MEDICAID INSTITUTE
AT UNITED HOSPITAL FUND

Measuring Quality for Complex Medicaid Beneficiaries in New York

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PREPARED FOR THE MEDICAID INSTITUTE AT UNITED HOSPITAL FUND BY

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Introduction

New York State is a national leader in measuring and reporting on quality of care in Medicaid. The New York State Department of Health has taken its public reporting role seriously, building internal capacity and creating external reporting of key indicators over many years. Now, as New York implements landmark Medicaid reform built in large part on enrolling complex beneficiaries into some form of care management, the Department has renewed its commitment to measuring quality for this population—a challenge that is, relatively speaking, new territory.

To ensure that it can adequately evaluate the impact of Medicaid reform and the value of emerging care models, the Department is considering how to structure comprehensive quality measurement focusing on organizations contracted to provide care management to complex beneficiaries—those with multiple chronic conditions, serious mental illness and/or substance use disorder, and those using long-term care services and supports.

Fortunately, there has been a simultaneous national surge in attention to how best to design quality measures for Medicaid beneficiaries. Work groups convened by the National Quality Forum, the National Committee on Quality Assurance, AARP, and the Centers for Medicare & Medicaid Services have addressed a range of related subjects, from the more general Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults, mandated for states by the Affordable Care Act, to specific measures for beneficiaries dually eligible for Medicare and Medicaid. While the work of these groups to identify existing measures and gaps in measurement for specific populations can be helpful to states, the multitude of activities can also lead to a bewildering set of options.

To help New York sift through these options and devise its own measurement approach, United Hospital Fund commissioned the Center for Health Care Strategies (CHCS) to conduct an environmental scan of state and national activities and propose a potential measurement framework. To accomplish this, CHCS conducted more than 40 interviews with leaders in state governments and their contracted health plans, as well as national organizations, to learn about innovative quality measurement practices for high-need, high-cost Medicaid populations. The interviews sought to identify innovative practices that go beyond routine measurement to address beneficiaries with complex and heterogeneous needs.

Drawing from these interviews, this report outlines opportunities for establishing a comprehensive measurement approach for New York's complex Medicaid beneficiaries. It begins with a look at the national context and the New York environment, and then outlines quality measurement strategies for three high-risk beneficiary subsets: individuals with multiple chronic

conditions; those with significant mental illness and/or substance use disorders; and those beneficiaries—many of them "duals," also eligible for Medicare—who rely on long-term care services. For each of these subpopulations, the report examines current and potential structural, process, and outcome measures, as well as measurement gaps. The final section outlines key considerations for successful implementation of quality measurement systems for these groups.

Overview of Quality Measurement

Since the 1980s, when Medicaid programs began enrolling individuals in managed care, the State has sought ways to ensure that beneficiaries are receiving quality care. Prior to the Balanced Budget Act of 1997, states could only enroll beneficiaries in managed care plans through waivers and requirements issued by the Centers for Medicare & Medicaid Services (CMS).[1] Building on typical approaches used by commercial health plans, waiver requirements for monitoring quality addressed medical care for a managed care population consisting mainly of women immediately pre- and post-partum and children under 18.

The requirements included process measures, such as timeliness of prenatal care, reflecting how care is delivered, and outcome measures, such as birth weight, which reflect the impact of care on health and/or functioning. Many states also began to monitor structural measures, which focus on administrative issues and are assumed to be necessary for overall care delivery in a managed care system—requirements, for example, that health plans have a medical doctor oversee utilization management decisions, including treatment and service denials.

With the Balanced Budget Act allowing states to enroll beneficiaries in managed care plans without a waiver, it became necessary for CMS to document state requirements for care monitoring and improvement. Thus, beginning with the Act's implementation, states' approaches to assessing health care quality—especially for those original managed care populations of largely healthy women and children—have become increasingly standardized. But the Act also created categories of beneficiaries with special health needs, requiring states to implement new monitoring procedures, such as special needs assessments and care planning, for plans with enrollees identified as being at greater risk of poor health outcomes.

Recently, quality measurement has become an important mechanism for promoting state health care purchasers' investment in more cost-effective strategies for improving health care delivery. Tying expenditures for care and services to outcomes creates a thrust toward "value-

[1] *Medicaid: A Timeline of Key Developments.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured. http://www.kff.org/medicaid/timeline/pf_entire.htm

based purchasing." These strategies allow states to use outcome measures to reward health plans for better care delivery, or to require health plans to implement incentives—such as pay for performance (P4P)—at the provider level.

While the majority of states have robust quality measurement approaches in place for relatively healthy Medicaid populations, few, if any, have established methods to comprehensively assess health care access and quality for complex Medicaid beneficiaries. For most states, the array of measures contained in the Health Effectiveness Data and Information Set (HEDIS) validated by the National Committee for Quality Assurance (NCQA) remains the primary assessment tool for their Medicaid beneficiaries. At the same time, NCQA acknowledges that these broad measures, developed for generally healthy populations, are inadequate for monitoring the quality of care for complex populations. As a result, NCQA is considering additional, cross-cutting measures that will allow a focus on care coordination and on the specific needs of dual eligibles.

