiaries and lower administrative costs of the programs.

3 The Balanced Budget Act of 1997 permitted states to not pay Medicare cost sharing if the Medicare rate minus the cost sharing is higher than the Medicaid rate for those services.

4 It is possible that there are community-dwelling duals with two or more physical impairments who, given our hierarchical categories, have been assigned to a cognitive impairment group.

5 Dual-eligible beneficiaries with end-stage renal disease (ESRD) were excluded from the analysis. They make up a small share of all dual-eligible beneficiaries (2 percent) and the very high spending on them would distort the underlying picture for the majority of dual-eligible beneficiaries. The average spending for ESRD dual-eligible beneficiaries is about three times that for other duals. In addition, physicians caring for beneficiaries with ESRD receive a monthly fee to manage their patients' dialysis. Therefore, ESRD patients have, to varying degrees, at least one of their underlying conditions managed by a physician.

6 The subgroups draw directly on the approach of Foote and Hogan in their analysis of the Medicare disabled population (Foote and Hogan 2001).

7 Most facilities are dually certified for both Medicaid and Medicare. To be covered under Medicare, a skilled nursing facility stay must be preceded by a three-day hospitalization and the patient must require skilled care (such as therapy or skilled nursing services). Medicare Advantage plans may waive the three-day hospital stay requirement and cover skilled care in a nursing facility as a Medicare-covered benefit.

8 In Duggan v. Bowen, beneficiaries and providers charged that Medicare's interpretation that services be "part-time or intermittent" was too narrow and denied care to eligible beneficiaries.

9 Many states have pursued Medicare maximization strategies to increase federal payments. When coverage for services is ambiguous for some beneficiaries—such as nursing home and home health services—states may require providers to first bill Medicare for services (or to pay the providers directly and then pursue Medicare reimbursement) as a way to have Medicare be the primary payer. States and providers prefer to have Medicare pay the claim: Providers prefer the higher payments generally paid by Medicare, while states can avoid paying for the service. Claims that are rejected by Medicare are then submitted to Medicaid for payments. This back-and-forth between payers can leave beneficiaries with unpaid bills until the coverage is sorted out. Some states have used contingency fee consultants to implement strategies—such as new methods to maximize federal reimbursements, state staff training in the claims submission process, and preparation of claims for federal reimbursement—designed to maximize federal reimbursements to state Medicaid programs (Government Accountability Office 2005).

10 Block grants to cover Medicaid services are not a new idea. A proposal to move Medicaid to block grants was made in 1981; they were again proposed in 1995 and 2003. These proposals outlined options for coverage and populations who had to be covered and included federal spending limits and annual increases. Although the limits on federal spending and the expanded state autonomy were attractive, a strong commitment to cover a vulnerable population and concerns about the fiscal impact on states have kept Medicaid as an entitlement program (Lambrew 2005).

11 For example, in 2003 the Bush Administration's block grant proposal included a provision that states show "maintenance of efforts" to receive federal funds—a kind of reverse matching funds (Mann 2004).

12 Application to §1915(c) HCBS Waiver Version 3.4. Appendix H. Available from http://www.hcbs.org/browse.php/sby/Date/type_tool/146/Waiver%20templates.

13 Commission calculations: estimated number of dual-eligible beneficiaries in integrated care programs and estimated number of dual-eligible beneficiaries in MA plans, including SNPs (Center for Health Care Strategies, Inc. 2009).

14 The 30 states with PACE programs are Arizona, California, Colorado, Florida, Hawaii, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, and Wisconsin. Source for states with PACE programs: MedPAC analysis of CMS, MA enrollment by state/county/contract, March 2010; source for PACE enrollment estimate: MedPAC calculation of CMS MA and Part D contract and enrollment data, February 2010.

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NQF
NATIONAL QUALITY FORUM

Measure Applications Partnership
Member Responsibilities

- Strong commitment to advancing the performance measurement and accountability purposes of the Partnership.

- Willingness to work collaboratively with other Partnership members, respect differing views, and reach agreement on recommendations. Input should not be limited to specific interests, though sharing of interests is expected. Impact of decisions on all healthcare populations should be considered. Input should be analysis and solution-oriented, not reactionary.

- Ability to volunteer time and expertise as necessary to accomplish the work of the Partnership, including meeting preparation, attendance and active participation at meetings, completion of assignments, and service on ad hoc groups.

- Commitment to attending meetings. Individuals selected for membership will not be allowed to send substitutes to meetings. Organizational representatives may request to send a substitute in exceptional circumstances and with advance notice. If an organizational representative is repeatedly absent, the chair may ask the organization to designate a different representative.

- Demonstration of respect for the Partnership's decision making process by not making public statements about issues under consideration until the Partnership has completed its deliberations.

- Acceptance of the Partnership's conflict of interest policy. Members will be required to publicly disclose their interests and any changes in their interests over time.

Adopted by the NQF Board of Directors on September 23, 2010

Measure Applications Partnership
Payment and Public Reporting

MAP

Americans cannot afford disjointed and inconsistent healthcare. Their dreams depend on healthy lives and on responsive, high-quality care when sickness comes. Their aspirations, as individuals and as a nation, depend on access to care with reasonable costs.

Performance measures move us toward care that is careful—careful to follow proven practices, use resources well, and focus on the patient's point of view. Performance measures will also be critical to achieving the priorities and goals of the soon-to-be-announced National Quality Strategy.

The choice of measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task. For that reason, the Patient Protection and Affordable Care Act directs the Secretary of Health and Human Services (HHS) to gain input from a consensus-based entity on the best measures to use in public reporting, value-based payment, and other programs.

In response to the Secretary's request, the National Quality Forum has established the Measure Applications Partnership. The MAP brings together stakeholder groups in a collaboration that balances the interests of consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers. The MAP also includes individual representatives with deep expertise in key areas and liaisons from public sector programs.

While HHS may consult many sources before making decisions on measure choices, the MAP will be a unique voice, blending the perspectives of diverse stakeholders informed by evidence.

Why the MAP?

The MAP will:

- Identify best available measures for use in specific applications.
- Provide input to HHS on measures for use in public reporting, value-based payment, and other programs.
- Encourage alignment of public and private sector efforts.

> *A collaboration like the MAP is a wonderful way to achieve the broad support America needs to make the fundamental changes in the delivery system that will produce meaningful gains in the health of people and communities.*
>
> George Isham, MD, MS, Co-Chair, the MAP Coordinating Committee

How the MAP will support better, more affordable care

At a policy level, we must create an environment that spurs alignment of programs around national goals and priorities through the key drivers of public reporting, value-based payment, and the provision of knowledge and tools to support improvement. Helping policy-makers and practitioners select the best measures to use in each application is where the MAP comes in.

The MAP will:

> STRENGTHEN PUBLIC REPORTING. Over the next several years, HHS will expand its Healthcare Compare websites to encompass a broader array of providers and include more information on their performance. Voters and their elected officials, patients and communities, clinicians, healthcare organizations, and every other stakeholder will have better information on which to base their choices. But the measures selected for these websites and other public reporting programs must provide meaningful and useful information that supports such decisions.
>
> SUPPORT IMPROVEMENTS IN QUALITY AND AFFORDABILITY. Because measures will tell us what does and doesn't work to sustain health and treat health problems, providers and payers will have better yardsticks for identifying best practices and channeling resources to health systems capable of providing care that is safe and effective.
>
> SERVE AS THE BASIS FOR PAYMENT, using models that align financial incentives with performance through Medicare and other publicly supported programs. Private payers will undoubtedly look to the MAP to drive their decisions on payment as well.

As requested by HHS, the MAP will first establish a framework that will guide the identification of performance measures for:

- Ambulatory practice settings.
- Post-acute settings, including long-term care hospitals, inpatient rehabilitation hospitals, skilled nursing facilities, and home healthcare.
- Cancer hospitals exempt from the prospective payment system.

The MAP will also develop guidance on measures related to care for dual eligible beneficiaries and reduction of readmissions and healthcare-acquired infections.

What is the MAP?

The MAP is a collaboration:

- Engaging more than 60 organizations representing major stakeholder groups; 40 individual experts; and eight federal agencies.
- Governed by a multi-stakeholder Coordinating Committee.
- Convened by the National Quality Forum.

> *The MAP will build on the remarkable work done for well over a decade to develop measures that can help us bring greater value into healthcare. We now have hundreds of measures. Our challenge is to help users pick the right ones for their application.*
>
> Elizabeth McGlynn, PhD, MPP, Co-Chair, the MAP Coordinating Committee

The MAP criteria

In each case, the appropriate MAP workgroup will:

- Consider measures already associated with the request for input. NQF will construct a catalog of current measures and analyze them for convergence and divergence and for alignment with the national goals.
- Identify a potential set of core measures, noting which ones are currently available and where gaps need to be filled.
- Look for ways to develop a more coordinated approach to measurement in the requested area.
- Provide input to the MAP Coordinating Committee, which will in turn provide guidance to HHS.

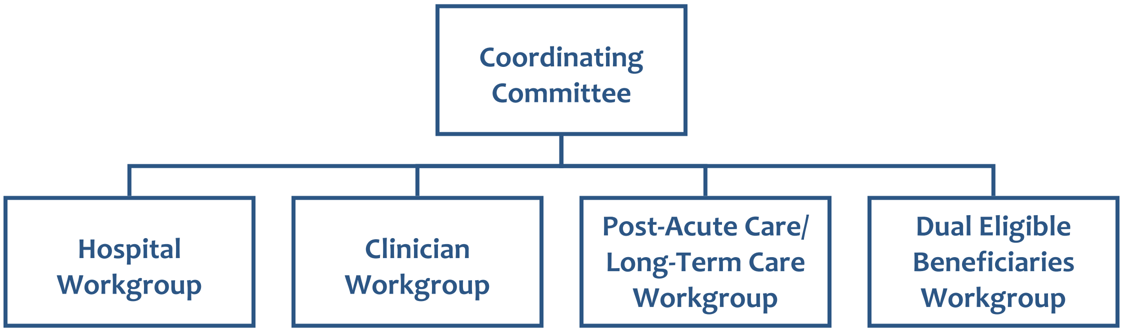
A few guiding principles

The MAP will:

- Use the priorities and goals of the National Quality Strategy *(soon to be announced)* to set its course.
- Give explicit consideration to the special issues of dual-eligible populations.
- Reinforce alignment across settings and between public and private efforts.
- Base recommendations on the latest science and evidence from the field.

How the MAP will work

The new partnership will operate through a two-tiered structure. A Coordinating Committee will provide direction. Four workgroups will advise the Coordinating Committee on measures needed for specific types of programs. Each workgroup will include individuals with content expertise and organizations particularly affected by that group's area of work.



The MAP will operate in a thoroughly transparent manner, broadcasting meetings, posting meeting summaries on the Web, and soliciting and responding to public comments. The MAP has already put this principle to work in every aspect of its start-up. As was the case for initial appointments, the MAP will continue to seek public nominations and comments on proposed members whenever slots open on the Coordinating Committee and work groups. While NQF convenes and staffs the MAP, the Coordinating Committee will provide guidance directly to the Department of Health and Human Services, not the NQF Board.

