Integrated Care for People with Medicare and Medicaid:
A Roadmap for Quality

White Paper

National Committee for Quality Assurance

March 2013

NCQA
Measuring quality.
Improving health care.

Integrated Care for People with Medicare and Medicaid

White Paper

National Committee for Quality Assurance

March 2013

This publication is supported by a grant from the The SCAN Foundation. The SCAN Foundation is dedicated to creating a society in which seniors receive medical treatment and human services that are integrated in the setting most appropriate to their needs. For more information, please visit www.TheSCANFoundation.org.

Printed in the U.S.A.

To order this or other publications, contact NCQA Customer Support at 888-275-7585 or log on to www.ncqa.org.

Item #11103-400-13

Executive Summary

The lack of coordination between Medicare and Medicaid for people who have coverage in both programs is well documented. This group incurs high levels of spending in both programs. Because of the complexities of different coverage and program administration requirements, states have found it challenging to work with plans and providers to create programs that provide the full range of services that people with Medicare and Medicaid need. And although a few states have moved forward, to date, program enrollment has been small.

As a result of fiscal pressure faced by most state Medicaid programs and new opportunities generated by the *Patient Protection and Affordable Care Act* (ACA), many states are actively pursuing initiatives to provide integrated care for the Medicare-Medicaid population, often through managed care arrangements. Managed care (including plans covering both general health care and long-term services and supports [LTSS]) and coordinated fee-for-service delivery systems are candidates for arranging and furnishing integrated care. However, there are few methods for assessing the quality of care through these arrangements.

Good integrated care holds the promise of eliminating the fragmented, medically-oriented care that often wastes state and federal dollars and leaves beneficiaries with substantial needs and their families feeling confused and overwhelmed without needed support for daily functioning. To achieve this promise, however, entities responsible for integrated care must be accountable across the full range of services (from medical and behavioral care to LTSS); must be flexible enough to design care that addresses the needs and preferences of individuals and their families; and must have a quality measurement, improvement and monitoring program.

This paper describes a strategy for evaluating the quality and person-centeredness of integrated care, using a roadmap of structure and process assessments of functions and capabilities needed by the entities responsible for integration of care and services and combining this with outcomes and other types of performance measures. In the paper, we use the word "framework" to describe the key concepts underlying the structure and process measures; it can be expanded to include the content of performance measures as companions to the structure and process measures. By "roadmap," we mean that the structure and process measures provide a roadmap around which entities can organize their model of care.

Over time, we envision adding more person-centered performance measures that provide robust information about the process and eventually the outcomes of the people served — that include their experience of care, functional status, quality of life and health outcomes — and that speak to the varied populations that have Medicare and Medicaid coverage.

With federal and state efforts moving rapidly to implementation, many stakeholders are concerned about the risks stemming from lack of experience among new entities taking on integrated care, and a paucity of evaluation approaches in this area. Our quality strategy, developed with consumer and other stakeholder input, offers a way to demonstrate and monitor efforts to improve care for this vulnerable population.

Introduction

More than 9 million Americans are enrolled in both the Medicare and Medicaid programs. Often, the care provided to these beneficiaries is fragmented and there is misalignment of administrative, regulatory, statutory and financing systems. Health care costs for people with Medicare and Medicaid are twice as high as for people with Medicare alone.[1] In the Medicaid system, these costs also are greater than for the average Medicaid beneficiary, primarily because of spending for long-term services and supports.[2] Better care for people who have Medicare and Medicaid has the potential to improve outcomes and to lower health-care spending.

The overarching goals of the National Committee for Quality Assurance (NCQA) are to:

- Improve the quality of care, the experience of care for beneficiaries and families, and their ability to realize their own goals, and
- Improve the value of care by eliminating unnecessary utilization and costs.

To achieve these goals, we have developed an approach for evaluating care provided in integrated models to people with Medicare and Medicaid. Our intention is to go beyond the existing capabilities of the types of entities likely to participate in state integration programs. We want to set expectations for capabilities that entities may not yet have but can aspire to achieve. Entities will need to do well in arranging for and coordinating across the full range of care that beneficiaries need, including medical, behavioral and long-term services and supports.

In this paper, we briefly discuss the Medicare-Medicaid eligible population and prior integration efforts; introduce a model for integrated entities and a framework for assessing and promoting quality of integrated care; and discuss the challenges to implementing and achieving the goals of person-centered, integrated care for this population. We use the word "framework" to describe the key concepts underlying the structure and process measures; it can be expanded to include the content of performance measures as companions to the structure and process measures. By "roadmap," we mean that the structure and process measures provide a roadmap around which entities can organize their model of care.

Problem: Vulnerable Population, Fragmented Care

Higher rates of poverty and disability contribute to higher costs of the population with Medicare and Medicaid

In general, people with Medicare and Medicaid differ from the general Medicare population in that they are poorer and more likely to have disabilities and be in ill health. They differ from the general Medicaid population in that they are older and sicker. Within the Medicare-Medicaid population, there are diverse subpopulations; for example, the frail elderly; younger people who have physical or mental health disabilities; and relatively healthy people who are poor enough to qualify for Medicaid and old enough to qualify for Medicare.

Of the 9.1 million adults with Medicare and Medicaid benefits, about 60 percent are 65 or older. More than 90 percent of these beneficiaries fall below 200 percent of the poverty line.[1] The eligibility criteria and level of Medicaid benefits vary by state. Medicaid also provides varying degrees of coverage: beneficiaries who qualify because of very low income or high medical spending (often for long-term services and supports [LTSS]), as well as being over age 65 or having disabilities, can obtain full coverage of all Medicaid services not covered by Medicare, often including Medicare premiums and cost sharing. Beneficiaries with higher incomes are entitled to Medicare coverage of premiums (and sometimes cost-sharing) only.*

People with Medicare and Medicaid are typically sicker and have higher medical spending and use of medical services than other Medicare or Medicaid beneficiaries. (Refer to Table A in the Appendix.) The high disease burden among these beneficiaries partially explains the higher spending; in many cases, higher spending is the result of using LTSS, including nursing home and other institutional care that qualified them for Medicaid coverage. People with Medicare and Medicaid account for a disproportionate share of both Medicare and Medicaid spending relative to their population size (Figure 1).

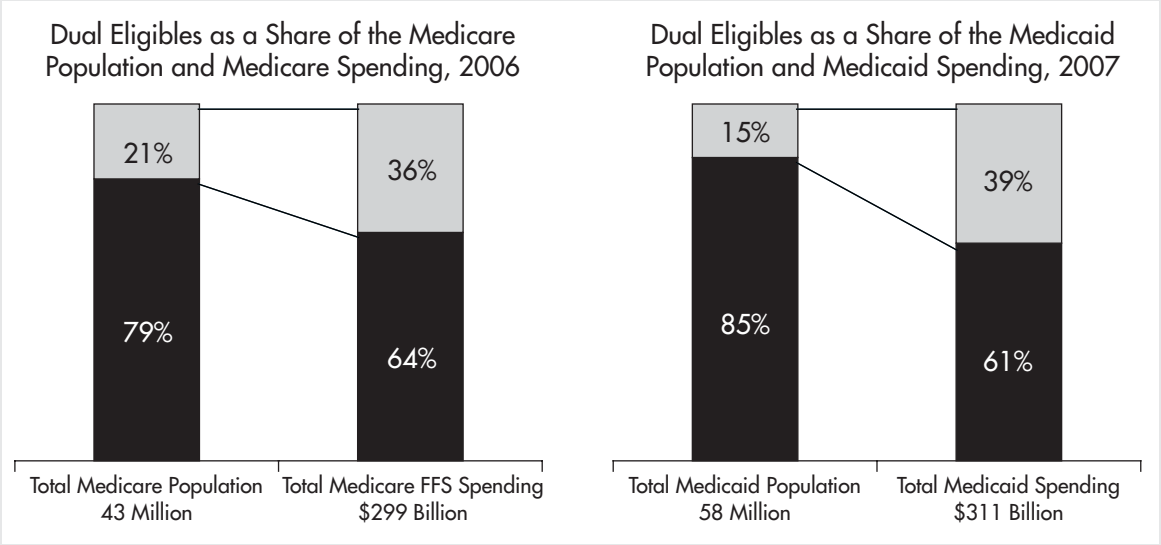
Still, there is wide variation in spending in the Medicare-Medicaid population, with a small portion of people accounting for 40 percent of program expenditures (Figure 2). Approximately 60 percent of Medicaid spending is for care (mostly institutional care) of the top 10 percent of people, and LTSS accounts for 69 percent of Medicaid spending on people with Medicare and Medicaid. Combined Medicare and Medicaid spending for this population varies across settings and conditions.[2] (Refer to Table B in the Appendix.)

Program benefits and design lead to fragmented care

One challenge of providing high-quality, coordinated care for people with Medicare and Medicaid is that each program offers different benefits, which can lead to a lack of coordination — and even to incentives that work, perversely, against good, person-centered care. Medicare covers most acute, preventive and post-acute services (e.g., home health and rehabilitation services) and tends to pay more than Medicaid. For beneficiaries with full Medicaid and Medicare benefits (and depending on the optional benefits offered

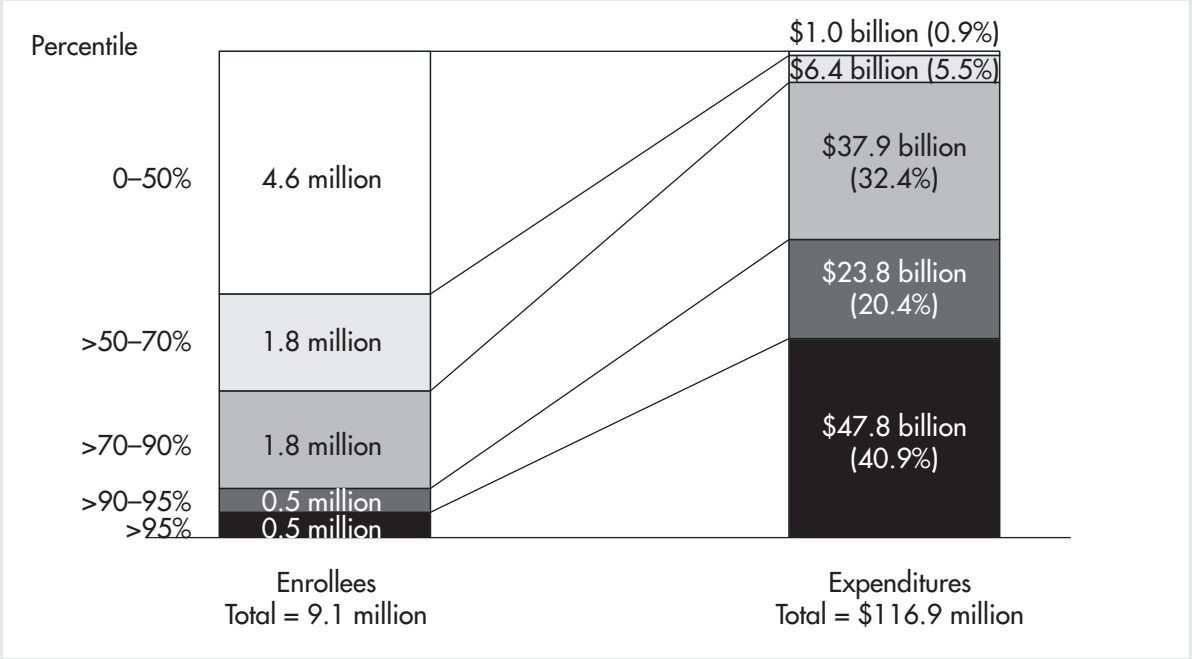
*In cases where beneficiaries qualify for Medicaid coverage of Medicare cost sharing, beneficiaries do not need to pay cost sharing amounts. However, states may not have to pay providers for these amounts if the Medicaid payment amount for the service is sufficiently lower than the Medicare rate.