For complex Medicaid beneficiaries, current state strategies typically involve a piecemeal approach that blends select HEDIS measures with other measurement tools. For example, for beneficiaries with behavioral health needs, states often focus on access issues. For long-term care recipients enrolled in Medicaid under 1915(c) waiver programs, states must report on quality of care to CMS, but such assessments are generally not coordinated with other measurement strategies. And, when it comes to duals, although CMS's Medicare-Medicaid Coordination Office is supporting ways for states to obtain Medicare data, only a small handful, including New York, are beginning to use those data to gain a more comprehensive picture of this high-risk population. Fewer still, Massachusetts and Minnesota among them, have begun to incorporate Medicare data into a cohesive quality measurement approach.

Even the states with the most sophisticated quality measurement approaches struggle to paint a full picture of their complex Medicaid beneficiaries, as evidenced by a recent national scorecard published by AARP, in conjunction with The Commonwealth Fund and The SCAN Foundation.[2] The scorecard provided a comprehensive view of state performance related to long-term care services for older people and adults with disabilities. It found that even the best-performing states were unable to measure effective transitions between hospitals, nursing homes, and home-care settings, or how well long-term care services are coordinated with primary care, acute care, and social services.[3]

[2] Reinhard SC, E Kassner, A Houser and R Mollica. *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* [Executive Summary]. September 2011. AARP, The Commonwealth Fund, and The SCAN Foundation. http://www.longtermscorecard.org/

[3] Ibid.

At the national level, health policy stakeholders have recently begun to invest considerable energy in seeking consensus on a nationally accepted set of measures for all populations, including those with complex needs. While standardized measures have yet to surface, opportunities are emerging nationally, as detailed below, to support more effective approaches to measuring health care quality for complex Medicaid beneficiaries. These include:

- **Adult Core Measures Set.** Under Section 2701 of the Affordable Care Act, a recommended Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults will be published by January 1, 2012, with input from public comments solicited early in 2011. The law calls for the establishment of a Medicaid Quality Measurement Program to develop, test, and validate new evidence-based measures and a standardized tracking and reporting process for states.[4] The Adult Core Measures are the basis for a common set of quality measures that CMS is preparing to release for states implementing a health home program under Section 2703 of the Affordable Care Act.
- **National Quality Forum's Measure Applications Partnership.** The National Quality Forum created the Measure Applications Partnership[5] to select quality measures for public reporting and performance-based payment programs, with a focus on people who are enrolled in Medicare and Medicaid. This public-private partnership was brought together to provide guidance to the Department of Health and Human Services, which is charged under the Affordable Care Act with establishing a National Quality Strategy to provide all Americans with access to safe, effective, and affordable health care.[6] The group has identified four "high-leverage" areas: care coordination by a multi-disciplinary team; quality of life beyond clinical aspects; appropriate screening and assessment; and mental health and substance abuse.[7,8] These federal activities are expected to provide helpful guidance to New York and other states in the coming year.
- **National Committee for Quality Assurance.** In 2009, NCQA convened the Medicaid Accreditation Advisory Committee, bringing together national experts on Medicaid and quality measurement, to develop new approaches to identifying plans that provide high-quality care to Medicaid beneficiaries. Another national NCQA work group, the Geriatric Measurement Advisory Panel, developed a core set of HEDIS measures, as well as structure

[4] Medicaid Program: Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults. Department of Health and Human Services, Office of the Secretary.
http://healthyamericans.org/assets/files/Notice%20On%20Proposed%20Medicaid%20Quality%20Measures.pdf

[5] National Quality Forum. Measure Applications Partnership.
http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx

[6] *Input to the Secretary of Health and Human Services on Priorities for the National Quality Strategy*. September 1, 2011. National Priorities Partnership, convened by the National Quality Forum.
http://www.qualityforum.org/Setting_Priorities/NPP/National_Priorities_Partnership.aspx

[7] Meeting Summary. Dual Eligible Beneficiaries Workgroup Meeting (In-Person Meeting). June 2-3, 2011.
http://www.qualityforum.org/Setting_Priorities/Partnership/Dual_Eligible_Beneficiaries_Workgroup.aspx

[8] Meeting Summary. Dual Eligible Beneficiaries Workgroup Meeting (In-Person Meeting). July 25-26, 2011.
http://www.qualityforum.org/Setting_Priorities/Partnership/Dual_Eligible_Beneficiaries_Workgroup.aspx

and process measures, for Special Needs Plans (SNPs), addressing complex care management, member satisfaction, clinical quality improvements, care transitions, and coordination of Medicare and Medicaid benefits.[9] While these measures are SNP-specific, they can inform the development of measures for similar populations. More recently, NCQA has convened a national work group to develop measures of integrated care quality that can be applied across all care settings.[10]

- **Health Information Technology for Economic and Clinical Health Act.** Through the Health Information Technology for Economic and Clinical Health Act (HITECH), CMS is supporting the creation of electronic health records that will facilitate the sharing of patient data across service delivery systems, among them pharmacies, hospitals, clinics, and managed care plans. This national initiative will potentially build a platform that can support data-sharing and emerging standardized measure sets.[11] Currently HITECH incentives are available only to certain eligible providers, including primary care providers, dentists, and pediatricians, as well as hospitals. Extending these efforts to mental health and long-term care providers and other health care professionals who provide essential services for complex Medicaid beneficiaries will be critical to ensure that they are not lost in the digital divide.