Working in concert

For more than a decade, the National Quality Forum has brought stakeholders together to bring strong measurement into the service of patients and communities. Its process for endorsement of best-in-class measures supports open dialogue among diverse members while it retains its grounding in science and evidence of impact. In 2008, NQF convened the National Priorities Partnership, which is now providing input to HHS on priorities and goals.

The MAP and the National Priorities Partnership focus their workgroups on different activities, but the two are closely aligned. The MAP identifies measures for specific applications such as public reporting and value-based payment; while NPP, within its broader brief, identifies more global measures of progress on the national priorities.

Over the last year, NQF has moved aggressively to support payment reform and public reporting by identifying gaps in measurement that must be filled; to accelerate the endorsement and review of measures in priority areas; and to recommend a framework for the choice of measures to assess "meaningful use" of health information technology. All of these activities will inform the work of the MAP and the National Priorities Partnership through overarching alignment with the National Quality Strategy.

What we see ahead

Performance measures give us a way to gauge improvements in our health and the quality of our healthcare. When well chosen, they can be powerful tools to make the course corrections our healthcare system so badly needs: coordinated care that centers on patients and families; focus on the chronic conditions that do so much to undermine health; and payment that correlates with performance. We will not achieve precise calibration overnight; but with its focus on measurement and alignment, the National Quality Strategy moves us in the right direction.

To learn more about the MAP, visit qualityforum.org.

This overview was prepared with support from the Robert Wood Johnson Foundation.

Measure Applications Partnership

Convened by the National Quality Forum

MAP Member Principles for Media and Public Engagement

As a participant in the MAP, you play a central and important role in making measure applications recommendations to the federal government. We anticipate sustained media and public interest in MAP. To ensure we are consistent in our approach to communications, and mindful of the sensitive nature of our collaborative work, please find below MAP Principles for Media and Public Engagement.

Press Releases and Supportive External Materials

NQF staff will develop all MAP-related press releases and supportive external materials, including releases about our public meetings and reports to HHS. MAP Coordinating Committee Co-Chairs will review and approve all press releases as part of their leadership responsibilities. NQF staff will share final press materials with members in advance of their public release. NQF media relations staff will serve as the central point of contact for members' communications staff and the press.

Press Engagement

MAP members will not engage with press on deliberations that are before the MAP. Members or their communications staff should refer press questions about deliberations, MAP processes, or MAP progress to the NQF press office. Once final reports that include recommendations are publicly issued, NQF is prepared to provide press and messaging support to you if you receive press calls. We encourage MAP members to answer press questions about the recommendations once they have been submitted; if you are not comfortable doing so, please refer any press calls to NQF. MAP members who are interested in developing their own press material about their role in MAP are encouraged to share drafts with NQF media relations staff in advance of distribution.

Public Engagement/Talks

MAP members are welcome to include information on MAP in their public engagements, but are asked to refrain from commenting on issues currently being deliberated by the MAP. Once final reports that include recommendations are publicly issued, members are encouraged to integrate information about the reports and recommendations into their scheduled talks. NQF staff will provide communications assistance in the form of Q&A, slides, key messages, and fact sheets to assist you with external engagement on the MAP.

Measure Applications Partnership (MAP) Backgrounder
(as of April 6, 2011)

The Measure Applications Partnership (MAP) will play a valuable role in improving the quality and value of healthcare.

As a participant in MAP, we thought you might benefit from this backgrounder for your use as you begin to receive and respond to inquiries about this important Partnership or weave information about MAP into your work. Please let us know if we can provide any additional background.

MAP Basics

1. What is MAP?

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum. MAP was created for the explicit purpose of providing input to the Department of Health and Human Services on the selection of performance measures for public reporting and performance-based payment programs.

2. Why is MAP important?

The choice of measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task. MAP is a unique voice in healthcare, blending the views of diverse groups who all have a vested interest in improving the quality of healthcare.

Through MAP activities, a wide variety of stakeholders will be able to provide input into HHS's selection of performance measures for public reporting and payment reform programs, which will allow for greater coordination of performance measures across programs, settings, and payers. MAP's balance of interests—representing consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers—ensures that HHS will receive well-rounded input on performance measure selection.

3. How will MAP determine on which priorities and goals to focus?

The MAP Coordinating Committee will compile a decision-making framework, which will include priorities from a number of different sources, including the newly released National Quality Strategy, the upcoming National Patient Safety Initiative and National Prevention and Health Promotion Strategy, the high-priority Medicare and child health conditions, and the patient-focused episodes of care model. Additionally, the committee will develop measure selection criteria to help guide their decision making.

4. Will MAP recommend only NQF-endorsed measures for government public reporting and payment reform programs? Will part of this effort point out measurement gaps and include those gaps in recommendations?

MAP will recommend the best measures available for specific uses, giving first consideration to NQF-endorsed measures. If MAP is seeking a type of measure currently not represented in the portfolio of NQF-endorsed measures, it will look outside for other available measures. When non-endorsed measures are used, the measure developer will be asked to submit the measure to an NQF endorsement project for consideration. Gaps identified in the endorsed measures available will be captured to inform subsequent measure development.

MAP Structure

5. How will MAP be structured?

MAP will be composed of a two-tiered structure. MAP's overall strategy will be set by the Coordinating Committee, and this committee will provide final input to HHS. Working directly under the Coordinating Committee will be four advisory workgroups—three that are settings-based and one that focuses on the dual eligible beneficiary population. The workgroups are flexible and can be changed as the work in the program evolves. More than 60 organizations representing major stakeholder groups, 40 individual experts, and nine federal agencies are represented in the Coordinating Committee and workgroups.

6. How will the Coordinating Committee and workgroups be appointed?

MAP's Coordinating Committee and workgroups were selected based on NQF Board-adopted selection criteria, which included nominations and an open public commenting period. Balance among stakeholder groups was paramount. Due to the complexity of MAP's tasks, it was also imperative that individual subject matter experts were included in the groups. Other considerations included adding individuals with expertise in health disparities and vulnerable populations, state representation, and individuals with experience in health IT. Federal government *ex officio* members are non-voting because federal officials cannot advise themselves.

A Nominating Committee, composed of seven NQF Board members, oversaw the appointment of the members of the Coordinating Committee through a public nominations process that was required by statute. The nomination period remained open for one month each for the Coordinating Committee (Sept. 29-Oct. 28, 2010) and the workgroups (Jan. 10-Feb. 7, 2011). The Nominating Committee proposed a roster for each group, which was vetted publicly, as required by statute. After careful consideration of public comments, the rosters were given final approval by the full NQF Board for the Coordinating Committee on Jan. 24, 2011, and for the workgroups on March 31, 2011. MAP members will serve staggered three-year terms, with the initial members drawing one-, two-, or three-year terms at random, allowing additional opportunities to serve to be available annually.

7. To whom will the committees report?

The Coordinating Committee will be overseen by the NQF Board, which was responsible for establishing MAP and selecting its members. The Board will review any procedural questions that arise about MAP's structure or function and will periodically evaluate MAP's structure, function, and effectiveness. The NQF Board will not review the MAP Coordinating Committee's input to HHS.

The Coordinating Committee will provide its input directly to HHS, while the workgroups will be charged by and report directly to the Coordinating Committee.

MAP: How NQF and HHS Work Together

8. Why did HHS choose NQF for this project?

The Affordable Care Act specifies the involvement of a neutral convener to manage engagement and coordination and to take a leadership role in the quality measurement field. With a wealth of measure endorsement experience, a deep network of members and partners, sufficient analytic support to assist in decision making, its relationship with HHS as a consensus-based entity, as well as its experience in convening the National Priorities Partnership, NQF is uniquely structured to meet these criteria. NQF's independence is also critical in filling this important advisory capacity.

9. Why can't HHS do this on its own?

Choosing measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task.

NQF's organizational structure and independent nature makes it uniquely positioned to be a neutral convener and to act as an additional resource to provide coordinated expertise into the HHS decision-making process.

10. Are HHS and CMS required to accept and implement NQF's recommendations?

HHS is required to take into consideration any input from MAP in its selection of quality measures for various uses, but final decisions about implementation are solely at HHS's discretion.

The Administrative Procedures Act requires that HHS's decisions be made through routine rulemaking processes. MAP is not a subregulatory process. Should HHS via its decision making decide to select a measure that is not NQF endorsed, it must publish a rationale for its decision.

11. How does all of this relate to the National Quality Strategy?

The National Quality Strategy (NQS) was released on March 21, 2011, by the Secretary of HHS. The NQS is very important to MAP, as it represents the primary basis not only for the MAP decision-making framework developed by the Coordinating Committee, but also for the overall MAP strategy designed to guide the workgroups. The MAP decision-making framework will remain somewhat fluid to allow it to evolve along with the NQS.

12. How quickly will MAP provide input, and how quickly thereafter do you predict the government will implements any or all of its recommendations?

The MAP Coordinating Committee will begin providing input to HHS in fall 2011, and HHS will begin utilizing this input in calendar year 2012.

MAP Impact on the General Public

13. How will the public benefit from this project?

MAP is designed to support broader national efforts to create better, more affordable care. Its work will strengthen public reporting, which has been demonstrated to improve quality, and will give people more and better information when making healthcare choices and help providers improve their performance. MAP recommendations also will help shape payment programs, creating powerful financial incentives to providers to improve care. Consumer and purchaser stakeholders will have a place and a voice in every discussion. Lastly, measure selection decisions made in public programs often have a spillover effect in private insurance markets, so choices made by HHS may have a much broader impact over time.

14. Will the public have input into the MAP process? How will MAP achieve transparency?

MAP's overriding goal in intent and in statute is to maintain transparency for the public and encourage public engagement throughout MAP's work.

The public has been involved in the MAP process from early on, starting with two rounds of public comment on the NQF Board's establishment of MAP to another two rounds of public nominations and public vetting of the rosters for both the MAP Coordinating Committee and its workgroups. All MAP meetings will be open to the public, and meeting summaries and conclusions will be posted on the NQF website. MAP will seek public comment on all input to HHS.

15. What might be the ultimate implication of MAP's work?

The Measure Applications Partnership has real potential to enact positive change in our nation's healthcare system and build on a decade of remarkable work to develop measures that can help bring greater value into healthcare. We now have hundreds of measures, but MAP can help users pick the right ones for their applications.

Some outcomes we hope to see from the project include a defragmentation of care delivery, heightened accountability of clinicians and providers, better and more information for consumer decision making, higher value for spending by aligning payment with performance, a reduced data collection burden through the alignment of measurement activities, and an improvement in the consistent provision of evidence-based care across measured domains.

MAP Member Press Release Template

FOR IMMEDIATE RELEASE
May XX, 2011

CONTACT: [Insert Name]
[Insert Phone Number]
[Insert Email Address]

[ABC Company] [Job Title] Selected as Member of Newly Formed Measure Application Partnership [Coordinating Committee/Workgroup Name]

Washington, DC – [Name, Title, Company], has been selected to participate as a member of the newly established Measure Applications Partnership (MAP) [Coordinating Committee/ Workgroup Name]. MAP is a public-private partnership convened by the National Quality Forum (NQF) for the explicit purpose of providing input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs, as required in The Affordable Care Act.