FIGURE 1. Medicare-Medicaid Beneficiaries Account for Disproportionate Shares of Medicare and Medicaid Spending



Source: Kaiser Family Foundation

FIGURE 2. Concentration of Medicaid Spending for People With Medicare and Medicaid



Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS and CMS-64 reports, 2012.

Note: Does not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data.

by the state), Medicaid covers vision, dental and hearing care; behavioral health care not already covered by Medicare; LTSS (i.e., nursing home, home and community-based care); Medicare premiums; and, often, Medicare cost sharing.

For some beneficiaries, there is overlap in the post-acute care services that Medicare covers and the LTSS that Medicaid covers (although these are theoretically discrete). Sometimes, Medicaid covers items or services that Medicare does not (e.g., drugs not covered in a Medicare Part D formulary).[3]

Ideally, entities responsible for integrated care for the Medicare-Medicaid population would have systems in place to ensure that beneficiaries are treated in the setting that best fits their needs and preferences, and that the care team has the flexibility to develop care plans and services that consider the full array of beneficiary needs. However, the few entities attempting to do so in the current environment struggle to streamline care because there are different benefits and payers and separate payments for services.

Perverse incentives come into play when care is more profitable in a particular setting or payment system; for example, transferring a person with Medicare and Medicaid from a nursing home (paid for by Medicaid) to hospital care (paid for by Medicare). In this example, the nursing home avoids the cost of providing care and may benefit from state "bed-hold" policies, in which the state continues to pay the nursing home for a short time while a beneficiary is in the hospital.

Discharging the member from the hospital back to the nursing home may qualify the facility to receive a higher payment under Medicare through the

BOX 1. Profiles of People With Medicare and Medicaid

Mr. C. is a 78-year-old man with multiple chronic illnesses (congestive heart failure, peripheral vascular disease, atrial fibrillation, schizophrenia). He lives alone and has limited family support. Before joining an integrated program, he did not take medications regularly or see a primary care provider. In 2008, he had seven inpatient hospital admissions. Once he joined an integrated program, his care manager, supported by an interdisciplinary care team that included a psychiatrist and a social worker, worked with the primary care provider to increase one medication. The team monitored Mr. C's conditions and his adherence to his medication regime and diet requirements. With the care team's help, the number of Mr. C's admissions per year has declined over time. In 2009, Mr. C. had four inpatient hospital admissions. In 2010 he was admitted twice, and since November 2011, he has had no admissions.

Mrs. L. is a Hispanic woman with diabetes. Before joining an integrated program she knew she had vision problems, but avoided seeing an eye doctor. Once joining a program, her care manager identified the overdue preventive service and arranged to visit Mrs. L. at home, along with a Spanish-speaking primary care physician who encouraged Mrs. L. to see an ophthalmologist. Early retinal disease was detected and was treated by laser surgery, preventing the loss of her sight. The care manager also arranged for better lighting in the hallway of her building to help prevent a fall.

Mrs. K., a 92-year-old woman with severe functional impairment and Alzheimer's disease, lived with her elderly and frail spouse. Before joining an integrated program, she had significant risk factors for wandering because of disorientation to time and place, agitation and restlessness, and she experienced frequent falls and injuries. Once joining a program, the care manager developed a plan of care, based on the initial comprehensive assessment that involved a home health aide and a chair and bed alarm. Whenever the alarm sounded, the home health aide responded immediately to assist Mrs. K. with mobility and activities of daily living. Her wandering and falls decreased, and she was able to remain in her own home and avoid being placed in a nursing home. Additionally, the care manager instructed the family and aide in behavioral interventions to decrease agitation, and implemented a regimen of regular activity and exercise. The care manager

continued on page 7

continued from page 6

also worked with Mrs. K.'s primary care physician to monitor and modify her medication regimen.

Mr. P. is a 30 year old man who was in a very serious automobile accident and was left with paralysis in both legs. Before joining a program, Mr. P had three surgeries and was deeply depressed. While his condition stabilized, he still must see a number of specialists, including a neurologist and urologist. Mr. P enrolled in a plan for people with Medicare and Medicaid; the plan covers acute care, physician services, drugs, long term services and supports and behavioral health, and helped Mr. P. get a motorized wheelchair. He is determined to pursue graduate studies and has been accepted into a program. He has worked with his care manager to arrange for his aide to help him prepare for classes. Another aide comes in the evening to help him with dinner, to work on his computer and get into bed. The care manager touches base with Mr. P. regularly and helped him prevent two emerging infections and inpatient stays that would have resulted. Mr. P. is happy that these services allow him to remain out of a nursing home and in his home and community pursuing his career. His depression has lifted and he has expressed satisfaction with his health plan despite the difficult circumstances.

Ms. M. is a 34-year-old woman who has battled severe and persistent mental illness since she was a teenager. Before joining an integrated program, at her family's urging, she had several inpatient stays and institutionalizations at crisis moments in the course of her illness. She is now in an integrated health plan for people with Medicare and Medicaid that includes coverage for behavioral health. Consequently, a behavioral health expert is part of her care team. This professional visited Ms. M. in her home upon enrollment in the plan. She reviewed medication and compliance extensively and consulted with Ms. M's primary care physician about a change in one medication and in the dosage of another medication. Ms. M.'s care manager has been calling her weekly to check on the medication regimen. She has expressed an interest in work. Her care manager explored resources in her community and reviewed the options with her for vocational training in a computer support program since she has technical aptitude. As a result of these efforts, Ms. M. is in a one-year program. After six months, her attendance has been excellent. Her engagement in this training has motivated her to comply with her medication regimen and she has been able to avoid any inpatient or institutional stays during this period.

skilled nursing facility benefit. This reduces the state's costs, but raises Medicare spending and increases beneficiary risk. Persons who are transferred from the nursing home to hospital are at risk of infection, delirium and decline in function, are susceptible to medical errors that often occur during transition and have higher overall costs than persons who remain in a nursing home.[4]

Disjointed funding and benefit design can result in a pattern of shifting beneficiaries from setting to setting for financial rather than clinical reasons, and offer little incentive to coordinate care or improve efficiency.[1] Although there has been dramatic growth in the use of Medicaid waivers to shift long-term care from institutions to home- and community-based services, many people who would prefer to stay in their homes still cannot get the needed long term supports and services and so get long-term services and supports from a nursing home. In 2007, an estimated 5 percent to 12 percent of nursing home residents could be cared for at home if they had appropriate services, though this number appears to be dropping.[5] There is no entity responsible both for organizing the care around the beneficiaries' needs and for making most effective use of available resources.

Opportunity: New Initiatives, Lessons Learned

Federal Integration Initiatives Seek Broader Implementation and Benefits

With enactment of the Patient Protection and Affordable Care Act (ACA), the Centers for Medicare & Medicaid Services (CMS) made a new commitment to improving integration of care for people with Medicare and Medicaid, by establishing the Medicare-Medicaid Coordination Office.* CMS has supported programs to promote greater coordination and streamlined management of care. It announced demonstration initiatives for states to integrate primary, acute, behavioral health and LTSS for full-benefit, Medicare-Medicaid beneficiaries (Box 2).

The federal government, state Medicaid programs and the broader policy community have long been aware of the large concentration of spending, poor coordination of care and perverse incentives associated with traditional financing and delivery of care for people with Medicare and Medicaid.[6,7] Over the years, federal and state initiatives have tried different approaches to integration, including the Program of All-Inclusive Care for the Elderly (PACE) and state-based initiatives in Wisconsin, Minnesota and Massachusetts. These have shown benefits in quality and beneficiary and caregiver satisfaction; findings are mixed on costs. All programs have low enrollment, relative to the potential Medicare-Medicaid population where they are offered. Medicare also has offered Special Needs Plans (SNP), including those that target people with Medicare and Medicaid. To promote integration, Congress required all SNPs for the Medicare-Medicaid population to establish agreements with state Medicaid programs by 2013; most duals SNPs have put these in place but this is a very recent change.

Several states have contracted with organizations to furnish Medicaid coverage of LTSS through capitated arrangements.[8] Some of these have integrated Medicaid acute care services with LTSS, but blended payment with Medicare is rare, due in part to rules that preserve beneficiary choice in Medicare. CMS cannot require people to use a managed care plan for Medicare (indeed, people with Medicare have the option to stay in the fee-for-service system), even if they are already enrolled in a plan for Medicaid services.

These efforts have demonstrated key challenges:

- **Integration is hard.** Medicare and Medicaid have their own benefits and cultures, and working with federal and state policymakers who may have different goals and priorities can be challenging. The two programs also have different administrative rules (e.g., marketing, grievance and appeal processes, development of payment rates, and quality improvement and reporting) that further inhibit integration.

- **Medicare advocates are wary of mandatory managed care.** Although Medicaid programs often require enrollment into managed care by people who are generally healthy (e.g., children and their mothers), more states have been moving to mandate that the elderly and those with disabilities enroll in managed care, but for Medicare-covered services, beneficiaries must be able to choose between traditional Medicare and managed care. Advocates often resist mandatory enrollment and assignment if beneficiaries do not actively

choose and they are especially concerned about how older people with many chronic conditions will fare in a new model of care. This is so even though many will acknowledge that the status quo is not optimal — for example, it relies too much on institutional care.

BOX 2. Recent Federal Initiatives to Support Integrated Care for Medicare-Medicaid Enrollees

State demonstrations to integrate care for people with Medicare and Medicaid. In this demonstration, CMS is supporting 15 states to develop new models for delivering integrated services to people with Medicare and Medicaid. (Support is for design, not necessarily for full implementation of new models.) The models are intended to coordinate care across primary, acute, behavioral health and long-term care. State design proposals indicate wide variation in the target populations and approaches to integration. Most states participating in this demonstration are also participating in the financial alignment demonstration.