New York State Policy Context

New York is in the process of transforming its Medicaid service delivery and financing to build a system that provides better care management for complex beneficiaries. The statewide Medicaid Redesign Team, launched in January 2011 to enhance the effectiveness and efficiency of New York's Medicaid program, is specifically pinpointing better care management as an opportunity to improve health care delivery and lower costs.[12] As in many other states, New York plans to enroll more high-cost, high-need beneficiaries in various models of care management—including Medicaid managed care plans, behavioral health organizations, long-term care coordination models, primary care case management, and health homes—to improve service delivery and to align payments with quality.

[9] 2009 Special Needs Plans. National Committee for Quality Assurance. 2011. http://www.ncqa.org/tabid/620/Default.aspx.

[10] Wilkerson J. NCQA to Craft Models of Care for Dual Eligibles as States, CMS Eye Reforms. *Inside Health Policy*, September 30, 2011. http://insidehealthpolicy.com/Inside-Health-General/Public-Content/ncqa-to-craft-models-of-care-for-dual-eligibles-as-states-cms-eye-reforms/menu-id-869.html

[11] Blumenthal D and M Tavenner. 2010. The "Meaningful Use" Regulation for Electronic Health Records. *New England Journal of Medicine* 363(6):501-504 (August 5).

[12] For more information, visit New York's Medicaid Redesign Team website at http://www.health.ny.gov/health_care/medicaid/redesign/

As part of this major policy shift, State officials are attempting to identify the best methods for monitoring the quality of organizations contracted to manage and/or coordinate care. On April 13, 2011, in a letter to CMS, New York requested amendments to its 1115 waiver to implement proposed improvements. Among the reforms now underway is a new Medicaid health home program that will provide more integrated care management for individuals with chronic medical and behavioral health conditions.[13] As of April 2012, New York will require enrollment in a managed long-term care plan or a long-term care coordination model for dual eligibles age 21 or older who are in need of more than 120 days of community-based long-term care services.[14] On a parallel track, in June 2011 New York's Office of Mental Health and Office of Alcoholism and Substance Abuse Services released a request for proposals to contract with regional behavioral health organizations to improve coordination and reduce fragmentation of mental health and substance abuse services—part of a phased strategy for moving from fee-for-service to managed behavioral health services.[15]

With all of these initiatives for enrolling complex Medicaid beneficiaries into some form of care management comes the need for a robust set of quality measures that can address accountability, align payment mechanisms (by, for example, properly supporting pay-for-performance), and establish quality improvement standards across different care models. Newly established measurement strategies must also acknowledge the heterogeneity of Medicaid's subpopulations, including those with multiple chronic conditions, co-occurring mental illness, and drug and alcohol disorders.

New York is starting in an enviable place, compared to many states. Tools that have already been developed include "Adults Living with Illness" and other measures falling under the State's Quality Assurance Reporting Requirements (see Appendix B); the managed long-term care plan member satisfaction survey created by IPRO;[16] and the managed care Supplemental Security Income (SSI) survey developed by IPRO and the New York State Department of Health to assess satisfaction levels of blind, disabled, and elderly beneficiaries enrolled in managed care.[17] Additionally, quality measures developed or envisioned for the Department of Health-proposed Health Home Program for Individuals with Chronic Medical and Behavioral Health Conditions (see Appendix C) can potentially be transferred to other care management

[13] Entrikin T. Posted August 15, 2011, 04:24. New York Launches Health Home Initiatives. Public Consulting Group Research. http://www.publicconsultinggroup.com/research/post/2011/08/15/New-York-Launches-Health-Homes-Initiatives.aspx

[14] State of New York, Department of Health. April 13, 2011. Letter to CMS requesting amendments to Section 1115 waiver program. http://www.health.ny.gov/health_care/managed_care/appextension/mrt_waiver_materials/cms_letter04_13_11.htm

[15] New York State Office of Mental Health. June 24, 2011. Press Release: OMH, OASAS Accepting Applications for Regional Behavioral Health Organizations. http://www.omh.state.ny.us/omhweb/News/2011/bho_announcement.html

[16] IPRO, for the New York State Department of Health. October 2007. *Managed Long Term Care (MLTC) Plan Member Satisfaction Survey Report.* http://www.health.ny.gov/health_care/managed_care/mltc/pdf/dmc_mltc_survey.pdf

[17] IPRO, for the New York State Department of Health, Office of Health Insurance Programs. July 2008. *SSI Survey: New York City Medicaid Managed Care Members.* http://www.health.ny.gov/health_care/managed_care/reports/docs/final_report_ssi_enrollees.pdf

models. Designed to help ensure basic access to care and services for beneficiaries transitioning to new systems of care, measures from existing tools include all-cause readmission rates, inpatient and ambulatory care utilization rates, and measures of comprehensive diabetes care.