The National Quality Forum, a private-sector, consensus-based, standard-setting organization whose efforts center on the evaluation and endorsement of standardized performance measurement, formalized its agreement with HHS to convene the multi-stakeholder groups established for MAP in late March.

[Insert quote from committee/workgroup member]

Through MAP activities, the private sector and a wide variety of stakeholders will be able to provide input into HHS's selection of performance measures for public reporting and payment reform programs, which will allow for greater coordination of performance measures across programs, settings, and payers. MAP's balance of interests—representing consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers—ensures that HHS will receive well-rounded input on performance measure selection. MAP activities, including comment periods and meetings, will be made open to the public via the NQF website.

MAP measure selections will be made within the framework of the newly released National Quality Strategy, with the intention of selecting measures that address our national healthcare priorities and goals, such as making care safer and ensuring that each person and family are engaged as partners in their care.

The MAP Coordinating Committee and its four workgroups span more than 60 organizations and include 40 subject matter experts and nine federal agencies. Subject matter experts and government agencies are ex-officio members and will not vote on items before the coordinating committee.

"The choice of measures for gauging and rewarding progress is so important that no one perspective is adequate to inform the task," said Janet Corrigan, PhD, MBA, president and CEO of the National Quality Forum. “MAP’s diverse composition—representing the full spectrum of healthcare stakeholders—and NQF’s strong background as a neutral convener will be instrumental in ensuring that well-rounded, evidence-based input makes its way to the HHS Secretary for her consideration on which measures to use for public reporting and performance-based payment programs.”

The MAP Coordinating Committee will begin providing input to HHS in fall 2011, and HHS will begin utilizing this input in the calendar year 2012. More information about MAP is available here.
http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx

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Measure Applications Partnership
Dual Eligible Beneficiaries Workgroup Charge

Purpose

The charge of the Measure Applications Partnership (MAP) Dual Eligible Beneficiaries Workgroup is to advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. The Workgroup will develop an approach to performance measurement for this population and identify the quality improvement opportunities with the largest potential impact. The Workgroup will construct a measurement framework, identify available measures, identify gaps in available measures, and propose modifications and/or new measure concepts to fill those gaps. The Workgroup will also advise the Coordinating Committee on a coordination strategy for measuring hospital readmissions and healthcare-acquired conditions across public and private payers and on pre-rulemaking input to HHS on the selection of measures for various care settings.

Through the two-tiered MAP structure, the Dual Eligible Beneficiaries Workgroup will not give input directly to HHS; rather, the Workgroup will advise the Coordinating Committee on quality issues and performance measures for dual eligible beneficiaries. The Workgroup will be guided by the decision making framework and measure selection criteria adopted by the Coordinating Committee, including alignment with the HHS National Quality Strategy.

The activities and deliverables of the MAP Dual Eligible Beneficiaries Workgroup do not fall under NQF's formal consensus development process (CDP).

Tasks

The Dual Eligible Beneficiaries Workgroup will provide input to the Coordinating Committee through the following tasks:

1. Assessment of the quality issues specific to the population of dual eligible beneficiaries and identification of high-leverage opportunities for improvement.
2. Construction of a measurement strategy appropriate to the unique needs of dual eligible beneficiaries (e.g., physically/mentally disabled, frail elderly, groups for whom there are large disparities).
3. Identification of a core set of current measures that address the identified quality issues and are applicable to both specific (e.g., Medicare Advantage Special Needs Plans, PACE Programs) and broader care models (e.g., traditional FFS, ACOs, medical homes).
4. Identification of critical measure development and endorsement gaps.
5. Proposed modifications to existing measures that account for unique needs of dual eligible beneficiaries and/or identification of measure concepts for future measure development.
6. Advice to the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers.

7. Advice to the Coordinating Committee on their pre-rulemaking input to HHS on measures to improve quality across care settings, based on the Workgroup's knowledge of the unique needs of the dual eligible population.

Timeframe

This work will begin in May 2011, with an interim report due to HHS on October 1, 2011 and a final report due to HHS on June 1, 2012.

Membership

The MAP Dual Eligible Beneficiaries Workgroup roster is separately attached.

The terms of MAP members are for three years. The initial members will serve staggered terms, determined by random draw at the first in-person meeting. MAP workgroups are convened as needed, thus a Workgroup may be dissolved after the completion of the initial timeframe.

Procedures

MAP member responsibilities and operating procedures are separately attached.

HHS Task 15 - Timeline by Group -- REVISED May 23

DRAFT

Group	2011										2012					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov		Dec	Jan	Feb	Mar	Apr	May	Jun
MAP Coordinating Committee Sets charges for all workgroups and centralizes input; provides pre-rulemaking input to CMS (15.1)	**April 8 10a-12p** - 2 hr web meeting	**May 3 -4** - 2 day in-person meeting: big picture planning, charge for workgroups, framework (**May 13 2-4p** - 2 hr ALL MAP optional attendance at group web meeting)	**June 21-22** - 2 day in-person meeting, clinician- coordination strategy, dual's interim report, framework	**Aug 5 11a-1p** - 2 hr web meeting	**Aug 17-18** - 2 day in-person meeting, HACs and readmissions, finalize WG input for September reports, begin work on quality issues in 11 settings		**Oct 18 11a-1p**- 2 hr web meeting **Oct 19 2-4p** - 2hr public webinar to update on all tasks	**Nov 1-2** - 2 day in-person meeting, finalize PAC report, finalize quality issues in 11 settings	Measures published **by CMS on December 1**	**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework	Early Jan - 2-day in-person meeting to finalize pre-rulemaking input 1-2 week public comment period	**REPORT Feb 1st 15.1** Early Feb - informational public webinar Late Feb - 2 hr web meeting	Mid March - 2 day in-person meeting, finalize input on June reports			
Clinician Workgroup Coordination of measures for physician performance improvement (15.2a), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 7-8** - 2 day in-person meeting, framework, strategy for coordination of physician measurement, HACs & readmissions **June 30 1-3p** - 2 hr web meeting	**July 20-21** - 2 day in-person meeting to finalize strategy and themes for report on physician performance measurement, HACs & readmissions	late Aug - 2 week public comment period for physician strategy and HACs/readmissions	**REPORT Sept 30th 15.2a**	**Oct 19 2-4p** - 2hr public webinar to update on all tasks			**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework **Dec 12** - 1 day in-person meeting to react to proposed measures						
Hospital Workgroup Measures for PPS-exempt cancer hospitals (15.2c), major input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework					**Oct 19 2-4p** - 2hr public webinar to update on all tasks Early Oct - 2 hr web meeting?	**Oct 12-13** - 2 day in-person meeting to discuss hospital coordination framework and finalize measures for cancer hospitals		**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework **Dec 15** - 1 day in-person meeting to react to proposed measures				Early April - public webinar and 30 day comment period on draft cancer report		**REPORT June 1st 15.2c**
Ad Hoc Workgroup HACs & readmissions (15.4)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 9-10** - 2 day in-person meeting with additional payers, consider HACs & readmissions, framework	**July 11-12** - 2 day in-person meeting, review other groups' work on HACs and readmissions to finalize report on HACs & readmissions	late Aug - 2 week public comment period for physician strategy and HACs/readmissions	**REPORT Sept 30th 15.4**	**Oct 19 2-4p** - 2hr public webinar to update on all tasks									

* All dates are tentative and highly subject to change. Bolded dates confirmed final.

HHS Task 15 - Timeline by Group -- REVISED May 23

DRAFT

Group	**2011**										**2012**					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov		Dec	Jan	Feb	Mar	Apr	May	Jun
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 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 2-3** - 1.5 or 2 day in-person meeting to discuss duals' quality issues, HACs & readmissions, framework	**July 6 11a-1p** - 2 hr web meeting **July 25-26** - 2 day in-person meeting to continue discussion of quality issues, finalize preliminary themes, HACs & readmissions		**Interim REPORT Sept 30th 15.3**	**Oct 19 2-4p** - 2hr public webinar to update on all tasks and 30-day comment period on interim report	Nov 15 or 16 - 1 day in-person meeting, present public and HHS feedback, begin next phase	Measures published **by CMS on December 1**	**Dec 8 1-3p** - ALL groups on 2 hr web meeting to distribute measures with homework **Dec 16** - 2 hr web meeting to react to proposed measures	Late Jan - 2 hr web meeting	Mid Feb - 2 day in-person meeting to finalize measure concepts and themes for report		Early April - public webinar and 30 day comment period on draft duals report		**REPORT June 1st 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)		**May 13 2-4p** - 2 hr 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		Aug 9 (1-3p) or Aug 10 (11a-1p) - 2 hr web meeting	**Sep 8-9** - 2 day in-person meeting to discuss measures for PAC and coordination strategy	**Oct 19 2-4p** - 2hr public webinar to update on all tasks	Nov 21 (11a-1p), Nov 29 (1a- 3p), Dec 2 (10a-12p)- 30 day public comment period on PAC report and public webinar to introduce public comment on PAC report		**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework **Dec 14** - 1 day in-person meeting to react to proposed measures		**REPORT Feb 1st 15.2b** Mid Feb - 2 hr web meeting Late Feb - 2 day in-person meeting to finalize measures for hospice		Early April - public webinar and 30 day comment period on draft hospice report		**REPORT June 1st 15.2d**

* All dates are tentative and highly subject to change. Bolded dates confirmed final.

MAP Dual Eligible Beneficiaries Workgroup – Worksheet for June In-Person Meeting

During the afternoon discussion on the first day, identify points of convergence between the National Quality Strategy priorities, the emerging National Priorities Partnership goals, and the high-impact areas identified by the workgroup (to be added). The issues you identify may present potential targets for quality improvement through performance measurement. The column on 'Coordination of primary and behavioral healthcare' is provided as an example.