Financial alignment demonstration. The goal of this demonstration is to test two models for aligning Medicare and Medicaid financing and integrating primary, acute, behavioral health and long term services and supports:

- **Capitated model.** CMS and states enter into a Memorandum of Understanding, and then CMS, the state and health plans enter into a three-way contract. In return for a prospective payment combining Medicare and Medicaid funds, plans provide comprehensive coverage. CMS and the state set the rate actuarially to return savings over what would have been spent in the absence of the demonstration, and a portion of plans' payment will be withheld contingent upon meeting quality thresholds.
- **Managed fee-for-service model.** Under this approach, CMS and the State also enter into a Memorandum of Understanding, but there is no three-way contract. The state manages its delivery systems directly. The Memorandum of Understanding allows shared savings between the two programs from initiatives that successfully reduce cost and improve quality for both programs. States invest in care coordination and, if they achieve savings for Medicare that equal or exceed a target, they receive payment from Medicare. States receive payments only if they meet or exceed pre-set quality goals for people in the program.

- **Integration requires new relationships and complementary skills.** Integrating care for people with Medicare and Medicaid requires working closely with providers who have long experience with specific types of beneficiaries (e.g., home- and community-based providers for people with disabilities; providers that serve people with severe and persistent mental illness or substance use). Many successful integration models serve few enrollees and are strongly embedded with the local providers and community. They often lack the analytic capacity and resources that traditional health plans have developed *for managing large datasets and provider networks*. Conversely, most traditional managed care plans do not have experience paying for or managing use of LTSS and may not be even familiar with the various non-medical providers in the community. Stakeholders are concerned about managed care's potential for reducing access to care in general, about too much focus and spending directed towards medical care over LTSS, "medicalizing" the delivery of social and personal supports, and about safety net providers and community resources specifically.

**Section 2602 of the Beneficiary Protection and Affordable Care Act* (Pub. L. 111-148) created the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office").

- **Quality measures are lacking.** Existing measures do not fully address the complex characteristics of people with Medicare and Medicaid (i.e., use of LTSS, functional decline, frailty, multiple coexisting conditions) nor do they address critical indicators of quality improvement through the provision of integrated care. Some existing measures are relevant (including those specifically designed for SNPs): for example, measures of transitions and readmissions are included for these plans and are equally useful in a managed fee-for-service environment. But we do not have measures that capture coordination of care across medical and long-term services and supports or that capture outcomes when enrollees may have different goals. Existing measures are necessary as a starting point, but are insufficient to provide the desired full picture of care.

Model of Integrated Care Entity and Quality Framework Needed

There is great promise to improve quality within integrated care models. Integrated care ultimately means person-centered care such that the care provided meets the specific needs of each individual to help them attain their goals. A well-defined vision that is translated into concrete statements of expectations — combined with performance measures — can influence entities to provide care in new ways or for new populations. In the following section, we describe this vision and the specific elements we have found are needed to be in place to deliver on the promise of integrated care.

Defining the entity that is accountable for integrated care

As states work with the federal government to develop new programs for providing integrated care, they are turning to a variety of organizations (both new and existing) to take financial responsibility and accountability for results (Box 3). States are building from existing relationships with managed care plans, managed long-term care plans, accountable care organizations, beneficiary-centered medical homes, health homes, care managers and Medicare SNPs. Any state's choice will reflect its existing health care system, politics and resources. Whatever the choice, three components are needed for success:

1. **Entities should be responsible for a comprehensive range of services that include medical care, behavioral health care and LTSS.** Entities must demonstrate that they can work across Medicare and Medicaid to present an integrated product, with benefits managed together and not carved out or administered as either "Medicaid" or "Medicare," and attempt to ensure that individuals get the right service, in the right setting, at the right time in a way that is organized around the person and his or her needs and preferences rather than around the facility or provider furnishing care.

2. **In the capitated model, financing must support integration, allowing for the streamlined provision of a mix of medical, behavioral and LTSS services, based on the individual's needs and preferences.** Flexibility is critical to "rebalance" use of home- and community-based LTSS against reliance on institutional care. Financial risk mitigation is also an important consideration to reduce any incentives for selection bias and to help enable entities to better manage caring for high-cost beneficiaries. Entities that manage care cannot use a "one size fits all" approach; they must target resources to individuals at

greatest risk. Financial incentives should support care decisions that avoid institutional care (hospital or nursing home).

3. **Entities must participate in a quality strategy with a quality measurement program tied to improved outcomes and program design.** At the outset, entities should be able to demonstrate key capabilities and functions critical to serving the Medicare-Medicaid population. They should develop additional capacity and demonstrate quality improvement as they grow and mature as organizations and as better measures become available. Quality indicators should provide continuous feedback to program improvement efforts.

BOX 3. Existing Models That Already Support Integration

Program for All-Inclusive Care for the Elderly (PACE). PACE was authorized as a permanent program in Medicare and as a state option in Medicaid by the 1997 Balanced Budget Act. As of April 2012, there were 23,000 enrollees.[9] Providers furnish comprehensive medical, LTSS and social services to frail, nursing home-eligible elderly, using a model of care that relies heavily on adult day health facilities that provide respite care and health care services. The goal of PACE is that members maintain their independence in their own homes.[10] PACE uses a model of pooled capitation funding to a fully at-risk health provider. Evaluations found that PACE had positive effects on functional status and patterns of care. Cost findings are mixed: there are Medicare savings, higher Medicaid costs and somewhat higher costs overall.[11,12]

State programs for people with Medicare and Medicaid. Wisconsin, Minnesota and Massachusetts have used health plans as the entities receiving pooled capitation payments from Medicare and Medicaid under federal waivers.[13] Evaluations conducted in 2000 and 2005 found mixed results in terms of quality, utilization and overall cost to Medicare.[13] Enrollment has grown from the initial enrollment of 3,000 in 2005.

Special Needs Plans (SNPs). These plans are a specific offering under Medicare Advantage, where a fully capitated health plan provides services to a targeted group of Medicare beneficiaries as an alternative to traditional fee-for-service Medicare. SNPs enroll three types of special needs beneficiaries: institutionalized, people with Medicare and Medicaid and people with severe or disabling chronic conditions. The law requires SNPs that focus on the Medicare-Medicaid population to establish relationships with states to coordinate Medicare and Medicaid services by 2013. This has been challenging because states do not have strong incentives to work through the complex issues associated with developing programs for people with Medicare and Medicaid, when Medicare is responsible for making most of the payments.[14] However, most of these SNPs have secured needed contracts. Some SNPs have delivered promising results, for example the Commonwealth Care Alliance in Massachusetts.

Managed long-term care. Some states have moved to managed long-term care for their Medicaid beneficiaries at high risk of needing nursing home care. For example, New York has a Medicaid managed long-term care program (to date, mainly in New York City) that relies on local provider-based entities (as opposed to traditional health plans) to assume full financial risk for providing the full array of LTSS, together with care management.[15] Arizona has the longest track record in providing all long-term care through capitated arrangements with private health plans; neither Arizona nor Tennessee offer traditional fee-for-service coverage of long-term care. In most state initiatives, entities are home grown and provider based, but some companies (UnitedHealthcare and Amerigroup) have developed long-term-care plans.[16]

Other models. Other care delivery models include Geriatric Resources for Assessment of Care and Resources for Elders (GRACE), and *Summa Health/Area Agency on Aging 10B/Geriatric Evaluation Project (SAGE). Descriptions are available at* http://www.thescanfoundation.org/sites/thescanfoundation.org/files/TSF_Policy_Brief_6_Model_Successes_3.pdf.

Quality Framework for Integrated Care

This section establishes a framework for evaluating the quality of entities that integrate care for people with Medicare and Medicaid. It was informed by a scan of existing research evidence and promising models of care; priorities set by a panel of consumers representing different subpopulations of the Medicare-Medicaid population; and guidance from a panel of experts and other stakeholders. It provides a common approach for measuring quality that can be applied across the diverse models of integration being considered in different states. This framework is unique among approaches to measurement in that it is built around care coordination — centered around individualized assessment of needs and preferences — occurring across providers and settings in a way that is flexible and meaningful and that most of the time does not happen for these beneficiaries today.

Our specific quality framework builds from several key assumptions.

First, we focused on issues common across subgroups of people with Medicare and Medicaid. Historically, most quality measures focus on specific clinical conditions or settings. These types of measures are unsatisfying because few of them can be applied universally to people with Medicare and Medicaid. In addition, many people with Medicare and Medicaid are specifically excluded from these measures because of comorbidities or upper age limits that are a part of the specific elements of the measure.

Instead, our framework focuses on components common across many subgroups and illuminates processes and outcomes of general interest to individuals with chronic or disabling conditions. As noted in the Institute of Medicine's 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, processes are critical for avoiding quality failures.[17] Processes can be both systematic and flexible enough to allow them to adapt to the needs of special subgroups (e.g., people with serious and persistent mental illness).

Second, we focused on services across care settings and disciplines — medical, behavioral, institutional, home- and community-based services, and other supportive social services. Most existing measure activities look within a care setting such as a nursing home, a medical practice or a hospital. This framework focuses on integration and coordination across all settings and providers serving the beneficiary and family, and includes the social and community services sectors that are critical for people with complex health care and social needs.

Third, we aimed to prioritize measures that address the beneficiary/family perspective. This priority is important, given the diversity of people represented and the lack of attention to beneficiary/family perspectives in existing systems. With diverse, vulnerable subgroups in this population and the need to customize and adapt care to individual needs, it is critical to gain input about care from beneficiaries and families.

Fourth, we recognized the need to balance the achievable with the aspirational. This framework is intended to be practical and achievable in the short term, with the recognition that expanding integrated care beyond the few existing programs will require substantial effort and provide experiences to learn from. The framework articulates a vision for what integrated care should look like in the future, where person-centered, collaborative care is a widespread.

BOX 4. Beneficiary-Centered Medical Home: Establish Expectations, Raise Expectations Over Time

With its Beneficiary-Centered Medical Home program, NCQA showed how to articulate a model of care and increase expectations over time, to both reflect and spur improvements in primary care practice. We turned broad principles for excellent team-based, coordinated primary care into concrete, challenging structure and process measures. The beneficiary-centered medical home is used across the country and many payers rely on it even if they use different approaches to payment. The program's standards articulate specific investments providers must make and what must be in place to support good results. Together with a detailed scoring system, the standards allow consistent and fair evaluation. Pilot-test results have shown that, on balance, beneficiary-centered medical homes improve quality and reduce cost.[19] With each update of the program, we have learned from the leading edge practices what is possible and set that as a new expectation.

We have added standardized measurement of beneficiary experience, recognizing that this is the foundation for capturing beneficiary-centeredness. We hope to incorporate results from clinical quality measures into the program, as well; many states that support beneficiary-centered medical homes require reporting on quality results.