New York officials recognize that there are real measurement gaps for beneficiaries with multiple chronic conditions, behavioral health conditions, and long-term care needs. Over the planned phase-in of new care management initiatives, the State Department of Health hopes to address those gaps and create more targeted quality measures in all three of these areas. Not surprisingly, our interviews found many other states at the same crossroads as New York. Many of them, however, did not necessarily have support to invest in new measurement approaches. Interviewed state officials almost uniformly expressed off-the-record frustration with legislators' requests to use care management as a cost-savings strategy, without a simultaneous acknowledgment of the staffing or front-end investment required to monitor health care quality for high-risk populations. Thus, while many states reported exploring new opportunities to test managed care for complex Medicaid beneficiaries, none had identified a comprehensive mechanism for standardizing and fine-tuning quality measurement for this population. As a result, these states are deriving measures for complex Medicaid beneficiaries from existing generic measures.

The interviews revealed another common theme as well: that fragmented care delivery systems led to fragmented quality measurement approaches. In the few instances in which statewide measurement initiatives were being explored, interviewees revealed that critical quality staff were left out of the discussion. At this state level, the interviews also identified few cross-cutting measures. Instead, states were more likely to have utilization-based measures—for example, rates of admissions or readmissions. In fact, the source of greatest innovation in cross-population management was the managed care plans that focused on intensive care management for the two to five percent of their members at highest risk.

Characteristics of Quality Measurement

The proliferation of quality measurement work at the national level can leave states frustrated about where to spend their increasingly scarce dollars. Considering the characteristics of and strategic approach behind various quality measures is useful as states design their measurement systems, and New York may find it helpful to take these into account as it evaluates and selects quality measures.

Standard versus Home-Grown or Adapted Measures

When planning performance measures for high-need, high-cost populations, most states and health care organizations recommended starting with standardized measures whenever possible. In a recently published guide to implementing patient-centered medical homes, for example, staff of The Commonwealth Fund recommended the use of standard measures for assessing the quality of care coordination.[18] Notably, some of the suggested measures available through the Department of Health and Human Services' Agency for Healthcare Research and Quality and the National Quality Forum are not nationally utilized or reported.

New York's current approach, using a mix of standard and "home-grown" measures, makes sense. The State's proposed health home measures for long-term care recipients have been developed from its Semi-Annual Assessment of Members, based on standard Outcome and Assessment Information Set (OASIS) reports (see Appendix D). Continuing this approach would allow the State to track improvement over time as it addresses the major gaps in New York's ability to monitor health processes and outcomes for those complex beneficiaries being added to care management.

Cross-Population versus Subpopulation

In many states, a move toward using cross-population quality measures is being considered as a strategy for focusing attention and resources—a way to drive interventions and activities that improve care for all beneficiaries. Arizona, for example, recently reviewed every required measure in its managed care contracts with an eye toward incorporating existing and new measurements that cross populations, such as those on behavioral health care in CMS's Adult Core Measures and other national measure sets. Arizona is preparing for a shift to the Adult Core Measures by adding these measures to health plan requirements now.

In looking at cross-population measures, though, Minnesota officials note, it is important to think about comparing like groups to like groups. State staff have become increasingly concerned about quality measurement strategies for health plans that enroll a disproportionate share of frail and elderly beneficiaries, especially when the results are used for health plan incentives or public reporting. One Massachusetts health plan raised a different concern, namely that standard surveys such as the Consumer Assessment of Healthcare Providers and Systems may exclude major groups of enrollees who require translations. Additionally, much of the Adult Core Measure set does not apply to beneficiaries whom states are most interested in studying, such as residents of nursing facilities.

[18] Abrams M and GG Lawlor. October 2011. Care Coordination Measurement: Guidance on Setting up Systems to Monitor Performance in Medical Homes. In *Core Value, Community Connections: Care Coordination in the Medical Home.* Patient-Centered Primary Care Collaborative.

Level of Accountability: State, Health Plan, Health Home

While many standard measures are effective for state-to-state comparisons, they may be inappropriate for comparisons of health plans or providers. The AARP Scorecard, for example, assesses quality in many areas that are beyond health plans' control, because they are based on state-level decisions about benefits and coverage. Each measure should, therefore, be examined for relevance and practicality at the level of accountability proposed—determining, for instance, whether the sample size for subpopulation measures will be large enough, or what impact the measured entity can have on improving the metric.

In developing a new measurement approach, New York needs to ensure that it considers these key decision criteria. That may be problematic, however, with the current economic climate raising an even larger policy issue: should states invest their resources in innovative quality measurement methods at a time when they are considering cuts to basic services? The pressures from both sides are intense, because proposed cuts to services can have an immediate impact on beneficiaries' lives. But there has never been a time when ensuring that the State gets the most out of its health care dollars—the value-based purchasing approach that relies on innovation in quality measurement—has been more important.

Quality Measurement for Care of Multiple Chronic Conditions

Overall Approach

Most states and health care organizations leverage existing measurement systems—whether HEDIS or similar ones—to collect data on the care and outcomes of complex conditions. Disease-specific measurement, such as comprehensive diabetes care or the use of appropriate medications with asthma, works for relatively healthy individuals and those with a single chronic disease. But it is inadequate for assessing care for Medicaid's high-need, high-cost beneficiaries, who commonly have three or more chronic (and often one or more behavioral health) conditions.[19,20] That is largely because of the likelihood of interactions among the treatments for those conditions—interactions that complicate or altogether change the quality picture being assembled.