		High-Impact Areas Identified by Dual Eligible Beneficiaries Workgroup					
National Quality Strategy Priorities	**Emerging National Priorities Partnership Goals**						*Coordination of primary and behavioral healthcare*
Making care safer	• Reduce preventable hospital admissions and readmissions • Reduce the incidence of adverse healthcare-acquired conditions (e.g. healthcare-associated infections, pressure ulcers, falls, VTE) • Reduce harm (e.g., adverse drug events, unnecessary diagnostic radiation exposure)						improve medication adherence and reconciliation
Promoting effective communication and coordination of care	• Improve the quality of care transitions and communications across care settings • Improve quality of life for patients with chronic illness and disability by following a current care plan that addresses pain and symptom management, psychosocial needs, functional status, and prevention of complications • Establish shared accountability and integration of community resources and healthcare systems to improve quality of care and reduce health disparities						communication across multiple providers family involvement for consumers with non-controlled behavioral health problems

MAP Dual Eligible Beneficiaries Workgroup – Worksheet for June In-Person Meeting

		High-Impact Areas Identified by Dual Eligible Beneficiaries Workgroup					
National Quality Strategy Priorities	**Emerging National Priorities Partnership Goals**						*Coordination of primary and behavioral healthcare*
Ensuring person- and family-centered care	- Improve patient, family, and caregiver experiences of care related to quality, safety, and access across all settings - In partnership with patients, families, and caregivers—and using a shared decision-making process—develop care plans that are culturally sensitive and understandable - Enable patients and their families and caregivers to appropriately and effectively navigate, coordinate, and manage their care						*person-centered care planning to span both primary care and behavioral health* *assess progress toward treatment goals*
Effective prevention and treatment of the leading causes of mortality, starting with cardiovascular disease	Promote cardiovascular health through: - community interactions to improve social and environmental factors (e.g., access to healthy foods and recreational areas) - adoption of healthy lifestyle behaviors (e.g., reducing tobacco use, reducing consumption of solid fats and added sugars) - effective clinical preventive services across the lifespan (e.g., aspirin use, blood pressure control, cholesterol control)						*maintain or improve functional status* *manage co-morbid conditions* *harm reduction*

MAP Dual Eligible Beneficiaries Workgroup – Worksheet for June In-Person Meeting

		High-Impact Areas Identified by Dual Eligible Beneficiaries Workgroup					
National Quality Strategy Priorities	**Emerging National Priorities Partnership Goals**						*Coordination of primary and behavioral healthcare*
Working with communities to promote wide use of best practices to enable healthy living and well-being	Promote healthy living and well-being through: • community interventions to improve social and environmental factors (e.g., social supports, prevention of injury) • healthy lifestyle behaviors (e.g., increasing exercise and healthy eating, reducing substance use) • effective clinical preventive services across the lifespan (e.g., depression screening, oral health care)						promote wellness access to supportive services, including housing and transportation
Making quality care more affordable	• Promote value by increasing efficiency without compromising quality of care • Reduce amount of health care spending that goes to administrative burden • Increase transparency related to cost						reduce ER utilization differing philosophies about treatment - how much is enough and who decides?

MAP Dual Eligible Beneficiaries Workgroup – Worksheet for June In-Person Meeting

As your overnight assignment, consider how the priority areas and their convergence might influence the criteria for selecting measures.

	Priorities Identified by Dual Eligible Beneficiaries Workgroup					
Issues Related to Measure Selection Criteria						*Coordination of primary and behavioral healthcare*
Known measure sets and/or criteria sets						ECHO: CAHPS Behavioral Health Survey
Challenges or unique considerations for measurement						Role of family or caregivers in the care process Confidentiality laws Limited number of behavioral health providers, less electronic data available
Other comments						

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

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 Meklir, MPP
HHS Office on Disability	Henry Claypool
Substance Abuse and Mental Health Services Administration	Rita Vandivort-Warren, MSW
Veterans Health Administration	Daniel Kivlahan, PhD

5/25/2011

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)

George Isham, MD, MS

Elizabeth McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Bios of the MAP Dual Eligible Beneficiaries Workgroup

Chair (voting)

Alice Lind, MPH, BSN

Alice R. Lind is Director of Long Term Supports and Services and Senior Clinical Officer at the Center for Health Care Strategies (CHCS). She plays an integral role in the organization's efforts to improve care for Medicaid's high-need, high-cost populations, providing technical assistance through a variety of national initiatives. She is also involved in ongoing efforts to improve provider practices and child health quality. Ms. Lind has extensive clinical and Medicaid program development expertise through her 15 years of work in Washington State. She was previously Chief of the Office of Quality and Care Management in the Division of Healthcare Services, Health and Recovery Services Administration for Washington State, where she was responsible for the development and implementation of care coordination programs for Medicaid beneficiaries with chronic conditions and disabilities. She led the start up of a disease management program for 20,000 fee-for-service clients with asthma, congestive heart failure, diabetes, and end-stage renal disease. Under her direction, Washington implemented managed care programs that integrate health care, behavioral health and long-term care for Medicaid and Medicare dual eligible beneficiaries. In prior positions, Ms. Lind managed Washington’s Quality Management section, which was responsible for conducting research and evaluation on the quality of care provided to Medicaid managed care clients. She has held clinical positions in occupational health, hospice home care, managing a long-term care facility for terminally ill persons with AIDS, and intensive care. Ms. Lind received a master's degree in public health from the University of North Carolina-Chapel Hill, and a bachelor’s degree in nursing from Texas Christian University.

Organizational Members (voting)

American Association on Intellectual and Developmental Disabilities

Margaret Nygren, EdD

Dr. Nygren has 20 years of experience in the field of intellectual and developmental disabilities in a variety of capacities, including administrator, researcher, policy analyst, and consultant. As Executive Director of AAIDD, she has the honor of leading the oldest Association of professionals concerned with the promotion of progressive policies, sound research, effective practices, and universal human rights for people with intellectual and developmental disabilities. In her most recent previous position as Associate Executive Director for Program Development at the Association of University Centers on Disabilities (AUCD), Dr. Nygren was responsible for the management of national datasets and programs funded by the US Administration on Developmental Disabilities (ADD), Maternal and Child Health Bureau (MCHB), US Department of Education (ED), and US Department of Labor (DOL). Within the Disabled and Elderly Health Programs Group at the Centers for Medicare and Medicaid Services (CMS), Dr. Nygren completed a Fellowship where she provided and technical assistance in program policy areas that supported the President’s New Freedom Initiative, including the development of Money Follows the Person initiative. Other previous positions include Director of the Center on Aging and Disabilities at the Lieutenant Joseph P. Kennedy Institute in Washington, DC, and Director of Family Support Services and Director of Mental Retardation Services at Kit Clark Senior Services in Boston. Dr. Nygren earned a Doctorate of Education in Organizational Leadership from Nova Southeastern University, a MA in Clinical Psychology from West Virginia University, and a BA in Psychology from Beloit College.

American Federation of State, County and Municipal Employees

Sally Tyler, MPA

Sally Tyler is the senior health policy analyst for the American Federation of State, County and Municipal Employees (AFSCME), based in Washington, DC. She reviews both federal and state health policy for potential impact on the union's members. Areas of specialization include Medicaid, health care delivery systems, health care information technology and quality standards reporting. She recently served as co-chair of the steering committee for the National Quality Forum's patient safety project on serious reportable events. She was a consumer member of the Health Care Information Technology Standards Panel (HITSP) as it made recommendations for interoperability regarding adoption of electronic health records. She is on the advisory board of the American Academy of Developmental Medicine. Tyler has an undergraduate degree from Emory University and a graduate degree from Harvard's Kennedy School of Government.

American Geriatrics Society

Jennie Chin Hansen, RN, MS, FAAN

Jennie Chin Hansen is CEO of the American Geriatrics Society and immediate past President of AARP. The AGS is the nation's leading membership organization of geriatrics healthcare professionals, whose shared mission is to improve the health, independence and quality of life of older people. As a pivotal force in shaping practices, policies and perspectives in the field, the Society focuses on: advancing eldercare research; enhancing clinical practice in eldercare; raising public awareness of the healthcare needs of older people; and advocating for public policy that ensures older adults access to quality, appropriate, cost-effective care. In 2005, Hansen transitioned after nearly 25 years with On Lok, Inc., a nonprofit family of organizations providing integrated, globally financed and comprehensive primary, acute and long-term care community based services in San Francisco. The On Lok prototype became the 1997 federal Program of All Inclusive Care to the Elderly (PACE) Program into law for Medicare and Medicaid. PACE now has programs in 30 states. In May 2010, she completed her two year term as President of AARP during the national debate over health care reform, in addition to, the other six years she was on AARP's national board of directors. Since 2005, she has served as federal commissioner of the Medicare Payment Advisory Commission (MedPAC). In 2010 she served as an IOM member on the RWJ Initiative on the Future of Nursing. She currently serves as a board member of the SCAN Foundation and a board officer of the National Academy of Social Insurance. In 2011 she begins as a board member of the Institute for Healthcare Improvement (IHI). Jennie has received multiple awards over the years including the 2003 Gerontological Society of America Maxwell Pollack Award for Productive Living, a 2005 Administrator's Achievement Award from the Centers for Medicare and Medicaid Services, and an honorary doctorate from Boston College in 2008.

American Medical Directors Association

David Polakoff, MS, MsC

Dr. David Polakoff is the Chief Medical Officer of MassHealth, and Director of the Office of Clinical Affairs of the Commonwealth Medicine Division of the University of Massachusetts Medical School. Dr. Polakoff is a noted Geriatrician, with over a decade of experience as a senior health care executive. Dr. Polakoff served as Chief Medical Officer of Mariner Health Care, and Genesis Health Care, and is the founder of Senior Health Advisors, a consulting firm. Dr. Polakoff has a longstanding interest in health policy, with a particular eye toward quality of services for the aging population, research on related topics, and has delivered hundreds of invited presentations.

Better Health Greater Cleveland

Patrick Murray, MD, MS

Dr. Patrick Murray is an associate professor of Physical Medicine and Rehabilitation at Case Western Reserve University School of Medicine. Dr. Murray has more than 30 years experience in practice, administration, and research related to long term care services and supports and rehabilitation services. He has worked in Cleveland for 26 years at both MetroHealth Medical Center and Case Western Reserve University serving as Director of the Department of Physical Medicine and Rehabilitation and as medical director of the PACE program in Cleveland. He was co-director of the Program for Research and Education on Aging in the Center for Health Care Research and Policy where he is currently a senior scholar. Before coming to Cleveland, Dr. Murray was on the faculty at the University of Rochester and was in medical practice in rural West Virginia in a practice focused on geriatrics at a community clinic sponsored by the United Mine Workers. Dr. Murray's research has focused on rehabilitation issues in long term care especially in the post acute settings. He serves on the editorial board of the Archives of Physical Medicine and Rehabilitation. He has participated with Better Health Greater Cleveland over the past three years with special interests in the care of persons in nursing homes. Presently his work is focused on developing and evaluating approaches that improve the efficiency and quality of long term services and supports in underserved urban settings. Dr. Murray has a bachelor's degree in Biology from the University of Chicago, an MD degree from SUNY at Stonybrook, and a Master's Degree in Health Services Research from Case Western Reserve University. He is board certified in both Internal Medicine with Special Qualifications in Geriatrics and Physical Medicine and Rehabilitation.

Center for Medicare Advocacy, Inc.
Patricia Nemore, JD

Patricia Nemore specializes in issues affecting low income beneficiaries dually eligible for Medicare and Medicaid. For the past ten years, she has done that work as an attorney in the Washington, DC office of the Center for Medicare Advocacy. She was actively involved in designing and advocating for low-income beneficiary-related provisions in legislation passed in 2008 and in the Affordable Care Act of 2010. Ms. Nemore's work includes litigation, testimony, training, and legislative and administrative advocacy. She has authored or co-authored three reports on the Medicare Savings Programs and several articles on Medicare Advantage Special Needs Plans. She received a J.D. from Catholic University and a B.A. from Northwestern University.