Fifth, our model combines a roadmap of "structures and processes" with performance measures that address use of effective care, costs of care and beneficiary experiences. Our experience implementing quality measurement and improvement in other settings (Box 4) has shown that it is critical to talk about the capabilities and infrastructure that providers or other entities must build as they learn how to care for beneficiaries in new ways. Our approach is consistent with that of the National Quality Forum's Dual Eligible Beneficiaries Workgroup of the Measure Applications Partnership, which recommends structural measures to support high-quality care, along with existing performance measures.[18] Table 1 illustrates the difference between structure and process measures which articulate expectations for and assess an entity's capacity and demonstrated ability to provide integrated care; performance measures assess the receipt of services, outcomes or perceptions among specific populations. Future work will develop performance measures that capture the essential outcomes of care, but that depend upon data that is not currently available. The structure and process roadmap calls for a plan of care that includes understanding, documenting and monitoring progress towards meeting beneficiaries' goals. Building these care processes and the information infrastructure needed to support them will enable measurement of outcomes such as how well beneficiary goals were met — whether functioning improved, care at home or more personal goals.

Key Domains of Quality for Integrated Care

This quality framework model distills the key functions of integrated care into three steps, the content of which depend on the person's level of need for coordination. These concepts go well beyond what is expected of health care entities today — the new contribution of this research is that our concept of screening and assessment is person-centered and encompasses elements beyond what is usually contained in the assessments that take place in a particular setting:

1. Screening and assessment.
2. Care planning.
3. Coordinated service delivery.

Person-centered care begins with respect, championship of rights and full participation of individuals in decisions about their care. Data systems with population health-management tools that can support

these steps are crucial, as well as a dedicated approach to routine quality measurement and improvement. This model is necessary for achieving (and for demonstrating achievement of) the goals of improving or slowing decline in health and well-being; reducing the overall costs of care; and improving the quality of care and — in particular — beneficiary and family experiences with care.

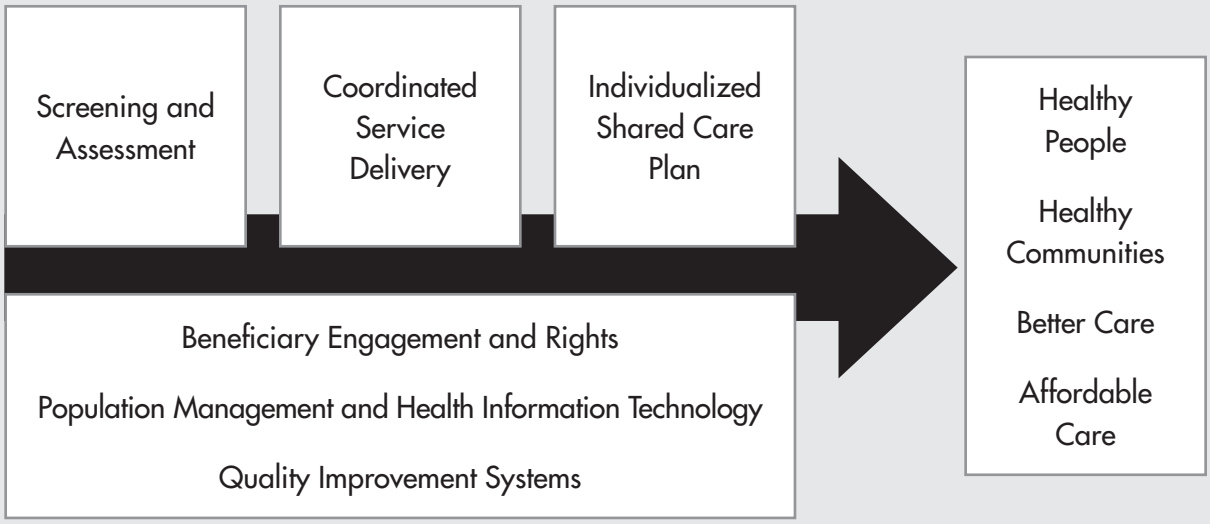
Figure 3 presents the overall framework for measuring quality of integrated care for people with Medicare and Medicaid. Organizations must put in place structures and processes for all three steps — both design and implementation are important. The structure and process measures follow the framework for quality in integrated care and array the key capabilities and functions for an entity to effectively integrate care.

For the beneficiary, these three steps are how organizations will personalize their care. Initial screening is done for everyone, to learn which beneficiaries need more comprehensive, in-person assessment. Screening and — if needed — comprehensive assessment — can identify the beneficiary's risk level, care needs and whether close monitoring is called for. These activities also can be the way for organizations to learn the beneficiary's preferences. All beneficiaries will have some kind of a care plan, whether a preventive care plan for those who are relatively healthy and stable, or a more active care plan, for those who need ongoing medical or behavioral care or long term supports and services. The care plan, built on the screening/assessment, guides not only the provision of care but also the frequency of reassessment. Unplanned transitions such as hospitalizations and other events, such as Emergency Department visits, health events or changes in support systems, will trigger reassessment of risk and if warranted, changes in the care plan.

Structure and Process Roadmap

Building on the quality framework and the measures NCQA developed for SNPs (on behalf of CMS), we identified the structures and processes needed to address the full range of Medicare and Medicaid benefits,

FIGURE 3. Framework for Quality in Integrated Care



as well as concerns about person-centered care. These structures and processes are statements of what program components must be in place. One way to evaluate performance of integrated care entities is to review evidence that the entity has implemented the required structures and follows the essential processes. Independent reviewers can provide an assessment of how well the entity satisfies the requirements on a point scale. Alternatively, regulators could conduct readiness reviews that take place before beneficiaries enroll or articulate expectations about structures and processes in a contract. Regardless of the timing and vehicle, it will be important to assess these capabilities and enforce their use. The structures and processes included in this framework provide a roadmap to establishing the infrastructure, including the data systems and care processes, needed to be able to measure performance.

Performance measures are expressed as a ratio — for example for a target population that should receive a type of treatment, what share actually received it. Performance measures are useful for evaluating performance in specific areas and domains, while evaluation of structures and processes can fill the gap in areas when performance measures are lacking. (See Table 1 for examples.)

These structures and processes address some of the measurement gap areas identified by the National Quality Forum (NQF) workgroup, including goal-directed, person-centered care planning and implementation and system structures to ensure connection between the health system and LTSS.

- **Screening and — if warranted — assessment.** Screening should occur at entry for all beneficiaries, more comprehensive assessment should occur for those found to be higher risk based on the screening. Screening and assessment should be holistic (i.e., include medical, behavioral, functional and psychosocial needs) and address individual preferences, and reassessment should take place in response to triggering events.

- **Individualized, shared care plan.** The shared care plan transforms the results of the screening and assessment into an individualized, person-centered, integrated care plan. The individual and family members or caregivers (as appropriate) collaborate with providers to develop a coordinated, comprehensive care plan that encompasses all care needed, across all settings. The plan should be accessible to the beneficiary, to the designated family/caregivers and to providers, and updated based on routine periodic assessment (depending on need) and on trigger events.

- **Coordinated service delivery.** The shared care plan supports and includes accountability for managing care transitions and for tracking and follow-up of services and referrals. In particular, coordination between Medicare and Medicaid benefits and services is included. For individuals with multiple chronic conditions, the plan would plan for and be the basis of coordination among multiple specialties.

- **Quality improvement.** Standardized approaches to measuring quality and implementing targeted quality improvement are needed to develop the data sources and capacity for measuring key indicators that are of greatest interest for people with Medicare and Medicaid, but are now lacking. Approaches include

attention to beneficiary experiences with the care-planning process, transitions and overall care, in addition to other performance measures, such as those recommended by the NQF or currently reported by a variety of entities. (Refer to Tables D and E in the Appendix.)

TABLE 1. Comparison of Structure/Process Measures and Performance Measures

In this document, we follow a convention developed for earlier work with CMS that distinguishes "structure and process measures" (also called "standards" in other NCQA programs) from "performance measures." Structure and process measures articulate expectations for and assess an entity's capacity and demonstrated ability to provide person-centered, integrated care and can serve as a roadmap to implementing integrated care systems; performance measures assess the receipt of specific services, outcomes or perceptions among specific populations. This table gives examples of these types of measures.

Structure and Process Measures	Performance Measures
Periodic Reassessment Process The organization's assessment procedures address: • Frequency of routine comprehensive reassessment based on risk. • Triggering events for off-schedule comprehensive reassessment. • Methods and sources of information to monitor individuals' risks and needs. *Individualized Care Plan* The organization, with each beneficiary, develops a coordinated, comprehensive, integrated care plan that encompasses all care needed across all settings and includes the following: • Development of an individualized care plan by, or representing the care provided by, the full care team, including prioritized goals that consider the beneficiary's and caregivers' goals, preferences and desired level of involvement in the care plan. • Identification of barriers to meeting goals or complying with the plan. • Development and communication of self-management plans. • A process to assess beneficiary progress against care plans. • Contact information for all care providers. • Identification of and contact information for the individual who is the first point of contact and who is responsible for managing the care plan.	*Medication Reconciliation Post-Discharge* The percentage of discharges from January 1 — December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge. *Diabetes Screening for People With Schizophrenia or Bipolar Disorder* The percentage of members 25 years and older with a schizophrenia diagnosis or bipolar disorder diagnosis who were prescribed any antipsychotic medication and received a diabetes screening during the measurement year. *Three-Item Care Transition Measure* One-dimensional, self-reported survey that measures the quality of preparation for care transitions: understanding the self-care role in the post-hospital setting, medication management and having one's preferences incorporated into the care plan. *Comfortable Dying* The percentage of beneficiaries who were uncomfortable because of pain on admission to hospice, whose pain was brought under control within 48 hours. *Care for Older Adults* The percentage of adults 66 years of age and older who had each of the following during the measurement year: • Advance care planning. • Medication review. • Functional status assessment. • Pain screening.

- **Beneficiary engagement and rights.** These processes enhance the role of individuals as partners in their care, communicating about their rights and responsibilities, and for handling and resolving beneficiary grievances.

- **Health information technology and population health management.** The data and infrastructure available for supporting the care process must capture and integrate information from multiple sources and support systems for sharing and using information to identify high-need participants. This information can help identify and track populations at different levels of risk and facilitate and integrate care, and is shared among members of the care team across settings.

Performance Measures

The evaluation framework envisions the use of new and existing performance measures to assess key goals related to population health, cost and quality of care and beneficiary experience. While some existing performance measures address issues of relevance for people with Medicare and Medicaid, adaptation is needed. New measures are needed to address critical topics including beneficiary experiences and preferences for care as well as quality of life and functional outcomes. The structures and processes described above complement performance measures and also support the development of new measures in key areas.