Nevertheless, interviews with state officials revealed an overall lack of focus on—and specific strategy for—these beneficiaries. Notably, interviewees acknowledged the shortcomings of the

[19] Kronick RG, M Bella and TP Gilmer. October 2009. *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions*. Hamilton, NJ: Center for Health Care Strategies.

[20] New Mexico's Coordinated Long-Term Services (CoLTS) Program. February 25, 2009. Presentation by the Hilltop Institute at the Medicaid Managed Care Summit. www.hilltopinstitute.org/News/MMC%20summit%20February%202009.pps

HEDIS data set for addressing complex issues. But a lack of time, resources, and alternative "plug and play" measures mean states still largely rely on HEDIS measures, including assessments of comprehensive diabetes care, preventive care, and utilization, among other quality areas. Interviewees also expressed concerns both that HEDIS leaves no room for clinical exceptions and *too much* room for administrative exceptions.

For beneficiaries whose health and social needs drive the highest Medicaid utilization and who are at highest risk of poor health outcomes, better-targeted measures are essential. These should reflect predictors of future utilization, processes that could prevent further declines in health of the beneficiaries, and related outcomes. Measures are also needed to help identify and monitor the quality of care delivered to those beneficiaries whose multiple conditions require an atypical approach to management.

Quality measures for high-risk populations should be closely aligned with requirements for care management organizations. States vary in their approach to mandating care management processes. One approach is requiring members with specific diagnoses to receive care management services from health plans. A number of health plans, however—driven by both the bottom-line impact of high-cost enrollees and a drive toward quality improvement—are looking at innovative, non-standardized approaches for these beneficiaries. They note that requiring the same intervention for all members with a common diagnosis, rather than triaging those most in need of care management services, does not lead to improvements in health outcomes and cost-effectiveness. Instead, they suggest that states should require screening processes for the entire population, but allow plans latitude to target care management to those who have the greatest potential to benefit from it.

Clarifying the goals of measurement is, in fact, an extremely worthwhile step at the very outset of developing new measures, as several interviewees made clear. Key questions include whether measures are being used for quality improvement, accountability, and/or evaluation, and whether they will stratify the population and identify those at risk. For New York, one obvious goal is to evaluate, and report to CMS, the success of the health home model. Measuring program success—and determining what merits funding after the 90 percent federal matching rate for health home services expires—is critical to the State's large investment in health homes as part of Medicaid redesign. The State also wants to hold other new kinds of care management organizations, such as behavioral health organizations and care coordination models for long-term care, accountable for improving care delivery for complex Medicaid populations.

Measurement Framework

Below we describe measurement approaches specifically for the subset of Medicaid beneficiaries with multiple chronic conditions. It is important to note that there is considerable overlap among all three subsets discussed in this report: beneficiaries with serious behavioral health conditions and those with long-term care needs often have multiple chronic conditions. These measures can therefore be considered relevant to all three groups.

Measures are divided into three categories: structural, process, and outcome. Within each category we first identify existing measures, those that are widely in use, in place in contracts, and/or standardized and nationally available. We then examine gaps, identifying domains where measures are not standardized, not in place in contracts, and/or beyond current measurement capacity.

Structural Measures

Existing Measures. Many states monitor health plans' attention to beneficiaries with special health care needs via contractual or structural requirements. The latter include requirements, under the Balanced Budget Act of 1997, that states monitor health plans using external quality review, and gather information on quality improvement via the Performance Improvement Projects submitted by plans. Although these projects can point to health plan characteristics that have impacts on beneficiaries with multiple chronic conditions, they are usually specific to a single disease, such as diabetes or asthma. More recently, states with complex populations enrolled in managed care have added the following structural requirements:

- Health home assessment and designation of a primary care network, with assignment of high-risk members to qualifying providers, and/or payment incentives for providers meeting the health home criteria;
- Use of health information technology to identify members at high risk and track care coordination and disease management interventions;
- Designation of a care manager for beneficiaries designated as higher risk;
- Specific Performance Improvement Projects for complex populations.

Gaps in Measures. While the following approaches to risk stratification, and measures of their implementation, are not standardized, states can require contractors to implement these or similar methods to ensure that beneficiaries at highest risk of poor outcomes are identified and targeted for special handling:

- Aetna, Healthfirst, and UnitedHealthcare representatives all suggest using multiple sources of data, including claims, health risk assessment, and "old-fashioned surveillance" (i.e., self- or provider referral). Predictive methods can be developed in house, as was Washington State's PRISM[21] model, or can be based on national models, such as that developed at NYU

[21] *Saving Costs and Transforming Lives through Integrated Case Management in Washington State* [RDA Report Number 11.162]. March 2011. http://www.dshs.wa.gov/pdf/ms/rda/research/11/162.pdf

by John Billings and used by Healthfirst, which predicts high risk of future inpatient episodes.

- Aetna additionally recommends that plans conduct “root cause analysis” to determine the specific factors putting individual members at risk—often evidenced as a lack of engagement or compliance with the care plan. Care managers look for underlying causes such as housing issues, social problems, and lack of transportation, and attempt to address those before concentrating on the beneficiary’s health issues themselves.
- Healthfirst also uses results of its health risk assessment as a basis for notifying providers of their high-risk members and alerting them to specific concerns.

Process Measures

Existing Measures. Innovative health plans with experience in care management for high-risk Medicaid beneficiaries are using a number of measures that New York can adopt to build contract requirements and monitoring approaches.