National Health Law Program
Leonardo Cuello, JD

Leonardo Cuello joined the National Health Law Program in December 2009 as a Staff Attorney in the D.C. office. Leonardo works on health care for older adults, reproductive health, and health reform implementation. Prior to joining NHeLP, Leonardo worked at the Pennsylvania Health Law Project (PHLP) for six years focusing on a wide range of health care issues dealing with eligibility and access to services in Medicaid and Medicare. From 2003 to 2005, Leonardo was an Independence Foundation Fellow at PHLP and conducted a project focused on immigrant and Latino health care, including direct representation of low-income immigrants and Latinos. From 2006 to 2009, Leonardo worked on numerous Medicaid eligibility and services issues though direct representation and policy work, and served briefly as PHLP's Acting Executive Director. During that time, he also worked on Medicare Part D implementation issues, PHLP's Hospital Accountability Project, and also served as legal counsel to the Consumer Subcommittee of Pennsylvania's Medical Care Advisory Committee. Leonardo graduated with a B.A. from Swarthmore College and a J.D. from The University of Pennsylvania Law School.

Humana, Inc.
Thomas James, III, MD

Dr. Tom James is Corporate Medical Director for Humana. In this capacity he is responsible for providing the clinical input into the quality and efficiency measurements and display of health care providers within the Humana network. Dr. James works closely with national and local professional organizations and societies to explain Humana's goals on transparency and other clinical issues, and to receive feedback that allows for greater alignment between Humana and the national professional groups. He is also involved with Humana's group Medicare clinical program development. He is providing consulting services to Humana's major and national accounts. Dr. James was previously Humana's chief medical officer for

Kentucky, Indiana and Tennessee and the Medical Advisor to the Strategic Advisory Group of Humana Sales. He has nearly thirty years of experience in health benefits having served as medical director for such health companies as HealthAmerica, Maxicare, Sentara, Traveler's Health Network, and Anthem, in the Mid-Atlantic, Midwest and South. Dr. James is board certified in Internal Medicine and in Pediatrics. He received his undergraduate degree from Duke University and his medical degree from the University of Kentucky. Dr. James served his residencies at Temple University Hospital, Pennsylvania Hospital, and Children's Hospital of Philadelphia. He is currently the chairman of the Patient Safety Task Force for the Greater Louisville Medical Society. He is on the Board of such organizations as Kentucky Opera, Hospice of Louisville Foundation, and Kentucky Pediatrics Foundation. He chairs the Health Plan Council for the National Quality Forum (NQF), and is on work groups for both the AQA Alliance and the AMA PCPI. Dr. James remains in part-time clinical practice of internal medicine-pediatrics.

L.A. Care Health Plan
Laura Linebach, RN, BSN, MBA

Laura Linebach, RN, MBA is the Quality Improvement Director for L.A. Care Health Plan, the largest public entity health plan in the country with over 800,000 members. She directs the company-wide quality improvement programs as well as the disease management program for several product lines including Medicaid and Medicare HMO Special Needs Plan. Before L.A. Care, she was the Quality improvement Director in the commercial HMO area. She has more than 30 years of experience as a healthcare quality professional and leader and has taught numerous classes on nursing history and Quality Improvement throughout her career. Ms. Linebach has had extensive experience in quality management in the military, managed care organizations, community mental health centers and the state mental health hospital setting. She has led organizations through multiple successful NCQA accreditation reviews as well as several of The Joint Committee visits. She founded the Nursing Heritage Foundation in Kansas City Missouri to collect and preserve nursing history and has written several articles related to nursing history. Ms Linebach also served as a flight nurse in the Air Force Reserves and later as Officer-in-Charge of the Immunization Clinic for the 442nd Medical Squadron. She is a member of the National Association for Healthcare Quality and the California Association for Healthcare Quality. Ms. Linebach has a Bachelor of Science degree in nursing from Avila College, Kansas City, Missouri and a master's in history as well as business administration from the University of Missouri-Kansas City.

National Association of Public Hospitals and Health Systems
Steven Counsell, MD

Steven R. Counsell, MD is the Mary Elizabeth Mitchell Professor and Chair in Geriatrics at Indiana University (IU) School of Medicine and Founding Director of IU Geriatrics, a John A. Hartford Foundation Center of Excellence in Geriatric Medicine. He serves as Chief of Geriatrics and Medical Director for Senior Care at Wishard Health Services, a public safety net health system in Indianapolis, Indiana. Dr. Counsell recently returned from Australia where as an Australian American Health Policy Fellow he studied "Innovative Models of Coordinating Care for Older Adults." Prior to his sabbatical, he served as Geriatrician Consultant to the Indiana Medicaid Office of Policy and Planning. Dr. Counsell is a fellow of the American Geriatrics Society (AGS), immediate past Chair of the AGS Public Policy Committee, and current member of the AGS Board of Directors. Dr. Counsell has conducted large-scale clinical trials testing system level interventions aimed at improving quality, outcomes, and cost-effectiveness of healthcare for older adults. He was the PI for the NIH funded trial of the Geriatric Resources for Assessment and Care of Elders (GRACE) care management intervention shown to improve quality and outcomes of care in low-income seniors, and reduce hospital utilization in a high risk group. Dr. Counsell was a 2009-2010 Health and Aging Policy Fellow and is currently working to influence health policy to improve integration of medical and social care for vulnerable elders.

National Association of Social Workers
Joan Levy Zlotnik, PhD, ACSW

Dr. Zlotnik has more than 20 years of experience working in leadership positions within national social work organizations. Her pioneering work has focused on forging academic/agency partnerships and on strengthening the bridges between research, practice, policy and education. She currently serves as the director of the Social Work Policy Institute (SWPI), a think tank established in the NASW Foundation. Its mission is to strengthen social work's voice in public policy deliberations. SWPI creates a forum to examine current and future issues in health care and social service delivery by convening together researchers, practitioners, educators and policy makers to develop agendas for action. Dr. Zlotnik served as the director of the Strengthening Aging and Gerontology Education for Social Work (SAGE-SW), the first project supported by the John A. Hartford Foundation as part of its Geriatric Social Work Initiative (GSWI) and has undertaken several projects to better meet psychosocial needs in long term care. Dr. Zlotnik's work in aging, family caregiving and long term care has been recognized through her election as a Fellow of the Gerontological Society of America and as a recipient of the Leadership Award of the Association for Gerontology Education in Social Work (AGE-SW). Prior to being appointed as director of SWPI, Dr. Zlotnik served for nine years as the Executive Director of the Institute for the Advancement of Social Work Research (IASWR), working closely with the National Institutes of Health (NIH), other behavioral and social science disciplines and social work researchers. Under her leadership the growth in social work research was documented and training and technical assistance was offered to doctoral students, early career researchers and deans and directors on building social work research infrastructure and capacity. Previous to IASWR she served as Director of Special Projects at the Council on Social Work Education (CSWE) and as a lobbyist and Staff Director of the Commission on Families for the National Association of Social Workers. Dr. Zlotnik is an internationally recognized expert on workforce issues for the social work profession, and is the author of numerous publications covering the lifespan including developing partnerships, enhancing social work's attention to aging, providing psychosocial services in long term care, and evidence-based practice. She holds a PhD in Social Work from the University of Maryland, an MSSW from the University of Wisconsin-Madison, and a BA from the University of Rochester. Dr. Zlotnik is an NASW Social Work Pioneer© was recognized by the National Institute of Health's (NIH) Social Work Research Working Group for her efforts on behalf of social work research at NIH, and is a recipient of the Association of Baccalaureate Social Work Program Director's (BPD) Presidential Medal of Honor.

National PACE Association

Adam Burrows, MD

Dr. Adam Burrows has been the Medical Director of the Upham's Elder Service Plan, the PACE program operated by the Upham's Corner Health Center in Boston, since the program's inception in 1996. Dr. Burrows is a member of the Boston University Geriatrics faculty and Assistant Professor of Medicine at the Boston University School of Medicine, where he has twice received the Department of Medicine's annual Excellence in Teaching Award for community-based faculty. Dr. Burrows has been active nationally in promoting and supporting the PACE model of care, serving as chair of the National PACE Association's Primary Care Committee, health services consultant for the Rural PACE Project, editor of the PACE Medical Director's Handbook, and member of the National PACE Association Board of Directors. Dr. Burrows is also the statewide Medical Director for the Senior Care Options program of Commonwealth Care Alliance, a Medicare Advantage Special Needs Plan and one of the four Massachusetts Senior Care Organizations. He has developed ethics committees for Commonwealth Care Alliance and for a consortium of rural PACE organizations, where he serves as chair. Dr. Burrows lectures frequently on dementia, depression, care delivery, ethical issues, and other topics in geriatrics, and since 1997 has led a monthly evidence-based geriatrics case conference at Boston Medical Center. He is a graduate of the Mount Sinai School of Medicine and completed his medical residency at Boston City Hospital, chief residency at the Boston VA Medical Center, and geriatric fellowship at the Harvard Division on Aging. He is board-certified in Internal Medicine and Geriatric Medicine.

Individual Subject Matter Expert Members (voting)

Substance Abuse
Mady Chalk, MSW, PhD

Mady Chalk, Ph.D. is the Director of the Center for Policy Analysis and Research at the Treatment Research Institute (TRI) in Philadelphia, PA. The Center focuses on translation of research into policy, particularly focused on quality improvement and standards of care, new purchasing strategies for treatment services, implementation and evaluation of performance-based contracting, and integrated financing for treatment in healthcare settings. The Center also supports the Mutual Assistance Program for States (MAPS) which provides an arena in which States and local policy makers, purchasers, elected officials, and treatment providers meet with clinical and policy researchers to exchange ideas and develop testable strategies to improve the delivery of addiction treatment. Prior to becoming a member of the staff of TRI, for many years Dr. Chalk was the Director of the Division of Services Improvement in the Federal Center for Substance Abuse Treatment (CSAT)/Substance Abuse and Mental Health Services Administration (SAMHSA). For 15 years before coming to the Washington area, Dr. Chalk was a faculty member in the Yale University School of Medicine, Department of Psychiatry and the Director of the Outpatient /Community Services Division of Yale Psychiatric Institute. She received her Ph.D. in Health and Social Policy from the Heller School at Brandeis University.

Emergency Medical Services
James Dunford, MD

Dr. Dunford has served as Medical Director of San Diego Fire-Rescue since 1986 and became City Medical Director in 1997. Jim is Professor Emeritus at the UC, San Diego School of Medicine where he has practiced emergency medicine since 1980. Dr. Dunford attended Syracuse University and Columbia University College of Physicians & Surgeons and is board-certified in Emergency Medicine and Internal Medicine. He previously served as flight physician and medical director of the San Diego Life Flight program and founded the UCSD Emergency Medicine Training Program. Dr. Dunford’s interests include translating research in heart attack, trauma and stroke care to the community. He investigates the interface between public health and emergency medical services (EMS). For his work with the San Diego Police Department Serial Inebriate Program (SIP) he received the 2007 United States Interagency Council on Homelessness Pursuit of Solutions Award. Dr. Dunford collaborates with the SDPD Homeless Outreach Team (HOT) and directs the EMS Resource Access Program (RAP) to case-manage frequent users of acute care services. He is a Co-investigator in the Resuscitation Outcomes Consortium (ROC), a US-Canadian effort responsible for conducting the largest out-of-hospital cardiac arrest and trauma resuscitation trials in North America.

