MEASURE APPLICATIONS PARTNERSHIP
DUAL ELIGIBLE BENEFICIARIES WORKGROUP
Convened by the National Quality Forum

Summary of the Web Meeting

A web meeting of the National Quality Forum (NQF) Measure Applications Partnership (MAP) Dual Eligible Beneficiaries Workgroup was held on Wednesday, September 5, 2012. An online archive of the web meeting is available on the MAP Dual Eligible Beneficiaries Workgroup project webpage.

Workgroup Members in Attendance at the September 5, 2012 Meeting:

Alice Lind, Workgroup Chair	David Polakoff, American Medical Directors Association
Richard Bringewatt, SNP Alliance	DEB Potter, Agency for Healthcare Research and Quality (AHRQ)
Mady Chalk, Subject Matter Expert: Substance Use	Cheryl Powell, Centers for Medicare & Medicaid Services (CMS)
Anne Cohen, Subject Matter Expert: Disability	Susan Reinhard, Subject Matter Expert: Home and Community-Based Services
Fran Cotter, Substance Abuse and Mental Health Services Administration (SAMHSA)	Rhonda Robinson Beale, Subject Matter Expert: Mental Health
Leonardo Cuello, National Health Law Program	Clarke Ross, Consortium for Citizens with Disabilities
Jim Dunford, Subject Matter Expert: Emergency Medical Services	Marisa Scala-Foley, Administration for Community Living (substitute for Henry Claypool)
Tom James, Humana	Gail Stuart, Subject Matter Expert: Nursing
Laura Linebach, L.A. Care Health Plan	

The primary objectives of the meeting were to:

- Introduce the workgroup's updated charge and the analytic approach to planned activities;
- Review NQF-endorsed Multiple Chronic Conditions Framework;
- Connect updated workgroup charge to other current activities across MAP; and
- Prepare for upcoming workgroup in-person meeting.

Welcome, Roll Call, and Review of Meeting Objectives

MAP Dual Eligible Beneficiaries Workgroup Chair, Ms. Alice Lind, began the meeting with a welcome and review of the meeting objectives. Ms. Lind summarized the major components of MAP's June 2012 Final Report to the Department of Health and Human Services (HHS) containing the workgroup's strategic approach to performance measurement for dual eligible beneficiaries. The report is grounded in the National Quality Strategy and includes a vision for high-quality care, guiding principles, and five high-leverage opportunity areas. The five high-leverage opportunity areas are: quality of life, care

coordination, screening and assessment, mental health and substance use, structural measures, and other (e.g., patient experience). The report also defines a core set of 26 measures, including a starter set of seven available measures and an expansion set of seven measures that need modification to best meet the needs of the dual eligible population. The June 2012 Final Report also prioritizes measure gap areas and provides input on levels of analysis, potential applications of measures, and program alignment.

Ms. Lind reviewed the updated 2012-2013 workgroup charge. It instructs the workgroup to advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to the Medicare and Medicaid dual eligible beneficiaries; specifically, the workgroup is charged with analyzing special measurement considerations for high-need population subgroups of these beneficiaries. MAP will also examine measures and measurement issues across the continuum of care, to include primary and acute care, behavioral health, and long-term services and supports (LTSS).

Activities to Accomplish the Workgroup's 2012-2013 Work

Ms. Sarah Lash, Senior Program Director at NQF, discussed the planned workgroup activities for 2012-2013 to build on the previous year accomplishments and ultimately result in a July 2013 Final Report to HHS. The first major area of activity will be to revise the core set of measures to respond to feedback from the field and accommodate changes in measure endorsement status. The core set is expected to remain largely intact, but targeted changes will allow the workgroup to fine-tune the set.

The second major area of activity is to consider measurement for high-need population subgroups. This work will progress with the understanding that the complex and heterogeneous dual eligible population does not lend itself well to categorization. One group will be adults 65 and older with one or more functional impairments and one or more chronic conditions, otherwise known as medically complex older adults. The other group will be younger adults 18-65 years old with a physical or sensory disability. The work planned for 2013 will address two populations of beneficiaries with behavioral health needs. The NQF Performance Measures department is currently conducting a behavioral health measure endorsement project, so a greater number of endorsed and up-to-date measures should be available for MAP review in 2013.

Understanding High-Need Dual Eligible Beneficiary Subgroups

Ms. Lash presented demographic data regarding high-need beneficiaries, drawn from a staff-conducted literature review. High-need dual eligible beneficiaries are both clinically vulnerable and socially disadvantaged. These needs exacerbate one another and present an opportunity to reduce cost and improve quality. High-need dual eligible beneficiaries consume a disproportionate amount of Medicare and Medicaid resources. Compared to other people with Medicare, dual eligible beneficiaries are more likely to be female, have one or more functional limitations, and live in institutions. In the cohort of dual eligible beneficiaries 18-65, 43% of people report a functional limitation. As the dual eligible population ages, the number of individuals with chronic conditions and functional impairments increases dramatically.