Existing measures addressing cross-cutting issues such as medication reconciliation, screening for depression and readmissions are reported by SNPs; other measures are reported by nursing homes and are used for assessing quality in LTSS. Some of these measures could be readily used for evaluating integrated care but may require adaptation. Tables D and E in the Appendix provide lists of measures that are currently used or have been recommended for evaluating quality both for general medical care and for LTSS. In the short term, some of these measures could be adapted for reporting by integrated care entities (such as those shown in Table 2), but new measures will be needed to address high-priority topics that reflect the needs of a diverse Medicare-Medicaid population, including (but not limited to):

- Appropriate prescribing and medication management.

- Autonomy.

- Sense of control/self-determination.

- Pain and symptom management.

- Effectiveness of supports for people with functional limitations.

Measures addressing these areas present challenges for implementation; for example, among the most commonly noted gaps are measures of beneficiary/family experience of care and measures evaluating beneficiary functioning. Existing standardized tools to measure physical and mental health functioning are not always appropriate in a frail population or in a population with multiple chronic conditions or significant cognitive impairment; nor do measures address self-determination and autonomy — often most important to people with Medicare and Medicaid.

We must develop new outcome measures of health-related quality of life and functioning that address the complex and unique needs and views of the Medicare-Medicaid population. To make beneficiary/family reported information valid, reliable and useful, a number of issues need to be considered:

- Do existing tools adequately account for health literacy and cognitive issues in people with Medicare and Medicaid?
- When are proxy reports from family members or caregivers acceptable or appropriate?
- What methods of data collection are feasible and replicable in different settings?
- What type of risk stratification or adjustment is needed for comparison over time or across organizations?

The answers to these questions may differ for the type of beneficiary-reported information and the measure purposes.

Alignment of Structure and Process Roadmap With Performance Measures

The structure and process roadmap lays the foundation for performance measures that measure aspects of a process and eventually outcomes of care. Table 2 shows the relationship between structures and processes, and existing performance measures. For example, in the area of screening and assessment where we have expectations for the two-part evaluation of beneficiaries' needs, we have identified three existing performance measures — depression screening, care for older adults and falls risk assessment. We

TABLE 2. Alignment of Existing and New Performance Measures With Structures and Processes

Structure and Process Domain	Screening and Assessment	Care Planning	Coordinated Service Delivery
Existing Performance Measures	• Depression screening • Care for older adults (pain assessment, functional status assessment, advanced care planning) • Falls risk assessment	• Depression follow-up • Care for older adults (medication review) • Falls risk plan of care • Diabetes screening • Cholesterol screening • Cancer screening	• Care transition record transmitted • Follow-up after hospitalization for mental health • Medication reconciliation
Potential New Performance Measures	• % of beneficiaries with risk assessment within X days of enrollment • Assessment of quality of life • Screening for low health literacy • Daily activity function	• % of beneficiaries with care plan within X days of enrollment • Shared decision making • Assessment of goals and preferences	• % of beneficiaries with discharge follow-up • Potentially avoidable hospitalization

also have begun to identify new opportunities for measures to assess the effectiveness of the screening and assessment process; for example, new measures could be developed to capture the timeliness of this process as well as whether important content areas such as quality of life, health literacy and daily activity function are addressed. In time, as the performance of assessments and documentation of their results become routine, it may be possible to measure the person-centered outcome at the heart of this process: progress towards achieving goals.

The structure and process roadmap described above could help both the development and the implementation of new measures. The structures and processes related to screening and assessment give organizations experience with defining populations that need specific kinds of screening or assessment. Information systems for population health management make it possible to capture key data about screening and assessment processes that are needed to construct a measure. Quality measurement and improvement processes allow organizations to understand patterns of care and to work to improve.

Implementation Challenges

A number of challenges face entities, states and the federal government as they move towards implementing programs to integrate care for people with Medicare and Medicaid.

Use of good measures of quality — whether structure and process or outcomes — is particularly important to assure stakeholders that efforts to integrate care — whether through managed care or managed fee-for-service — improve care even as care models and financial incentives change. Ideally, these measures will allow us to learn which of the diverse approaches to person-centered care management yield the best results.

Traditionally, it has been unusual for providers to coordinate care across long-term services and supports, medical care and behavioral health. Some people refer to this problem as that of "silos," where each type of provider thinks only about the beneficiary in terms of the services that provider furnishes. This is true of the U.S. health care system in general; it relies on specialized services for different health care problems, which is reinforced by benefit design and payment systems. Quality measures have tended to follow the silos, being collected within a particular setting and for particular diseases. Measuring HbA1c for diabetes, for example, is more straightforward than measuring "good, person-centered" care, and the quality of the communication and collaboration among the separate providers that provide that care for a person with diabetes, congestive heart failure, hypertension and depression.

The shift in the LTSS world from funding specific programs (e.g., adult day health care) to funding services based on an individualized assessment (e.g., personal care, home modifications and medical management) will be challenging for LTSS providers. This idea will be even more foreign to providers of Medicare services who are used to providing care within the definitions and payment incentives of Medicare post-acute care, including the 100-day skilled nursing facility benefit.

For the managed care models, one would expect that capitated payments to entities would create the incentive for the entities themselves to consider more broadly a beneficiary's needs under a single budget. For managed fee-for-service models with shared savings opportunities, incentives may also encourage more person-centered approaches. For both managed care and managed fee-for-service models, developing new payment systems, focusing providers on new goals and improving the flow of information across providers will be challenging.

As noted above, the Medicare and Medicaid programs themselves have vastly different cultures. Medicare operated federally, with uniform rules, participation requirements and consumer protections. Medicaid varies a great deal across the states, reflecting the political priorities, budget and local delivery system. These different cultures could result in challenges from the perspective of entities that will need to respond to both purchasers.

Also challenging are the shortages of many types of providers — starting with primary care providers but going on to include providers with specialized expertise. Providers will need to use electronic health information to support this work, but it is not clear that the technology has all the needed functions yet. While more hospitals and clinician offices are using electronic health information, health information exchange among medical

providers is still in its infancy, and providers of long-term services and supports have rarely been considered in the construction of health information exchange programs. Even providers with health information technology will need support from analytical staff to use the systems to target services and monitor care.

Finally, integrated models need to take into account the different configuration and capabilities and historic role that providers have, which will vary enormously across the country. Entities will need to play a clear and direct role in assuring provider network adequacy for both Medicare and Medicaid services. Adequacy encompasses the appropriate mix of services; geographic distribution to meet the needs of beneficiaries in the entire service area; and physical accessibility. Entities will need to select, credential and monitor providers who can serve a complex population, are willing to collaborate across professions and settings and can work with multiple stakeholders from the aging, behavioral health and disability communities. This is an especially critical issue in LTSS as personal care providers in self-directed programs allow beneficiaries to use non-certified family and friends as providers.

Use of Quality Framework for Integrated Care

A quality framework that combines structure and process measures with performance measures offers a way to demonstrate and monitor quality for a vulnerable population. State and federal government agencies can refer to the PCMH program evolution as a way to build programs serving people with Medicare and Medicaid. Over time, standardized measurement of beneficiary experience and outcomes (clinical, functional and quality of life) can be added and performance expectations can be raised.

Here are three potential approaches for incorporating this quality framework into integrated care evaluation:

- **For state-based programs, states can build evaluation metrics into integrated programs.** Many states and private purchasers/sponsors have formal or informal partnerships with private evaluation entities that review contracting entities (e.g., managed care organizations, beneficiary-centered medical homes) and furnish the results to program sponsors. Sponsors are free to develop payment, reimbursement and incentive structures, but can rely on the independent results to identify the entities most ready to take on the challenge of managing the population.

  States can use other strategies, such as an accreditation program, to satisfy some program elements. Some state governments require accreditation; others use accreditation results to satisfy some state requirements. For example, state insurance departments deem NCQA-Accredited health plans to meet state requirements for a robust approach to verifying provider credentials.

- **Direct federal funding.** For example, CMS has funded (a) the SNP measure development and mandated that the measures be used in a program, paying for a contractor to do training, collection of measures and evaluation of models of care; (b) development of measures and measure resporting systems for Medicaid and CHIP; and (c) support for assessing quality in demonstrations.

Finally, while this paper is focused on the Medicare-Medicaid population, the quality framework and measures have the potential to be relevant to other groups that share the same characteristics; for example, people who have only Medicare, Medicaid or private insurance, yet also experience chronic physical and behavioral problems, along with functional impairment.[20]

Conclusion

Designing new models for providing person-centered, integrated care for beneficiaries with Medicaid and Medicare coverage is a critical policy challenge. Good integrated care holds the promise of eliminating the fragmented, medically-oriented care that often wastes state and federal dollars and leaves beneficiaries and their families feeling confused and overwhelmed. This paper offers an approach to evaluating the quality of integrated care, starting with structures and processes measures that set expectations for key functions and capabilities and create the foundation for the development and application of outcome measures. It also identifies existing performance measures that could be adapted for evaluating entities in the short run. Over time, as the structures and processes become fully embedded in integrated care programs, we envision adding measures to capture outcomes for diverse groups of people with Medicare and Medicaid.