Disability
Lawrence Gottlieb, MD, MPP

Larry Gottlieb is a board-certified internal medicine physician with 25 years of experience in health care quality management and improvement with numerous publications on quality in the medical and health policy literature. He has held several senior leadership positions in managed care and clinical information systems development and has been widely recognized for strategic thinking and effective leadership among healthcare industry executives. Larry has also been a leader in the launching and ongoing success of several healthcare collaborative efforts designed to improve care for patients and simplify processes for providers and has numerous publications. Immediately prior to joining Commonwealth Care Alliance, Larry served as Vice President and Senior Medical Director at Health Dialog, a Boston-based international wellness and chronic care support organization. From 2000 to 2007, Larry served as Senior Vice President and Chief Medical Officer of two early stage care management information technology companies using internet technology and home monitoring technology to support improved care for patients with chronic diseases. From 1987 to 2000, Larry served as a Medical Director at Harvard Community Health Plan and Harvard Pilgrim Health Care in a variety of leadership positions focused on improving the quality of care delivered to the Health Plan's members. During that time, Larry led multiple successful NCQA accreditation efforts, oversaw the development of highly successful preventive care and chronic disease management programs, and developed and implemented the first comprehensive managed care evidence-based clinical practice guidelines program in the United States, achieving international recognition. Larry also played a leadership role in the launching of several Massachusetts healthcare collaboratives, including the Massachusetts Healthcare Quality Partnership, the Alliance for Health Care Improvement, the New England Region Public Health Managed Care Collaborative, and the Massachusetts eHealth Collaborative. He has served on the Board of Directors of several other healthcare organizations, including Health New England, Network Health, and MassPRO. Larry obtained his undergraduate degree in engineering and his medical degree from Tufts University and a Master of Public Policy degree from Harvard's Kennedy School of Government. He completed a residency in internal medicine at Tufts New England Medical Center and was a Robert Wood Johnson Clinical Scholar at Stanford University.

Measure Methodologist

Juliana Preston, MPA

Juliana Preston is the Vice President of Utah Operations for HealthInsight. Ms. Preston is responsible for leading the organization's quality improvement division in Utah. As the leader of the quality improvement initiatives, she oversees the management of the Medicare quality improvement contract work and other quality improvement related contracts in Utah. Ms. Preston has extensive experience working with nursing homes. She has developed numerous workshops and seminars including root cause analysis, healthcare quality improvement, human factors science, and resident-centered care. In addition to her experience at HealthInsight, she has held various positions during her career in long-term care including Certified Nursing Assistant, Admissions & Marketing Coordinator. Ms. Preston graduated from Oregon State University in 1998 with a Bachelor's of Science degree with an emphasis in Long Term Care and minor in Business Administration. In 2003, she obtained her Master's degree in Public Administration from the University of Utah with an emphasis in Health Policy.

Home & Community-Based Services

Susan Reinhard, RN, PhD, FAAN

Susan C. Reinhard is a Senior Vice President at AARP, directing its Public Policy Institute, the focal point or public policy research and analysis at the federal, state and international levels. She also serves as the Chief Strategist for the Center to Champion Nursing in America at AARP, a national resource and technical assistance center created to ensure that America has the nurses it needs to care for all of us now and in the future. Dr. Reinhard is a nationally recognized expert in nursing and health policy, with extensive experience in translating research to promote policy change. Before coming to AARP, Dr. Reinhard served as a Professor and Co-Director of Rutgers Center for State Health Policy where she directed several national initiatives to work with states to help people with disabilities of all ages live in their homes and communities. In previous work, she served three governors as Deputy Commissioner of the New Jersey Department of Health and Senior Services, where she led the development of health policies and nationally recognized programs for family caregiving, consumer choice and control in health and supportive care, assisted living and other community-based care options, quality improvement, state pharmacy assistance, and medication safety. She also co-founded the Institute for the Future of Aging Services in Washington, DC and served as its Executive Director of the Center for Medicare Education. Dr. Reinhard is a former faculty member at the Rutgers College of Nursing and is a fellow in the American Academy of Nursing. She holds a master's degree in nursing from the University of Cincinnati, and a PhD in Sociology from Rutgers, The State University of New Jersey.

Mental Health

Rhonda Robinson Beale, MD

Rhonda Robinson Beale, MD, has more than 30 years' experience in the fields of managed behavioral healthcare and quality management. She is the chief medical officer of OptumHealth Behavioral Solutions (formerly United Behavioral Health). Before joining United, she served as the senior vice president and chief medical officer of two prominent organizations, PacifiCare Behavioral Health (PBH) and CIGNA Behavioral Health. As a highly respected member of the behavioral health community, Dr. Robinson Beale has been involved extensively with the National Committee for Quality Assurance (NCQA), National Quality Forum, and the Institute of Medicine. Dr. Robinson Beale was a member of the committee that produced To Err is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century. Dr. Beale served over 8 years on Institute of Medicine's (IOM) Neuroscience and Behavioral Health and Health Care Services Boards. She serves as a committee member and consultant to various national organizations such as NQF, NCQA, NBGH, NIMH, SAMHSA, and is a past Board Chair of the Association for Behavioral Health and Wellness.

Nursing

Gail Stuart, PhD, RN

Dr. Gail Stuart is dean and a tenured Distinguished University Professor in the College of Nursing and a professor in the College of Medicine in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina. She has been at MUSC since 1985 and has served as Dean of the College of Nursing since 2002. Prior to her appointment as Dean, she was the director of Doctoral Studies and coordinator of the Psychiatric-Mental Health Nursing Graduate Program in the College of Nursing. She was also the Associate Director of the Center for Health Care Research at MUSC and the administrator and Chief Executive Officer of the Institute of Psychiatry at the Medical University where she was responsible for all clinical, fiscal, and human operations across the continuum of psychiatric care. She received her Bachelor of Science degree in nursing from Georgetown University, her Master of Science degree in psychiatric nursing from the University of Maryland, and her doctorate in behavioral sciences from Johns Hopkins University, School of Hygiene and Public Health. Dr. Stuart has taught in undergraduate, graduate, and doctoral programs in nursing. She serves on numerous academic, corporate, and government boards and represents nursing on a variety of National Institute of Mental Health policy and research panels, currently serving on the NINR Advisory Council. She is a prolific writer and has published numerous articles, chapters, textbooks, and media productions. Most notable among these is her textbook, *Principles and Practice of Psychiatric Nursing*, now in its 9th edition, which has been honored with four Book of the Year Awards from the *American Journal of Nursing* and has been translated into 5 languages. She has received many awards, including the American Nurses Association Distinguished Contribution to Psychiatric Nursing Award, the Psychiatric Nurse of the Year Award from the American Psychiatric Nurses Association, and the Hildegard Peplau Award from the American Nurses Association.

Federal Government Members (non-voting, ex officio)

Agency for Healthcare Research and Quality (AHRQ)

D.E.B. Potter, MS

D.E.B. Potter is a Senior Survey Statistician, in the Center for Financing, Access and Cost Trends (CFACT), Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services (HHS). Her work focuses on improving the measurement of the long-term care (LTC) and disabled populations at the national level. Efforts include data collection and instrument design; measuring use, financing and quality of health care; and estimation issues involving people with disabilities that use institutional, sub-acute and home and community-based services (HCBS). In 2002, she (with others) received HHS Secretary's Award "for developing and implementing a strategy to provide information the Department needs to improve long-term care." She currently serves as Co-Lead, AHRQ's LTC Program, and is responsible for AHRQ's Assisted Living Initiative and the Medicaid HCBS quality measures project.

Centers for Medicare & Medicaid Services (CMS), Medicare-Medicaid Coordination Office

Cheryl Powell

Cheryl Powell has recently been appointed the Deputy Director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services (CMS). As the Deputy Director, Ms. Powell will assist the Director in leading the work of this office charged with more effectively integrating benefits to create seamless care for individuals' eligible for both Medicare and Medicaid and improving coordination between the federal government and states for such dual eligible beneficiaries. Ms. Powell has extensive experience in both Medicare and Medicaid policy development and operations. She is an expert on Medicaid reform activities and policy development. During her tenure at CMS, she designed and oversaw the implementation of Medicaid program and financial policy as well as national Medicaid managed care, benefits and eligibility operations. While working at Hilltop Institute, Ms. Powell evaluated Medicaid programs and worked with state and local officials to improve quality and health care delivery. Ms. Powell also has extensive knowledge of Medicare operations which will assist in the management of the new office. As Director of Medicare Policy at Coventry Health Care, she worked to improve compliance processes and business operations for Medicare Advantage plans. Ms. Powell previously managed Medicare beneficiary services at the CMS Chicago regional office and played a key role in the implementation and outreach of the Medicare Modernization Act. Ms. Powell earned a master's degree in public policy from The John F. Kennedy School of Government at Harvard University and graduated *summa cum laude* from the University of Virginia a bachelor's degree in psychology.

Health Resources and Services Administration (HRSA)

Samantha Wallack Meklir, MPP

Samantha Wallack Meklir, MPP, is an Analyst in the Office of Health Information Technology and Quality (OHITQ) of the Health Resources and Services Administration, U.S. Department of Health and Human Services, where she supports planning and implementing policies and programs related to quality and to health information technology across HRSA and with external stakeholders. As such, some of her activities include (but are not limited to) serving as the Federal Government Task Leader on a Report to Congress on quality incentive payments currently underway and helping to prepare HRSA grantees for meaningful use stage two measures. Samantha began her federal career as a Presidential Management Intern (PMI) and worked at both HRSA and CMS in various positions focusing on Medicaid legislation and programs, health information technology and quality, and the safety net. She served as Legislative Fellow for the late U.S. Senator Paul Wellstone (D-MN) and later as a Social Science Research Analyst in the CMS Office of Legislation Medicaid Analysis Group. Samantha worked for CMS not only in their OL but also in their Chicago Regional Office where she focused on home and community based waivers and later in the Baltimore Center for Medicaid and State Operations Children's Health Program Group where she focused on Section 1115 demonstration programs in family planning, health insurance flexibility employer-sponsored insurance programs, and SCHIP. Samantha contributed to the President's New Freedom Initiative during her tenure at CMS OL. Since 2006, Samantha has been focused on health information technology and quality at HRSA. Samantha has a bachelor's degree in American Studies from Tufts University and a master's degree in public policy from the Lyndon B. Johnson School of Public Affairs (UT Austin).