- Percent of beneficiaries identified as at high risk who are referred to care management: While the “engagement rate” of high-risk members is a non-standardized measure, it is fairly common to track the rate at which members are identified and referred to care management. The State can then follow this subset of beneficiaries to monitor health plans’ ability to follow through with engagement, intervention, and outcomes.
- Caseload: The caseload of high-risk members assigned to each care manager should be monitored. Some states set maximum caseloads, such as no more than 50 members per case manager serving the highest two-percent risk stratum.
- Utilization of primary care or health home: An early indicator of care management success is the beneficiary’s engagement with a primary care or health home, as measured by an increased primary care provider visit rate.

Gaps in Measures. The following measures are not standardized, making it difficult to determine the efficacy of various care management approaches.

- Engagement rate: The rate at which beneficiaries assigned to care management arrive at consensus with their care managers on the goals of their care plans can be a useful indicator of member engagement. The State could monitor the percent of beneficiaries engaged in high-risk care management as a proportion of both the targeted sub-population and the overall population.
- Discharge by consensus: Beneficiaries leave care management under many different circumstances; care management organizations can monitor the rate at which members “graduate,” as they achieve the goals of their care plan, versus those who “drop out.”

Outcome Measures

Existing Measures. Quality measures currently in use by many states and their contracted health plans include utilization measures that tend to trend upwards or downwards over long periods of time.

- Emergency Department (ED) utilization: For high-risk beneficiaries, recurrent ED visits can trigger more intensive care management and opportunities for intervention.
- Preventable or avoidable hospitalizations: Increases or decreases in avoidable hospitalization rates can be linked to the effectiveness of care coordination. The Prevention Quality Indicators (PQI), for example, are measures that reflect individual conditions, but can be aggregated to provide acute or chronic PQI rates.[22]
- HEDIS all-cause readmissions: This measure is the percentage of acute inpatient stays followed by an acute readmission for any cause within 30 days for patients 18 years and older. Stratifying this measure by subgroup can support more focused improvements.

Gaps in Measures. Quality measures that focus on the unique needs of beneficiaries with multiple chronic conditions are not part of the standard Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey methodology or family of survey tools. Areas that could be addressed by supplemental surveys or other direct reports from beneficiaries and their family members, and that would offer value, include the following:

- Beneficiary surveys that are actionable: Determining whether care is satisfactory from the beneficiary perspective was a recurrent theme in our interviews. Health plans agree that CAHPS surveys, while helpful for identifying big changes over time, do not provide actionable, timely data. To pinpoint important topics to beneficiaries who use care coordination services they recommend short, frequent surveys instead. Dr. Karen Nelson, of Union Health Center in New York City, for example, recommends brief surveys with simple questions such as "When you need us, can you get through?" and the reverse, "How often do you fail to get through on the first try?" By using such questions, Union's leadership has determined that it is important to train telephone staff to handle most calls without passing beneficiaries along to the next person.
- Beneficiary-focused outcome measures: These measures can be used to assess beneficiaries' experience of care management and its impact on their overall independence. They might include the percent of beneficiaries with enhanced protective factors, such as social supports, and the percent engaged in self-management of their conditions.
- Care coordination: The National Committee for Quality Assurance has tested care coordination questions that could be added to CAHPS, but has found that using these questions with standard survey methods is problematic given the small number of current Medicaid beneficiaries who qualify for care management. There are no standard approaches

[22] For more information, see Prevention Quality Indicators Technical Specifications, Version 4.3, Agency for Healthcare Research and Quality, June 2011. http://www.qualityindicators.ahrq.gov/modules/PQI_TechSpec.aspx

to measuring the quality of care coordination at this time, although this is an area that would offer value to beneficiaries. The federal Agency for Healthcare Research and Quality (AHRQ) has developed an atlas of care coordination measures, in part to advance the dialogue around consensus measures for this important domain.[23]

- Access to care: Access to care for people with multiple chronic conditions is another area not currently being measured in a standardized way. Possible measures could include a per-patient average ratio of specialist to primary care provider visits, assessment of the overall number and types of specialists available through the plan, and a comparison of diagnoses/conditions managed directly by primary care providers versus those referred to specialists.
- Simplicity of medication regimens: Potential drug interactions increase with the number of medications prescribed, so the total number of individual medications a beneficiary is taking may be a useful indicator of potential problems. Effective interpretation of this measure could require the establishment of benchmarks to indicate targeted levels of performance.
- Events that predict hospital admissions and readmissions: This area is largely unexplored, but care management strategies described above may identify predictive events and factors that can be used to create effective measures. New Mexico, for example, is analyzing data on multiple Emergency Department visits and checking for decreased primary care visits in the immediately preceding time period. Using this combination of data, New Mexico hopes to decrease avoidable ED use and increase primary care visits—a strategy that could also be modified and applied to hospital admissions.
- End-of-life care: This can be assessed by measuring the percent of beneficiaries reporting conversations about their end-of-life preferences with their primary care providers. The National Quality Measures Clearinghouse, for example, recommends tracking the percentage of nursing facility patients with heart failure who have had documented discussions regarding advance directives, and/or the rate of adherence to those directives.[24]