References

1. MedPAC. June 2011. A Data Book: Health Care Spending and the Medicare Program, Section 3: Dual-eligible-beneficiaries. http://www.medpac.gov/document_TOC.cfm?id=617
2. The Kaiser Commission on Medicaid and the Uninsured. July 2005. Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries. http://www.kff.org/medicaid/upload/4091-04 final(v2).pdf
3. New York State Dept. of Health. October 1, 2011. Drugs Covered by Medicaid for Dual Eligible Beneficiaries. http://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-10-01_medicare_exempt_drugs.pdf
4. The Commonwealth Fund. Rehospitalization of Skilled Nursing Facility Medicare Beneficiaries. http://www.commonwealthfund.org/Performance-Snapshots/Nursing-Home-and-Home-Health-Care/Rehospitalization-of-Skilled-Nursing-Facility-Medicare-Beneficiaries.aspx
5. Mor, V., J. Zinn, P. Gozalo, Z. Feng, O. Intrator and D.C. Grabowski. 2007. Prospects For Transferring Nursing Home Residents To The Community. *Health Affairs* 26, no.6:1762–71
6. Walsh, E.G, and W.D. Clark. 2002. Managed care and dually eligible beneficiaries: Challenges in coordinating. *Health Care Financing Review* 24, no 1: 63–82.
7. Ryan, J., and N. Super. 2003. Dually eligible for Medicare and Medicaid: Two for one or double jeopardy? National Health Policy Forum Issue Brief, no 794 (September 30), Washington DC: The George Washington University.
8. Center for Health Care Strategists. November 2010. Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services. http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf
9. Centers for Medicare & Medicaid Services. April 2012. Medicare Advantage/Part D Contract and Enrollment Data. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Contract-and-Enrollment-Summary-Report-Items/Contract-Summary.html
10. National PACE Association. Philosophy, History. http://www.npaonline.org/website/article.asp?id = 12
11. White, A.J., Abt Associates. October 27, 2000. Evaluation of the Program of All-Inclusive Care for the Elderly Demonstration. http://www.cms.gov/Medicare/Health-Plans/pace/downloads//abtreport.pdf
12. Abt Associates. July 1998. Evaluation of the Program of All Inclusive Care for the Elderly (PACE) Demonstration. http://www.npaonline.org/website/download.asp?id=1933
13. Robert Wood Johnson Foundation. October 31, 2008. Medicare/Medicaid Integration Program. http://www.rwjf.org/files/research/MLT.final.pdf
14. Edwards, B. AARP Public Policy Institute. Modified September 2009. Integrating Medicare and Medicaid: State Experience with Dual Eligible Medicare Advantage Special Needs Plans. http://assets.aarp.org/rgcenter/ppi/health-care/2009_14_maplans.pdf
15. Hokenstad, A. April 2009. Medicaid Institute at United Hospital Fund, An Overview of Medicaid Long-Term Care Programs in New York. http://www.uhfnyc.org/assets/604
16. Saucier, P. April 2009. University of Southern Maine, The Past, Present and Future of Managed Long Term Care. http://muskie.usm.maine.edu/Publications/ihp/ASPE_MLTC_Report2005.pdf
17. Institute of Medicine. March 1, 2001. Crossing the Quality Chasm: A New Health System for the 21st Century.
18. National Quality Forum. June 2012. Final Report to HHS: Measure Applications Partnership: Measuring Healthcare Quality for the Dual Eligible Beneficiary Population. http://www.qualityforum.org/Setting_Priorities/Partnership/People with dual eligibility_Workgroup/Dual_Eligible_Beneficiaries_Workgroup.aspx (May 8, 2012)
19. Takach, M. 2011. Reinventing Medicaid: State Innovations to Qualify And Pay For Beneficiary-Centered Medical Homes Show Promising Results. *Health Affairs*, 30, no.7:1325–34.
20. The SCAN Foundation. Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services. http://thescanfoundation.org/sites/thescanfoundation.org/files/Georgetown_Trnsfrming_Care_2.pdf.

Appendix

TABLE A. Demographics, Health Characteristics and Utilization for People With Medicare and Medicaid versus Medicare Only

	Medicare and Medicaid		Medicare Only
Demographics[1]			
Below 200% of poverty line	91%		33%
Female	63%		54%
Under 65 (disabled)	41%		12%
African-American	18%		8%
Hispanic	14%		7%
No high school education	53%		22%
Rural residence (vs. urban)	30%		22%
Lives in institution	20%		2%
Lives alone	27%		26%
Lives with spouse	15%		46%
Lives with others (e.g., child)	30%		13%
Physical Impairment			
No activities of daily living impaired[1]	46%		72%
1-2 activities of daily living impaired[1]	24%		19%
3-6 activities of daily living impaired[1]	30%		9%
	Nursing Home	**Community**	
Any activities of daily living impaired[2]	88%	43%	
Cognitive/mental health			
Any impairment[2]	58%		25%
	Aged	**Disabled**	
Dementia[3]	30%	5%	
Depression[3]	18%	28%	
Schizophrenia[4]	4%	12%	
Other serious disorder[4]	18%	27%	
	Nursing Home	**Community**	
Any impairment[2]	92%	52%	
Chronic conditions			
3+ chronic conditions[2]	55%		44%

	Medicare and Medicaid		Medicare Only
	Aged	**Disabled**	
Ischemic heart disease[3]	43%	17%	
Diabetes[3]	36%	23%	
Heart failure[3]	33%	11%	
Rheumatoid arthritis/osteoarthritis[3]	31%	13%	
COPD[3]	18%	10%	
Annual Utilization	**Aged**	**Disabled**	
1+ inpatient visit[2]	29%	22%	18%
1+ ER visit[2]	13%	22%	12%
1+ home health visit[2]	15%	7%	8%
1+ skilled nursing facility stay[2]	13%	4%	4%
	Nursing Home	**Community**	
1+ inpatient visit[2]	42%	23%	
1+ ER visit[2]	3%	20%	
1+ home health visit[2]	8%	12%	
1+ skilled nursing facility stay[2]	37%	4%	

[1] MedPac. A Data Book: Health Care Spending and the Medicare Program (June 2011), Section 3: Dual-eligible-beneficiaries. http://www.medpac.gov/document_TOC.cfm?id=6172

[2] Kaiser Family Foundation. Issue Brief: Medicare's role for dual eligible beneficiaries (April 2012). http://www.kff.org/medicare/8138.cfm

[3] MedPac. Report to the Congress: Improving Incentives in the Medicare Program (June 2009), Chapter 5: Coordinating the care of dual-eligible beneficiaries. http://www.medpac.gov/document_TOC.cfm?id=576

[4] Kaiser Family Foundation Chronic Disease and co-morbidity among people with dual eligibility: implications for patterns of Medicaid and Medicare Service Use and Spending (July 2010). http://www.kff.org/medicaid/upload/8081.pdf

TABLE B. Total Medicare and Medicaid per Capita Spending for People With Medicare and Medicaid[1]

	All	Spending Relative to Average
All Beneficiaries	$26,185	
No nursing home spending	$19,171	0.72
Top nursing home spending[2]	$75,496	2.88
Aged	$26,841	1.03
No nursing home spending	$16,916	0.65
Top nursing home spending	$74,439	2.84
Disabled (<65)	$24,924	0.95
No nursing home spending	$22,530	0.86
Top nursing home spending	$84,339	3.22
Dementia	$46,578	1.78
COPD	$40,645	1.55
Depression	$38,829	1.48
Diabetes	$32,188	1.23
Heart failure	$40,632	1.55
Ischemic heart disease	$34,568	1.32
Rheumatoid arthritis/Osteoarthritis	$31,864	1.22
4+ chronic conditions	$43,989	1.68
5+ chronic conditions	$50,278	1.92

[1] MedPac. June 2009. Report to the Congress: Improving Incentives in the Medicare Program, Chapter 5: Coordinating the care of dual-eligible beneficiaries. http://www.medpac.gov/document_TOC.cfm?id=576

[2] Top nursing home spending includes the top 20th percentile of spending for beneficiaries who used nursing home services.

TABLE C. Structure and Process Measures for Integrated Care

Domains	Measures
Comprehensive Assessment	*CA 1: Screening and Assessment Process* Element A: Screening Process Element B: Comprehensive, Individualized Assessment Process Element C: Comprehensive Assessment Content Element D: Risk Stratification Element E: Periodic Re-Screening and Re-Assessment Process Element F: Providing Screening and Comprehensive Assessment
Individualized Care Plan	*ICP 1: Individualized Care Plan* Element A: Individualized Care Plan Element B:Using the Care Plan Element C: Care Plan Performance Element D: Informing and Educating Providers
Coordinated Care Delivery	*CCD 1: Care Transitions* Element A: Reducing Transitions Element B: Managing Transitions Element C: Supporting Beneficiaries Through Transitions Element D: Identifying Unplanned Transitions *CCD 2: Coordination of Medicare and Medicaid* Element A: Administrative Coordination Element B: Service Coordination Element C: Network Adequacy Assessment
Population Health Management and Health Information Technology	*HITP 1: Population Health* Element A: Process for Data Collection and Integration Element B: Using Data for Risk Stratification Element C: Information Systems Element D: Coordinating Information Exchange
Quality Measurement and Improvement	*QI 1: Measure and Improve Performance* Element A: Measure Performance Element B: Measure Beneficiary Experience Element C: Implement Continuous Quality Improvement Element D: Demonstrate Continuous Quality Improvement
Beneficiary Engagement and Rights (BER)	*BER 1: Engaging and Informing Beneficiaries* Element A: Beneficiary Rights Information Element B: Information about Benefits Element C: Beneficiary Expectations Element D: Handling Beneficiary Grievances Element E: Resolving Grievances

TABLE D. Existing Performance Measures Used/Recommended for Evaluating General Medical Care in National Programs in Medicare or Medicaid

Measures in the table were identified through the multiple sources: (1) The Special Needs Plan (SNP) reporting requirements; (2) The initial core set of health care quality measures for Medicaid-eligible adults; (3) The National Quality Forum (NQF) Measurement Applications Partnership (MAP) recommended measures (C-core set; E-expansion set) for beneficiaries with dual eligibility for Medicare and Medicaid; (4) The Medicare Advantage (MA) Plan Rating measure reporting requirements; (5) Specific measures identified in state proposal to CMS for the integrated care demonstration project; and (6) Measures for adults included in the final rule for Medicare and Medicaid electronic health record incentive program for eligible providers stage 2 (Meaningful Use — MU). These measures address the aspects of care related to general medical care (ambulatory care and acute care).

National Quality Strategy Measurement Domains Performance Measures	SNP	Medicaid Core	NQF MAP	MA	State Demo	MU	NQF #	Data Source	Owner
Health and Well-Being Outcomes									
Assessment of health related quality of life in adults with ESRD			E				260	Survey	RAND
Change in daily activity function as measured by the AM-PAC			E				430	Survey	CREcare
Improving or maintaining physical health				✓			NA	Survey	NCQA/ HOS
Improving or maintaining mental health				✓			NA	Survey	NCQA/ HOS
Prevention and Screening									
Adult BMI assessment		✓		✓	✓		NA	Admin/ Paper	NCQA
Adult weight screening and follow-up			E		✓	✓	0421	Admin/ EHR	CMS/QIP
Counseling on physical activity in older adults				✓	✓		0029	Survey	NCQA/ HOS
Care for older adults: Functional status assessment	✓			✓	✓		NA	Admin/ Paper	NCQA
Care for older adults: Pain screening	✓			✓	✓		NA	Admin/ Paper	NCQA
Flu shots for adults		✓		✓	✓		0039	Survey	NCQA/ CAHPS®
Influenza immunization					✓	✓	0041	Admin/ EHR	AMA/PCPI