HHS Office on Disability

Henry Claypool

As the Director of the Office on Disability, Mr. Henry Claypool serves as the primary advisor to the HHS Secretary on disability policy and oversees the implementation of all HHS programs and initiatives pertaining to Americans with disabilities. Mr. Claypool has 25 years of experience with developing and implementing disability policy at the Federal, State, and local levels. As an individual with a disability, his personal experience with the nation's health care system provides a unique perspective to the agencies within HHS and across the Federal government. Mr. Claypool sustained a spinal injury more than 25 years ago. In the years following his injury, he relied on Medicare, Medicaid, Social Security Disability Insurance and Supplemental Security Income, which enabled him to complete his bachelor's degree at the University of Colorado. After completing his degree, he spent five years working for a Center for Independent Living, after which he became the Director of the Disability Services Office at the University of Colorado-Boulder. Mr. Claypool also served as the Director of Policy at Independence Care System, a managed long-term care provider in New York City. Mr. Claypool served for several years as an advisor to the Federal government on disability policy and related issues. From 1998-2002, he held various advisory positions at HHS, including Senior Advisor on Disability Policy to the Administrator of the Centers for Medicare and Medicaid Services during the Clinton administration. From 2005-2006, he served as a Senior Advisor to the Social Security Administration's Office of Disability and Income Support Programs. In 2007, Mr. Claypool was also appointed by Governor Tim Kaine of Virginia to serve on the Commonwealth's Health Reform Commission.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Rita Vandivort-Warren, MSW

Rita Vandivort-Warren is a Public Health Analyst and government project officer in the Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. She has over 20 years' experience in mental health, substance abuse and health administration, program development and policy formulation. At SAMHSA, she handles numerous assignments in financing of treatment, including the SAMHSA Spending Estimates, CSAT lead on Medicaid and health reform issues, directs cost studies, and provides technical assistance on financing to states, grantees and providers. Previously, she worked at the National Association of Social Workers over eight years, crafting responses--through speeches, papers and acting in coalitions--on social work policy in the areas of managed care, mental health and substance abuse, Medicaid and other funding systems, behavioral health care best practices and telehealth. In Hawaii, Rita worked at the Queen's Medical Center in Honolulu for 10 years, as Ambulatory Manager, directing an intensive outpatient substance abuse treatment program, an interdisciplinary mental health clinic, a psychiatric partial hospitalization program. Prior to that at Queens, she created a foster family for elderly program and obtained foundation and ultimately Medicaid home and community based funding.

Veterans Health Administration (VHA)

Daniel Kivlahan, PhD

Dr. Kivlahan received his doctoral degree in clinical psychology from the University of Missouri-Columbia in 1983. Since 1998, he was been Director of the Center of Excellence in Substance Abuse Treatment and Education (CESATE) at VA Puget Sound in Seattle where he has been an addiction treatment clinician and investigator since 1985. He is Associate Professor, Department of Psychiatry and Behavioral Sciences, University of Washington and from 2004 – 2010 served as Clinical Coordinator of the VA Substance Use Disorders (SUD) Quality Enhancement Research Initiative to implement evidence-based practices in treatment of SUD. He co-chaired the work group that in 2009 completed the revision of the VA/DoD Clinical Practice Guideline for SUD and participated in the VHA expert consensus panel on clinical guidance for integrated care of concurrent SUD and PTSD. In May 2010, Dr. Kivlahan accepted the new field-based position as Associate National Mental Health Director for Addictive Disorders, Office of Mental Health Services, VHA. He was recently appointed as the representative from the Office of Mental Health Services to the Pain Management Working Group chartered by the VA/DoD Health Executive Council. Among his 100+ peer reviewed publications are validation studies on the AUDIT-C to screen for alcohol misuse across care settings and reports from clinical trials including the COMBINE Study for combined pharmacologic and psychosocial treatment of alcohol dependence.

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)

George Isham, MD, MS

George Isham, M.D., M.S. is the chief health officer for HealthPartners. He is responsible for the improvement of health and quality of care as well as HealthPartners' research and education programs. Dr. Isham currently chairs the Institute of Medicine (IOM) Roundtable on Health Literacy. He also chaired the IOM Committees on *Identifying Priority Areas for Quality Improvement* and *The State of the USA Health Indicators*. He has served as a member of the IOM committee on *The Future of the Public's Health* and the subcommittees on the Environment for Committee on Quality in Health Care which authored the reports *To Err is Human* and *Crossing the Quality Chasm.* He has served on the subcommittee on performance measures for the committee charged with redesigning health insurance benefits, payment and performance improvement programs for Medicare and was a member of the IOM Board on Population Health and Public Health Policy. Dr. Isham was founding co-chair of and is currently a member of the National Committee on Quality Assurance's committee on performance measurement which oversees the Health Employer Data Information Set (HEDIS) and currently co-chairs the National Quality Forum's advisory committee on prioritization of quality measures for Medicare. Before his current position, he was medical director of MedCenters health Plan in Minneapolis and In the late 1980s he was executive director of University Health Care, an organization affiliated with the University of Wisconsin-Madison.

Elizabeth McGlynn, PhD, MPP

Elizabeth A. McGlynn, PhD, is the director for the Center of Effectiveness and Safety Research (CESR) at Kaiser Permanente. She is responsible for oversight of CESR, a network of investigators, data managers and analysts in Kaiser Permanente's regional research centers experienced in effectiveness and safety research. The Center draws on over 400 Kaiser Permanente researchers and clinicians, along with Kaiser Permanente’s 8.6 million members and their electronic health records, to conduct patient-centered effectiveness and safety research on a national scale. Kaiser Permanente conducts more than 3,500 studies and its research led to more than 600 professional publications in 2010. It is one of the largest research institutions in the United States. Dr. McGlynn leads efforts to address the critical research questions posed by Kaiser Permanente clinical and operations leaders and the requirements of the national research community. CESR, founded in 2009, conducts in-depth studies of the safety and comparative effectiveness of drugs, devices, biologics and care delivery strategies. Prior to joining Kaiser Permanente, Dr. McGlynn was the Associate Director of RAND Health and held the RAND Distinguished Chair in Health Care Quality. She was responsible for strategic development and oversight of the research portfolio, and external dissemination and communications of RAND Health research findings. Dr. McGlynn is an internationally known expert on methods for evaluating the appropriateness and technical quality of health care delivery. She has conducted research on the appropriateness with which a variety of surgical and diagnostic procedures are used in the U.S. and in other countries. She led the development of a comprehensive method for evaluating the technical quality of care delivered to adults and children. The method was used in a national study of the quality of care delivered to U.S. adults and children. The article reporting the adult findings received the Article-of-the-Year award from AcademyHealth in 2004. Dr. McGlynn also led the RAND Health’s COMPARE initiative, which developed a comprehensive method for evaluating health policy proposals. COMPARE developed a new microsimulation model to estimate the effect of coverage expansion options on the number of newly insured, the cost to the government, and the effects on premiums in the private sector. She has conducted research on efficiency measures and has recently published results of a study on the methodological and policy issues associated with implementing measures of efficiency and effectiveness of care at the individual physician level for payment and public reporting. Dr. McGlynn is a member of the Institute of Medicine and serves on a variety of national advisory committees. She was a member of the Strategic Framework Board that provided a blueprint for the National Quality Forum on the development of a national quality measurement and reporting system. She chairs the board of AcademyHealth, serves on the board of the

American Board of Internal Medicine Foundation, and has served on the Community Ministry Board of Providence-Little Company of Mary Hospital Service Area in Southern California. She serves on the editorial boards for Health Services Research and The Milbank Quarterly and is a regular reviewer for many leading journals. Dr. McGlynn received her BA in international political economy from Colorado College, her MPP from the University of Michigan's Gerald R. Ford School of Public Policy, and her PhD in public policy from the Pardee RAND Graduate School.

National Quality Forum Staff

Janet Corrigan, PhD, MBA

Janet M. Corrigan, PhD, MBA, is president and CEO of the National Quality Forum (NQF), a private, not-for-profit standard-setting organization established in 1999. The NQF mission includes: building consensus on national priorities and goals for performance improvement and working in partnership to achieve them; endorsing national consensus standards for measuring and publicly reporting on performance; and promoting the attainment of national goals through education and outreach programs. From 1998 to 2005, Dr. Corrigan was senior board director at the Institute of Medicine (IOM). She provided leadership for IOM's Quality Chasm Series, which produced 10 reports during her tenure, including: To Err is Human: Building a Safer Health System, and Crossing the Quality Chasm: A New Health System for the 21st Century. Before joining IOM, Dr. Corrigan was executive director of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Among Dr. Corrigan's numerous awards are: IOM Cecil Award for Distinguished Service (2002), American College of Medical Informatics Fellow (2006), American College of Medical Quality Founders' Award (2007), Health Research and Educational TRUST Award (2007), and American Society of Health System Pharmacists' Award of Honor (2008). Dr. Corrigan serves on various boards and committees, including: Quality Alliance Steering Committee (2006–present), Hospital Quality Alliance (2006–present), the National eHealth Collaborative (NeHC) Board of Directors (2008–present), the eHealth Initiative Board of Directors (2010–present), the Robert Wood Johnson Foundation's Aligning Forces for Healthcare Quality (AF4Q) National Advisory Committee (2007–present), the Health Information Technology (HIT) Standards Committee of the U.S. Department of Health and Human Services (2009–present), the Informed Patient Institute (2009 – present), and the Center for Healthcare Effectiveness Advisory Board (2011 – present). Dr. Corrigan received her doctorate in health services research and master of industrial engineering degrees from the University of Michigan, and master's degrees in business administration and community health from the University of Rochester.

Thomas Valuck, MD, JD, MHSA

Thomas B. Valuck, MD, JD, is senior vice president, Strategic Partnerships, at the National Quality Forum (NQF), a nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Dr. Valuck oversees NQF-convened partnerships—the Measure Applications Partnership (MAP) and the National Priorities Partnership (NPP)—as well as NQF's engagement with states and regional community alliances. These NQF initiatives aim to improve health and healthcare through public reporting, payment incentives, accreditation and certification, workforce development, and systems improvement. Dr. Valuck comes to NQF from the Centers for Medicare & Medicaid Services (CMS), where he advised senior agency and Department of Health and Human Services leadership regarding Medicare payment and quality of care, particularly value-based purchasing. While at CMS, Dr. Valuck was recognized for his leadership in advancing Medicare's pay-for-performance initiatives, receiving both the 2009 Administrator's Citation and the 2007 Administrator's Achievement Awards. Before joining CMS, Dr. Valuck was the vice president of medical affairs at the University of Kansas Medical Center, where he managed quality improvement, utilization review, risk management, and physician relations. Before that he served on the Senate Health, Education, Labor, and Pensions Committee as a Robert Wood Johnson Health Policy Fellow; the White House

Council of Economic Advisers, where he researched and analyzed public and private healthcare financing issues; and at the law firm of Latham & Watkins as an associate, where he practiced regulatory health law. Dr. Valuck has degrees in biological science and medicine from the University of Missouri-Kansas City, a master's degree in health services administration from the University of Kansas, and a law degree from the Georgetown University Law School.