Mr. Amaru Sanchez, Project Analyst at NQF, reviewed data describing approximately 3.6 million dual eligible beneficiaries younger than 65 years old who live with a physical disability. Of this population, 18.2% have one to two limitations in their activities of daily living (ADL), and 17.1% have three or more

ADL limitations. This population of younger beneficiaries tends to use different types of providers and services and is more interested in navigating the health and LTSS systems on their own. To illustrate his points, Mr. Sanchez described a hypothetical dual eligible beneficiary of this type. Ms. Megan Duevel Anderson, Project Analyst at NQF, provided a similar overview of the medically complex older adult population. Service utilization is high in this cohort, with 40% using hospital services, almost 35% using post-acute care, 38% using Medicaid nursing home care, and 22% using home and community-based services in a given year. Annual Medicare and Medicaid spending exceeds $30,000 per beneficiary. Ms. Duevel Anderson also described a hypothetical dual eligible beneficiary who would be part of this population.

Literature Review to Support Quality Issue Analysis for High-Need Dual Eligible Beneficiary Subpopulations

Ms. Lash described the literature review approach undertaken by NQF staff to identify and prioritize high-leverage quality issues for medically complex older adults. The NQF staff collaborated with workgroup members with expertise in disability to develop a related list of key issues for that population. Evidence was organized and evaluated based on the Institute of Medicine "Three I's" Framework defined by the impact, inclusiveness, and improvability of the five high-leverage opportunities.[1] Ms. Lash provided an example of the analysis for the topic of care coordination. The workgroup will be asked to review and respond to the draft lists of identified quality issues. The objective will be to trace numerous quality issues across the continuum of care and identify a measure or measure gap for each care setting.

The workgroup members requested clarification or modification of a few key terms used in the presentation. A participant asked what was included in the term "cognitive conditions." Cognitive conditions for older adults might include dementia or the sequelae of stroke. For persons in all age groups, cognitive conditions might include intellectual or developmental disability. Mr. Clarke Ross requested that the workgroup refer to Long Term Supports and Services (LTSS) in its work instead of long-term care. Ms. Susan Reinhardt requested that the workgroup replace the term end-of-life care with advanced illness care.

Ms. Gail Stuart commented that behavioral health care is provided throughout inpatient and ambulatory care settings therefore it should be represented within all care settings. Ms. Lash clarified that the intention of the separate column was to make sure that behavioral health care was always considered explicitly for each quality improvement issue, but that staff will review the construction of the table before the October meeting. Workgroup members also commented on the concepts of frailty and disability, highlighting articles that might be valuable for review. At members' suggestions, articles by Linda Fried and Lisa Iezzoni will be provided to the workgroup members in advance of the October meeting.

[1] *Priority Areas for National Action: Transforming Health Care Quality*. Summary of Institute of Medicine report. January 2003. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/iompriorities.htm

Multiple Chronic Conditions Framework

Ms. Lind introduced Ms. Aisha Pitman, Senior Program Director at NQF, to review the recently completed NQF-endorsed Multiple Chronic Conditions Framework, available on the NQF website. This HHS-funded framework is intended to identify measure gaps, guide endorsement decisions for assessing and improving the quality of care, guide selection of measures for public reporting and payment, suggest a roadmap for new delivery models, and inform research.

From an individual's perspective, the presence of multiple chronic conditions can affect functional roles and health outcomes across the lifespan, compromise life expectancy, and hinder a person's ability to self-manage or a family or caregiver's capacity to assist in that individual's care. Ms. Pitman provided an example of how the conceptual model applies across sites, providers, and types of care for a hypothetical person with multiple chronic conditions. She explained how application of the model would lead to the selection of measures important to this person and his care within each of the priority domains of measurement. She also described how the guiding principles for measuring care provided to individuals with multiple chronic conditions are designed to evaluate the full spectrum of care for this population. Strategic opportunities for implementing the MCC Framework include identifying and filling measure gaps; standardizing data collection, measurement, and reporting; and payment and delivery system reform.

Connections to Other MAP 2012-2013 Activities for and Next Steps

Ms. Lind introduced Dr. Connie Hwang, Vice President, MAP, to provide an overview of the related MAP work including the three-year strategic plan, families of measures, and pre-rulemaking input to HHS. The strategic plan details the goals, objectives, strategies, and tactics for MAP. It also describes MAP planned activities for the ACA-mandated role of providing input to HHS on selection of performance measures for public reporting in programs as well as promoting alignment between the public and private sectors. Dr. Hwang outlined the current informational inputs MAP will use for pre-rulemaking activities, including families of measures and core measure sets. Four families of measures were developed in 2012, activity in which several Dual Eligible Beneficiaries Workgroup members participated. The Dual Eligible Beneficiaries Workgroup will also provide targeted guidance to the setting-specific workgroups and Coordinating Committee regarding the potential inclusion of specific measures under consideration for rulemaking by HHS. Ms. Lind facilitated group discussion and questions on MAP strategy, including explaining the possibility of stratification of measures within the federal programs.

Workgroup members were assigned follow-up work to provide detailed feedback from users' experiences applying the dual eligible beneficiaries core set of measures. Workgroup members are asked to provide information on implementation, feasibility, and suggested modifications of the core measure set. Results will inform deliberations at the October meeting.

The meeting concluded with a discussion of next steps. The next meeting of the Dual Eligible Beneficiaries Workgroup will be held in-person on October 11-12, 2012, in Washington, DC. Please see the meeting registration website for details.