National Quality Strategy Measurement Domains Performance Measures	SNP	Medicaid Core	NQF MAP	MA	State Demo	MU	NQF #	Data Source	Owner
Pneumococcal vaccination in older adults					✓	✓	0043	Survey/ EHR	NCQA/ CAHPS®
Breast cancer screening		✓		✓	✓	✓	0031	Admin/ EHR	NCQA
Colorectal cancer screening	✓				✓	✓	0034	Admin/ Paper/EHR	NCQA
Cervical cancer screening		✓			✓	✓	0032	Admin/ Paper/EHR	NCQA
Chlamydia screening in women		✓				✓	0033	Admin/ EHR	NCQA
Glaucoma screening in older adults	✓			✓			NA	Admin	NCQA
Screening for falls risk			C		✓	✓	0101	Admin/ EHR	NCQA/ AMA/PCPI
Falls risk management				✓	✓		0035	Survey	NCQA/ HOS
Depression screening and follow up		✓	C		✓	✓	0418	Admin/ EHR	CMS/QIP
Tobacco use: Screening and cessation intervention					✓	✓	0028	Admin/ ERH	AMA/PCPI
Medical assistance with smoking and tobacco use cessation		✓			✓		0027	Survey	NCQA
Pregnant women that had HBsAg testing						✓	0608	Admin/ EHR	Ingenix
Fasting LDL-C test has been performed						✓	NA	EHR	CMS/QIP
Aspirin use and discussion					✓		NA	Survey	NCQA
Screening for high blood pressure and follow-up documented						✓	NA	EHR	CMS/QIP
Effective Treatment of Chronic Conditions									
HIV/AIDS: Annual medical visit		✓				✓	0403	Admin/ EHR	AMA/ PCPI/ NCQA
HIV/AIDS: PCP prophylaxis						✓	0405	Admin/ EHR	NCQA

National Quality Strategy Measurement Domains Performance Measures	SNP	Medicaid Core	NQF MAP	MA	State Demo	MU	NQF #	Data Source	Owner
HIV/AIDS: RNA control for beneficiaries with HIV						✓	0407	Admin/ EHR	NCQA
Diabetes: Eye exam				✓	✓	✓	0055	Admin/ Paper/EHR	NCQA
Diabetes: Foot exam				✓	✓	✓	0056	Admin/ Paper/EHR	NCQA
Diabetes: Hemoglobin A1c testing		✓			✓		0057	Admin/ Paper	NCQA
Diabetes: Hemoglobin A1c poor control				✓	✓	✓	0059	Admin/ Paper/EHR	NCQA
Diabetes: Hemoglobin A1c control				✓	✓		0575	Admin/ Paper	NCQA
Diabetes: LDL-C screening		✓		✓	✓		0063	Admin/ Paper	NCQA
Diabetes: LDL-C control				✓	✓	✓	0064	Admin/ Paper/EHR	NCQA
Diabetes: Urine protein screening					✓	✓	0062	Admin/ Paper/EHR	NCQA
Diabetes: Blood pressure management					✓		0061	Admin/ Paper	NCQA
Diabetes: Diabetes treatment (Part D)				✓	✓		NA	Admin	PQA
Diabetes: Medication adherence for oral diabetes medications (Part D)				✓	✓		0541	Admin	PQA
Diabetes: Optimal diabetes care			E				0729	Paper/EHR	MN Community
Diabetic retinopathy: Documentation of macular edema and severity						✓	0088	Admin/ EHR	AMA/PCPI
Respiratory: Pharmacotherapy management of COPD exacerbation	✓				✓		0549	Admin	NCQA
Respiratory: Use of spirometry test in assessment and diagnosis of COPD	✓				✓		0577	Admin	NCQA

National Quality Strategy Measurement Domains Performance Measures	SNP	Medicaid Core	NQF MAP	MA	State Demo	MU	NQF #	Data Source	Owner
Respiratory: Management of poorly controlled COPD			C				1825	Admin	ActiveHealth
Respiratory: Use of appropriate medications for asthma					✓	✓	0036	Admin/ EHR	NCQA
Cardiovascular: Medication adherence for cholesterol (Part D)				✓	✓		0541	Admin	PQA
Cardiovascular: Cholesterol management for beneficiaries with cardiovascular cond.				✓	✓		NA	Admin/ Paper	NCQA
Cardiovascular: Medication adherence for hypertension (Part D)				✓	✓		0541	Admin	PQA
Cardiovascular: Controlling high blood pressure	✓	✓		✓	✓	✓	0018	Admin/ Paper/EHR	NCQA
Cardiovascular/ Hypertension: Improvement in blood pressure						✓	N/A	EHR	CMS
Cardiovascular: Persistence of beta-blocker treatment after a heart attack	✓				✓		0071	Admin	NCQA
Cardiovascular/ Coronary artery disease: Beta-blocker therapy						✓	0070	Admin/ EHR	AMA/PCPI
Cardiovascular/ Ischemic vascular disease: Complete lipid panel and LDL control						✓	0075	Admin/ EHR	NCQA
Cardiovascular/Ischemic vascular disease: Use of aspirin or another antithrombotic						✓	0068	Admin/ EHR	NCQA
Cardiovascular/Heart failure: ACE inhibitor or ARB therapy					✓	✓	0081	Admin/ EHR	AMA/PCPI

National Quality Strategy Measurement Domains Performance Measures	SNP	Medicaid Core	NQF MAP	MA	State Demo	MU	NQF #	Data Source	Owner
Cardiovascular/ Heart failure: Beta-blocker therapy						✓	0083	Admin/ EHR	AMA/PCPI
Primary open angle glaucoma: Optic nerve evaluation						✓	0086	Admin/ EHR	AMA/PCPI
Colon cancer: Chemotherapy						✓	0385	Admin/ EHR	AMA/ PCPI/ ASCO
Breast cancer: Hormonal therapy						✓	0387	Admin/ EHR	AMA/PCPI
Cataracts: 20/40 or better visual acuity within 90 days following cataract surgery						✓	0565	Admin/ EHR	AMA/ PCPI/ NCQA
Rheumatoid arthritis: Use of disease modifying anti-rheumatic drug (DMARD) Therapy				✓	✓		0054	Admin	NCQA
Management of urinary incontinence				✓			0030	Survey	NCQA/ HOS
Osteoporosis management in women who had a fracture	✓			✓	✓		0053	Admin	NCQA
Dementia: Cognitive assessment						✓	NA	Admin/ EHR	AMA/PCPI
Mental Health and Substance Abuse									
Adherence to antipsychotics in individuals with schizophrenia		✓			✓		1879	Admin	CMS-QIP
Antidepressant medication management	✓	✓			✓	✓	0105	Admin/ EHR	NCQA
Initiation and engagement of alcohol and other drug dependence treatment		✓	C		✓	✓	0004	Admin/ EHR	NCQA
Unhealthy alcohol use: Screening and brief counseling			E				N/A	Admin	AMA/PCPI
Major depressive disorder: Suicide risk assessment						✓	0104	Admin/ EHR	AMA/PCPI

National Quality Strategy Measurement Domains Performance Measures	SNP	Medicaid Core	NQF MAP	MA	State Demo	MU	NQF #	Data Source	Owner
Bipolar disorder and major depression: Appraisal for alcohol or chemical substance use						✓	0110	Admin/ EHR	CQAIMH
Depression remission at 12 months						✓	0710	EHR	MNCM
Depression utilization of the PHQ-9 tool						✓	0712	EHR	MNCM
Safety									
Annual monitoring for beneficiaries on persistent medications	✓	✓			✓		NA	Admin	NCQA
Potentially harmful drug-disease interactions in the elderly	✓						NA	Admin	NCQA
Use of high-risk medication in the elderly	✓		E		✓	✓	0022	Admin/ EHR	NCQA
High-risk medication use in the elderly (Part D)				✓	✓		NA	Admin	PQA
Plan all-cause readmission	✓	✓	C	✓	✓		1768	Admin	NCQA
Hospital-wide readmission			C				1780	Admin	CMS/Yale
PQI 01: Admission for diabetes, short-term complication		✓			✓		0272	Admin	AHRQ
PQI 05: Admission for COPD		✓			✓		0275	Admin	AHRQ
PQI 08: Admission for CHF		✓			✓		0277	Admin	AHRQ
PQI 15: Admission for adult asthma		✓			✓		0283	Admin	AHRQ
Cataracts: Complications within 30 days following cataract surgery						✓	0564	Admin/ EHR	AMA/ PCPI/ NCQA
Adverse drug event prevention and monitoring: Warfarin time in therapeutic range						✓	NA	EHR	CMS

National Quality Strategy Measurement Domains Performance Measures	SNP	Medicaid Core	NQF MAP	MA	State Demo	MU	NQF #	Data Source	Owner
Effective Communication and Care Coordination									
Care for older adults: Advance care planning	✓		E		✓		0326	Admin/ Paper	NCQA
Care for older adults: Medication review	✓			✓	✓		0553	Admin/ Paper	NCQA
Documentation of current medication in the medical record						✓	0419	Admin/ EHR	CMS/QIP
Follow-up after hospitalization for mental illness	✓	✓			✓		0576	Admin	NCQA
Medication reconciliation post-discharge	✓			✓	✓		0554	Admin/ Paper	NCQA
Three-item care transition measure			C		✓		0228	Survey	University of CO
Medical home system survey			E				0494	Survey	NCQA
Transition record received by discharged beneficiary			E				0647	Admin/ EHR	AMA-PCPI
Care transition record transmitted to health care professional		✓			✓		0648	Admin/ EHR	AMA-PCPI
Post-discharge continuing care plan created			E				0557	Admin/ Paper	Joint Commission
Post-discharge continuing care plan transmitted to next level of care provider upon discharge			E		✓		0558	Admin/ Paper	Joint Commission
Diabetic retinopathy: Communication with physician managing diabetes care						✓	0089	Admin/ EHR	AMA/PCPI
Closing the referral loop: Receipt of specialist report						✓	NA	EHR	CMS
SNP 6: Coordination of Medicare and Medicaid coverage			E				NA	Docu-mented praocesses	NCQA/ CMS
Affordable Care and Appropriate Resource Use									
Prostate cancer: Avoidance of overuse of bone scan						✓	0389	Admin/ EHR	AMA/PCPI

National Quality Strategy Measurement Domains Performance Measures	SNP	Medicaid Core	NQF MAP	MA	State Demo	MU	NQF #	Data Source	Owner
Use of imaging studies for low back pain						✓	0052	Admin/ EHR	NCQA
Avoidance of antibiotic treatment in adults with acute bronchitis					✓		0058	Admin	NCQA
Total cost of care PMPM					✓		NA	Admin	NCQA
Emergency department visits per 1,000 enrollees					✓		NA	Admin	NCQA
General hospital inpatient utilization admissions					✓		NA	Admin	NCQA
Mental health services utilization per 1,000 enrollees					✓		NA	Admin	NCQA
Beneficiary- and Family-Centered Care									
Functional status assessment for knee replacement						✓	N/A	EHR	CMS
Functional status assessment for hip replacement						✓	N/A	EHR	CMS
Functional status assessment for complex chronic conditions (heart failure)						✓	N/A	EHR	CMS
CAHPS® health plan survey of beneficiary experience		✓	C	✓	✓		0006	Survey	NCQA/ AHRQ
Cultural competency implementation measure			E				1919	Survey	RAND
CARE — Consumer assessment and reports of end of life			E				1632	Survey	Center for Gerontology
Comfortable dying: Pain brought to a comfortable level within 48 hours of initial assessment			E				0209	Survey	National Hospice and Palliative Org
Beneficiaries admitted to the ICU who have care preferences documented			E				1626	Paper/EHR	RAND