Diane Stollenwerk, MPP

Diane Stollenwerk, MPP, is Vice President, Community Alliances at the National Quality Forum (NQF), where she leads efforts to identify and pursue opportunities to engage and provide stronger support for state and community leaders. Ms. Stollenwerk has more than 20 years experience in public affairs, strategic communication, fundraising and sustainability, product development, and organizational strategic planning. Before joining NQF, she provided consulting services for local and national organizations involved in healthcare quality improvement. Ms. Stollenwerk was one of the first directors of the nationally-recognized Puget Sound Health Alliance (the Alliance), a coalition of employers, unions, doctors, hospitals, consumer groups, insurers, pharmaceutical companies, government, and others in the Pacific Northwest. She served as project director of the Robert Wood Johnson Foundation's Aligning Forces for Quality program in the Puget Sound region, was liaison to the Agency on Healthcare Research and Quality's Chartered Value Exchange efforts, and represented the Alliance in the Washington Health Information Collaborative to promote the use of health information technology. She has also held public affairs and marketing roles at the executive level for several Catholic healthcare systems, a Blue Shield plan, and within the software and transportation industries. She has been an active board member and volunteer for several businesses and nonprofit groups, such as the Association of Washington Business, Epilepsy Foundation, American Marketing Association, and the Society of Competitive Intelligence Professionals. Ms. Stollenwerk has a bachelor's degree in English and speech communication from San Diego State University, and a master's degree in public policy from Harvard University.

Sarah Lash, MS, CAPM

Sarah Lash is a Program Director in the Strategic Partnerships department at the National Quality Forum. Ms. Lash staffs the NQF-convened Measure Applications Partnership, leading a task focused on measuring and improving the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. Prior to joining NQF, Ms. Lash spent four years as a policy research consultant at The Lewin Group, where she specialized in supporting Federal initiatives related to aging, disability, and mental/behavioral health issues. Ms. Lash studied Public Health and Psychology at Johns Hopkins University and went on to earn a master's degree in Health Systems Management from George Mason University. Ms. Lash was recognized with GMU's Graduate Award for Excellence in Health Policy and is also a Certified Associate in Project Management (CAPM).

MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE
Convened by the National Quality Forum

Summary of In-Person Meeting #1

An in-person meeting of the Measure Applications Partnership (MAP) Coordinating Committee was held on Tuesday, May 3 and Wednesday, May 4, 2011. For those interested in reviewing an online archive of the web meeting please click on the link below:

http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Coordinating_Committee.aspx

The next meeting of the Coordinating Committee will be an in-person meeting on June 21-22, 2011, in Washington, DC.

Committee Members in Attendance at the May 3-4, 2011 Meeting:

George Isham (Co-Chair)
Elizabeth McGlynn (Co-Chair)
Richard Antonelli
David Baker, ACP
Christine A. Bechtel, National Partnership for Women and Families
Bobbie Berkowitz
Joseph Betancourt
Judith A. Cahill, AMCP
Mark R. Chassin, The Joint Commission
Maureen Dailey, ANA (substitute for Marla Weston)
Suzanne F. Delbanco, Catalyst for Payment Reform
Joyce Dubow, AARP
Steven Findlay, Consumers Union
Nancy Foster, AHA (substitute for Rhonda Anderson)
Victor Freeman, HRSA
Foster Gesten, NAMD
Aparna Higgins, AHIP
Eric Holmboe, ABMS (substitute for Christine Cassel)
Chip N. Kahn, FAH
William E. Kramer, PBGH
Sam Lin, AMGA
Karen Milgate, CMS
Elizabeth Mitchell (phone), MHMC
Ira Moscovice
Michael A. Mussallem, AdvaMed
John O'Brien, OPM
Peggy O'Kane, NCQA
Frank G. Opelka, ACS
Cheryl Phillips, LeadingAge
Harold Pincus
Carol Raphael
Chesley Richards, CDC
Gerald Shea, AFL-CIO
Carl A. Sirio, AMA
Thomas Tsang, ONC
Nancy J. Wilson, AHRQ

This was the first in-person meeting of the Measure Applications Partnership Coordinating Committee. The primary objectives of the meeting were to:

- Establish the decision making framework for the MAP,
- Consider measure selection criteria,
- Finalize workgroup charges,
- Review the Ad Hoc Safety Workgroup roster, and
- Direct workgroups to consider measurement strategies for HACs and readmissions.

Committee Co-Chairs, George Isham and Beth McGlynn, as well as Janet Corrigan, President and CEO, NQF, began the meeting with a welcome and introductions. This was followed by disclosures of interest by the Committee and a review of the MAP member responsibilities and media policies.

Tom Valuck, Senior Vice President, Strategic Partnerships, NQF, provided an overview of the Coordinating Committee charge and brief review of the strategies and models that contribute to the MAP decision making framework. These inputs include the HHS National Quality Strategy, the HHS Partnership for Patients safety initiative, the NQF-endorsed Patient-focused Episode of Care Model, and the high impact conditions as identified by the NQF-convened Measure Prioritization Advisory Committee. Regarding the high impact conditions, the Committee discussed the importance of viewing these lists as inputs to the MAP, not limitations, and the need to consider how measurement may impact persons with multiple chronic conditions. NQF staff raised how the HHS Multiple Chronic Conditions Framework and the Multiple Chronic Conditions Performance Measurement Framework (currently in development as an NQF project under contract with HHS) will help support this consideration.

The Committee members drew for their terms of membership. The chart below presents the terms for all Coordinating Committee members.

Helen Burstin, Senior Vice President, Performance Measures, NQF, provided background information on NQF's current endorsement criteria. Tom Valuck discussed the relationships among the roles of the National Priorities Partnership, a multi-stakeholder group that provides input to the HHS National Quality Strategy; the role of measure endorsement, which endorses measures for public reporting and quality improvement; and the role of the MAP in selecting measures for particular purposes, such as public reporting and payment reform.

Tom Valuck, Helen Burstin, and Beth McGlynn discussed how the measure selection criteria, which are currently in development and will be used by the MAP with regard to selection of measures, should not duplicate the endorsement criteria and are meant to build on the foundation of endorsement. Arnie Milstein, Director, Stanford Clinical Excellence Research Center, presented the work of the MAP measure selection criteria project. The Committee's discussion led to the following considerations that the measure selection criteria should address:

- Promoting 'systemness' and shared accountability,
- Addressing the various levels of accountability in a cascading fashion to contribute to a coherent measure set,
- Enabling action by providers,
- Helping consumers make rational judgments,
- Assessing quantifiable impact and contributing to improved outcomes, and
- Considering and assessing the burden of measurement.

Additionally, consideration was given to tailoring the criteria for various purposes (e.g., payment reform, public reporting, and program evaluation), addressing public/private alignment, and contributing to parsimony.

George Isham and Nalini Pande, Senior Director, Strategic Partnerships, NQF, discussed the charges and tasks for each of the Workgroups. In discussing the workgroup charges, the Committee offered the following considerations for all of the workgroups:

- While addressing the specific HHS tasks contractually outlined, each workgroup should consider alignment with the private sector;
- Given that this work is on a short timeline, each workgroup should take the timeline into consideration, setting expectations accordingly and identifying what work will need to be done in subsequent phases; and
- There should be a focus on models of care rather than individual measures.

Further, the Coordinating Committee proposed the following:

- The Hospital Workgroup should consider cancer care beyond PPS-exempt cancer hospitals.
- The Dual Eligible Beneficiaries Workgroup should consider opportunities for cross-linking with the post-acute care/long-term care tasks.
- The Post-Acute Care/Long-Term Care Workgroup should specifically look at quality from a family perspective of hospice care delivery.

The first day of the meeting concluded with a review of the evening assignment where Committee Members were asked to further consider a list of inputs to the measure selection criteria; specifically, members were asked to identify historical sets of criteria that should be considered and to recommend additional strategies to resolve the criteria gaps and conflicts in existing criteria. Committee Members were asked to email the Co-Chairs and NQF staff with any additional information they would like to share after the meeting.

The second day of the meeting began with Beth McGlynn providing a recap of day 1, followed by the full Committee providing comments regarding the evening assignment. Additional considerations raised regarding the measure selection criteria included the following:

- Resource use, efficiency, and cost need to be explicitly addressed within the criteria;
- Appropriateness needs to be considered as efficiency cannot be addressed without considering appropriateness;
- Patient preference should be incorporated;
- While there is agreement that there needs to be ‘systemness’, it is a data challenge to do so, therefore, usability and feasibility need to be addressed to promote ‘systemness’;
- Measures need to serve multiple audiences and cross points of delivery;
- The criteria stress test needs to look for unintended consequences.

George Isham and Nalini Pande reviewed the healthcare-acquired conditions (HACs) and readmissions tasks, including the formation of the Ad Hoc Safety Workgroup. The Ad Hoc Safety Workgroup must be composed of MAP workgroup members that have already been vetted through the nomination and roster review process. The Committee’s Co-Chairs proposed that the Ad Hoc Safety Workgroup be composed of the Hospital Workgroup and all the payers and purchasers represented on the other MAP workgroups and the Coordinating Committee. The Committee accepted this recommendation, while noting that the Ad Hoc Safety Workgroup should invite additional experts to present during Safety Workgroup meetings. Regarding the charge of the Ad Hoc Safety Workgroup, the Coordinating Committee discussed that alignment of the strategy for addressing HACs and readmissions is more important to this task than specific metrics. Additionally, the current set of metrics does not address regional variation.

The meeting concluded with a summary of day 2 and discussion of next steps. The next meeting of the Coordinating Committee will be in-person on June 21-22, in Washington, DC.

Coordinating Committee Member Terms, Beginning May 2011

1-Year Term	2-Year Term	3-Year Term
National Partnership for Women and Families, represented by Christine A. Bechtel, MA	Bobbie Berkowitz, PhD, RN, CNAA, FAAN	AHA, represented by Rhonda Anderson, RN, DNSc, FAAN
The Joint Commission, represented by Mark R. Chassin, MD, FACP, MPP, MPH	Joseph Betancourt, MD, MPH	Richard Antonelli, MD, MS
Catalyst for Payment Reform, represented by Suzanne F. Delbanco, PhD	AMCP, represented by Judith A. Cahill	ACP, represented by David Baker, MD, MPH, FACP
HRSA, represented by Victor Freeman, MD, MPP	ABMS, represented by Christine Cassel, MD	NAMD, represented by Foster Gesten, MD
AHIP, represented by Aparna Higgins, MA	AARP, represented byJoyce Dubow, MUP	George Isham, MD, MS
PBGH, represented by William E. Kramer, MBA	Consumers Union, represented by Steven Findlay, MPH	Elizabeth McGlynn, PhD, MPP
MHMC, represented by Elizabeth Mitchell	FAH, represented by Chip N. Kahn	CMS, represented by Karen Milgate, MPP
LeadingAge, represented by Cheryl Phillips, MD, AGSF	AMGA, represented by Sam Lin, MD, PhD, MBA, MPA, MS	Ira Moscovice, PhD
Harold Pincus, MD	ACS, represented by Frank G. Opelka, MD, FACS	AdvaMed, represented by Michael A. Mussallem
Carol Raphael, MPA	AMA, represented by Carl A. Sirio, MD	OPM, represented by John O'Brien
AFL-CIO, represented by Gerald Shea	ONC, represented by Thomas Tsang, MD, MPH	NCQA, represented by Peggy O'Kane, MPH
AHRQ, represented by Nancy J. Wilson, MD, MPH	ANA, represented by Marla J. Weston, PhD, RN	CDC, represented by Chesley Richards, MD, MPH