Quality Measurement for Behavioral Health Care

Overall Approach

As states across the country are attempting to better integrate physical and behavioral health services, they are also considering new ways to measure both the quality of behavioral health care and the extent of its integration with other health care services. The measurement strategies targeting care management for beneficiaries with multiple chronic conditions, described

[23] McDonald KM, E Schultz, L Albin et al. December 2010. *Care Coordination Measures Atlas* (AHRQ Publication No. 11-0023-EF). Rockville, MD: Agency for Healthcare Research and Quality. http://www.ahrq.gov/qual/careatlas/

[24] For more information on the AHRQ National Quality Measures Clearinghouse heart failure measures, see http://www.qualitymeasures.ahrq.gov/content.aspx?id=26708

above, are also applicable to many beneficiaries with mental health conditions and/or substance use disorders. Many states have begun to incorporate specific measures of behavioral health care into their quality assessment efforts, however. Common practice includes the use of HEDIS measures such as "Antidepressant Medication Management" and "Follow-up after Hospitalization for Mental Illness."

Because quality measurement is so thin in this area, several states, including New York and Washington, have engaged in some very innovative thinking about how to capture the quality and integration of behavioral health care services. New York recently applied innovative analyses using mental health claims to identify gaps in care for beneficiaries with serious mental illness. Presented at a Medicaid Redesign Team Behavioral Health Reform work group meeting, the results revealed lags in treatment following institutional care. The data analysis also pointed to key areas for future measurement of care for beneficiaries with behavioral health needs,[25] with a focus on the following goals for a redesigned system:

- Individuals who have been ill enough to be hospitalized will be engaged in appropriate follow-up services promptly upon discharge;
- Almost all individuals who were ill enough to have had a psychiatric hospitalization will receive pharmacotherapy post-discharge;
- Access to less costly, community-based behavioral health services will increase as managed care strategies are implemented, while utilization of costly inpatient and Emergency Department services will be reduced—but remain available whenever needed;
- Individuals' treatments will be consistent with evidence-based care;
- Readmissions will decrease.

Complicating the assessment of care for beneficiaries with behavioral health issues are questions about the effectiveness of some commonly used tools. There is some debate over the applicability, for individuals with serious mental illness, of self-reporting measures. Routine collection of widely used self-reported measures such as health status, for example, may not capture individual beneficiaries' goals, particularly in cases where shelter, food, and clothing are of higher priority. Similarly, while some interviewees recommend the use of the Patient Health Questionnaire-9 (PHQ-9), a commonly used depression-screening tool, to track outcomes of care management and integrated care approaches, others suggest this method has weaknesses for beneficiaries with disordered thought processes.

On another note, multiple interviewees spoke of a "Holy Grail" of integrated quality of care measurement, in which providers have access to real-time data and can track actions taken when outcomes are not improving. Dr. Jürgen Unützer, of the University of Washington,

[25] Restructuring Behavioral Health Care: Performance Standards to Promote Good Care at a Reasonable Cost. August 23, 2011. Presentation by Susan M. Essock, PhD, Acting Deputy Commissioner for Evaluation, New York State Office of Mental Health, and Director, Division of Mental Health Services and Policy Research, Columbia University, Department of Psychiatry.

urged that providers monitor outcome measures for people with serious mental illness to assess whether interventions are making a difference, pointing out that even in individuals with schizophrenia, increased rates of depression can be monitored with the PHQ-9. Given the extent of physical co-morbidities among individuals with serious mental illness, as well as their significantly reduced life expectancy, interviewees also recommended tracking measures related to tobacco use, body mass index, hemoglobin A1c levels, and blood pressure.

The recommendations recently submitted by the Medicaid Redesign Team's Behavioral Health Reform work group and fully adopted by the larger Team offer additional valuable input for New York's behavioral health quality measurement strategy.[26] Among its principles for effective management and coordination of behavioral health services, the work group recommended monitoring a number of important indicators, including:

- Good clinical outcomes for key chronic medical conditions;
- Reduced hospital admissions for inpatient detoxification and substance abuse rehabilitation services;
- Reduced mortality and health disparities associated with mental illness and substance use;
- A narrower gap between the prevalence of conditions in the population and the prevalence of engagement with services;
- Reduced involvement with the criminal and juvenile justice systems;
- A reduction in court-ordered outpatient mental health treatment;
- Improved care transitions (e.g., follow-up appointments after hospitalizations);
- Meaningful and useful communication among physical and behavioral health providers.

The work group further recommended that:

- Health plans responsible for managing behavioral health services be assessed based on validated measures across a variety of domains—including access, network adequacy, adoption of best practices, patient/consumer satisfaction, compliance, efficiency, care coordination and continuity, and clinical and recovery outcomes;
- Disparities in measures between racial/ethnic and other socio-demographic groups also should be tracked;
- Plans should also be assessed on their coordination of enrollees' social service and support needs.

Measurement Framework

The Behavioral Health work group's recommendations, taken together with the full set of interviews with state and health plan officials conducted for this report, suggest a measurement framework for behavioral health care containing the elements below. Some of these

[26] *Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations.* October 15, 2011. New York State Department of Health. http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

would require collection of new data and could be included in requirements for health homes and/or behavioral health organizations.