National Quality Strategy Measurement Domains Performance Measures	SNP	Medicaid Core	NQF MAP	MA	State Demo	MU	NQF #	Data Source	Owner
Hospice and palliative care — Treatment preferences documented			E				1641	EHR	UNC Chapel Hill
Oncology: Medical and radiation — Pain intensity quantified						✓	0384	Admin/ EHR	AMA/PCPI
Adults' access to preventive/ambulatory health services				✓	✓		NA	Admin	NCQA
Beneficiary access and performance problems				✓	✓		NA	Admin	CMS
Members choosing to leave the plan				✓	✓		NA	Admin	CMS
Plan makes timely decisions about appeals				✓	✓		NA	Admin	CMS
Review appeals decisions				✓	✓		NA	Admin	CMS
Call center — Foreign language interpreter and TTY/TDD avail.				✓	✓		NA	Admin	CMS
Call center — Pharmacy hold time				✓	✓		NA	Admin	CMS
Appeals auto-forward				✓	✓		NA	Admin	CMS
Appeals upheld				✓	✓		NA	Admin	CMS
Enrollment timeliness				✓	✓		NA	Admin	CMS
Complaints about the drug plan				✓	✓		NA	Admin	CMS
Members choosing to leave the drug plan				✓	✓		NA	Admin	CMS
Getting information from drug plan				✓	✓		NA	Admin	CMS

SNP: Required HEDIS reporting for all Special Needs Plans (SNP)

Medicaid Core: Department of Health and Human Services Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults

NQF MAP: Measure recommended by the NQF Measurement Application Partnership for Beneficiaries Dually Eligible for Medicare and Medicaid (MAP); C — Core set recommended measure; E — Expansion set recommended measure

MA: Medicare Advantage Plan Rating Program (also known as Star rating system)

State Demos: States which have proposed the use of specific measures to evaluate care for beneficiaries enrolled integrated care plans (MA,CO, CT, HI, IA, OH, MO, OK, IL, NM). Note, CT did not list specific measures but the measure domains matched closely to existing measures.

MU: Measures for adults included in the final rule for Medicare and Medicaid electronic health record incentive program for eligible providers stage 2 (Meaningful Use — MU)

NQF#: NQF Endorsed Measure Number

TABLE E. Existing Performance Measures for Long Term Services and Supports Measures Used in National Programs

Measures in this table were identified through two sources: (1) The National Quality Forum Measurement Application Partnership (NQF-MAP) recommendations for post-acute care and long-term care and (2) The NQF MAP recommendations for Home and Community Based Services (HCBS) measures applicable to beneficiaries with dual eligibility for Medicare and Medicaid. These measures address aspects of care related to post-acute care and long-term services and supports (nursing home, home and community-based care, skilled-nursing facility, rehabilitation facility).

Measurement Domains/ Performance Measures	Nursing Home Compare	Home Health Compare Measures	AARP LTSS Score-card	National Balancing Indicators	NQF HCBS Limited Set	NQF #	Source
Falls Measures							
Percentage of residents experiencing one or more falls with major injury (long stay)	✓					0674	MDS
Multi-factorial fall risk assessment conducted for beneficiaries 65 and over		✓				0537	OASIS-C
Percentage of residents who self-report moderate to severe pain (short-stay)	✓					0676-0677	MDS
Pain Measures							
The percentage of residents on a scheduled pain medication regimen on admission who self-report a decrease in pain intensity or frequency (short-stay)	✓					0675	MDS
Pain assessment conducted		✓				0523	OASIS-C
Pain intervention implemented during short-term episode of care		✓				0524	OASIS-C
Improvement in pain interfering with activity		✓				0177	OASIS-C
Pressure Ulcers Measures							
Percentage of residents with pressure ulcers that are new or worsened (short stay)	✓					0678	MDS
Percentage of high-risk residents with pressure ulcers (long stay)	✓					0679	MDS

Measurement Domains/ Performance Measures	Nursing Home Compare	Home Health Compare Measures	AARP LTSS Score-card	National Balancing Indicators	NQF HCBS Limited Set	NQF #	Source
Pressure ulcer prevention in plan of care		✓				0538	OASIS-C
Pressure ulcer prevention plans implemented		✓				0539	OASIS-C
Pressure ulcer risk assessment conducted		✓				0540	OASIS-C
Vaccination Measures							
Percentage of nursing home residents who were assessed and appropriately given the seasonal influenza vaccine (short stay)	✓					0680-0681	MDS
Influenza immunization received for current flu season		✓				0522	OASIS-C
Percentage of residents who were assessed and appropriately given the pneumococcal vaccine	✓					0682-0683	MDS
Pneumococcal polysaccharide vaccine (PPV) ever received		✓				0525	OASIS-C
ADL/Functioning Measures							
Percentage of residents whose need for help with activities of daily living has increased	✓					0688	MDS
Improvement in bathing		✓				0174	OASIS-C
Improvement in bed transferring		✓				0175	OASIS-C
Improvement in management of oral medications		✓				0176	OASIS-C
Improvement in ambulation/locomotion		✓				0167	OASIS-C
Degree to which beneficiaries experience an increased level of functioning					✓		Commission on Accreditation of Rehabilitation Facilities

Measurement Domains/ Performance Measures	Nursing Home Compare	Home Health Compare Measures	AARP LTSS Score-card	National Balancing Indicators	NQF HCBS Limited Set	NQF #	Source
Unmet need in ADLs/ IADLs (11 measures total)					✓		Senior Center Performance Outcome Measures Project Participant Experience Survey
Other Clinical Measures							
Improvement in status of surgical wounds		✓				0178	OASIS-C
Improvement in dyspnea		✓				0179	OASIS-C
Diabetic food care and beneficiary/caregiver education implemented during short-term episode of care		✓				0519	OASIS-C
Drug education on all medications provided to beneficiary/caregiver during short-term episodes of care		✓				0520	OASIS-C
Heart failure symptoms addressed during short-term episodes of care		✓				0521	OASIS-C
Acute care hospitalization		✓				0171	OASIS-C
Percentage of residents with urinary tract infection	✓					0684-0685	MDS
Percentage of residents who have/had a catheter inserted and left in their bladder	✓					0686	MDS
Percentage of residents who were physically restrained	✓					0687	MDS
Percentage of residents who lose too much weight	✓					0689	MDS
Mental Health Measures							
Percentage of residents who have depressive symptoms	✓					0690	MDS
Depression assessment conducted		✓				0518	OASIS-C

Measurement Domains/ Performance Measures	Nursing Home Compare	Home Health Compare Measures	AARP LTSS Score-card	National Balancing Indicators	NQF HCBS Limited Set	NQF #	Source
Beneficiary Experience							
Degree to which beneficiaries report that staff are sensitive to their cultural, ethnic, or linguistic backgrounds and degree to which beneficiaries felt they were respected by staff					✓		Commission on Accreditation of Rehabilitation Facilities
Degree of active beneficiary treatment decision participation					✓		Commission on Accreditation of Rehabilitation Facilities
Case manager helpfulness					✓		Senior Center Performance Outcome Measures Project Participant Experience Survey
Degree to which beneficiaries were satisfied with overall services					✓		Commission on Accreditation of Rehabilitation Facilities
Service satisfaction scales: home worker; personal care; home-delivered meals					✓		Service Adequacy and Satisfac-tion Instrument
Home health CAHPS®		✓				0517	OASIS-C
Beneficiary Quality of Life							
Degree to which people express satisfaction with relationships					✓		Commission on Accreditation of Rehabilitation Facilities
Satisfaction with close friends					✓		Quality of Life Scale (modified by Burkhardt)
Satisfaction with parents, siblings, other relatives relationships					✓		Quality of Life Scale (Burkhardt version for chronic illness)
Percentage of adults age 18+ with disabilities in the community satisfied or very satisfied with life			✓				Data from 2009 BRFSS (NCCDPHP, BRFSS 2009)

Measurement Domains/ Performance Measures	Nursing Home Compare	Home Health Compare Measures	AARP LTSS Score-card	National Balancing Indicators	NQF HCBS Limited Set	NQF #	Source
Participants reporting unmet need for community involvement					✓		Senior Center Performance Outcome Measures Project Participant Experience Survey
Access Measures							
Emergency department use without hospitalization		✓				NA	OASIS-C
Timely initiation of care		✓				0526	OASIS-C
Percentage of caregivers usually or always getting needed support			✓		✓		Institute analysis of 2009 BRFSS (NCCDPHP, BRFSS 2009)
Ability to identify case manager					✓		Senior Center Performance Outcome Measures Project Participant Experience Survey
Ability to contact case manager					✓		Senior Center Performance Outcome Measures Project Participant Experience Survey
Degree to which people with identified physical health problems obtain appropriate services and degree to which health status is maintained and improved					✓		Commission on Accreditation of Rehabilitation Facilities
Percentage of adults age 18+ with disabilities in the community usually or always getting needed support			✓		✓		Data from 2009 BRFSS (NCCDPHP, BRFSS 2009)
Waiver waitlist				✓	✓		NBIC using CMS Medicaid Waiver Database, and State Self-Assessment

Measurement Domains/ Performance Measures	Nursing Home Compare	Home Health Compare Measures	AARP LTSS Score-card	National Balancing Indicators	NQF HCBS Limited Set	NQF #	Source
Proportion of people with disabilities reporting recent preventive health care visits (individual-level)				✓	✓		NBIC calculations using the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS) data
Proportion of people reporting that service coordinators help them get what they need (individual-level)				✓	✓		NBIC using National Core Indicators (NCI) Data
Availability of self-direction options				✓	✓		NBIC using CMS Medicaid Waiver Database, and State Self-Assessment
Tools and programs to facilitate beneficiary choice (composite indicator, scale 0-4)			✓		✓		AARP conducted a state survey to collect information about states' single entry point systems and various functions that facilitate beneficiary choice. Data from State LTSS Scorecard Survey (AARP PPI, Scorecard 2010).
Other Measures							
Nurse staffing hours — 4 parts	✓					0190	MDS
Proportion of Medicaid HCBS spending of the total Medicaid LTC spending				✓	✓		NBIC using Thomson Reuters
Coordination between HCBS and institutional services				✓	✓		State Self-Assessment

Data Sources: NQF Long-Term Care/Post-Acute Care MAP; NQF Duals MAP review of Home and Community Based Waiver Measures

MDS (Minimum Data Set Nursing home survey); OASIS (Medicare Home and Community Based Care Survey); NBIC (National Balancing Indicators Contract); BRFSS (Behavioral Risk Factor Surveillance System);

1100 13th Street, NW
Suite 1000
Washington, DC 20005
www.ncqa.org
Phone 202.955.3500
Fax 202.955.3599