New York's new approach to analyzing patterns of care and gaps in services based on mental health claims is a best practice. As responsibility for care is shifted to new organizations, the State should continue to monitor underutilization of services, as reflected in missed outpatient visits within specific timeframes and after Emergency Department visits, unfilled prescriptions for psychotropic medications, and other measures. Underutilization data can then be transmitted to providers responsible for care and to the care manager.

Structural Measures

Existing Measures. The application for New York's Health Home Program for Individuals with Chronic Medical and Behavioral Health Conditions requires the following structural measures, which should be considered minimum standards for meeting behavioral health needs (detailed structural requirements related to each element are found in the Provider Qualification Standards document):[27]

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family (including authorized representatives) support;
- Referral to community and social support services, if relevant;
- The use of health information technology to link services, as feasible and appropriate.

Gaps in Measures. A number of potential structural requirements not currently in place would add value to the contracting and monitoring process and could help New York meet its goals:

- Co-location of behavioral health counselors in primary care offices;
- Co-location of primary care professionals in behavioral health settings;
- Risk stratification using both medical conditions and indicators of serious mental illness and substance use disorders;
- Behavioral health staff trained in the treatment of co-occurring mental health and substance use disorders.

Process Measures

Existing Measures. The following are all standard measures widely available for use; those concerning prescription drugs are closely related to outcomes for beneficiaries with serious

[27] Interim NYS Health Home Provider Qualification Standards for Chronic Medical and Behavioral Health Patient Populations. June 1, 2011. http://nyhealth.gov/health_care/medicaid/program/medicaid_health_homes/docs/inter_health_home.pdf

mental illness. Additional standardized measures are contained in the Health Home State Plan Amendment.[28]

- Follow-up care
  - Number of days from discharge to first outpatient mental health visit;
  - Number of days from discharge to first provider visit;
  - Number of days from discharge to first prescription fill (for specific diagnoses).
- Prescription drugs
  - Number of "gap days" between refills for antipsychotic medications and/or mood disorder medications (adult-only measure);
  - Percent of beneficiaries on multiple antipsychotics;
  - Percent of beneficiaries on drug dosages above FDA recommended levels;
  - Percent of beneficiaries on three or more psychotropic medications;
  - Percent of beneficiaries with schizophrenia taking clozapine.
- Health homes
  - Initiation of and engagement in substance use treatment;
  - Follow-up after hospitalization for mental illness and/or substance use disorder;
  - Joint care planning between behavioral health practitioners/case managers and primary care providers;
  - Antidepressant medication management.

Gaps in Measures. Ideally, other process measures will be developed that support care management and integration of physical and behavioral health services, similar to those outlined for people with multiple chronic conditions. For this population, with its high proportion of beneficiaries with multiple prescribers, one particularly critical element of care is medication reconciliation:

- Percent of beneficiaries prescribed medications by multiple prescribers for whom medication reconciliation is performed.

Outcome Measures

Existing Measures. Currently, outcomes for beneficiaries with behavioral health needs are based on utilization:

- Rate of Emergency Department use for all beneficiaries with serious mental illness or substance use disorder;
- Rate of hospitalization for these beneficiaries;
- Rate of hospital readmission for these beneficiaries;
- Community tenure, measured as the average number of days between admissions.[29]

[28] *NYS Health Home SPA for Individuals with Chronic Behavioral and Medical Health Conditions.* SPA # 11-56. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/nys_health_home_spa_phase1.pdf

[29] Community tenure can also be measured as the number of days out of the hospital, divided by the number of admissions plus one.

Gaps in Measures. Specific survey methods for beneficiaries with serious mental illness are needed, as standard approaches have limitations for this population. Additional data analysis, currently outside the capacity of most health plans and states, is also required to assess a number of elements of behavioral health care:

- Percent of beneficiaries meeting self-defined goals of their care plan;
- Percent of beneficiaries "graduated" from care management to routine community services;
- Rate of utilization of substance use treatment (including by mental health professionals trained in treating co-occurring mental health and substance use disorders) among all beneficiaries with indications of substance use disorder.

Quality Measurement for Long-Term Care

Overall Approach

Two efforts underway in New York have begun to make preliminary progress on the development of measures for assessing long-term care for Medicaid beneficiaries, including duals. The Medicaid Redesign Team's Managed Long-Term Care Implementation and Waiver Redesign work group's Quality Metrics Subcommittee, charged with identifying measures that "advance quality in a redesigned long-term care system," recently released an initial set of recommendations on quality measurement criteria, proposing measures in the following domains:

- Reducing inappropriate utilization associated with nursing home admissions, emergency and urgent care, and inpatient admissions;
- Improving quality of life, emotional and behavioral status, and preventive care and patient safety;
- Improving care management;
- Improving or stabilizing functional status;
- Ensuring continuity of workers and care to the fullest extent possible.[30]

In addition, New York's demonstration project to ultimately integrate Medicaid-funded services (including long-term care) with Medicare-funded services for dual eligibles will also identify new measures for this complex-need population, although those measures may relate more to integrating duals' Medicare- and Medicaid-financed care than to managing their long-term care services and supports. As part of the Centers for Medicare & Medicaid Services demonstration to create new systems of care for dual eligibles, New York will need to participate in a national evaluation. At the same time, the State will want to focus its measurement effort on those aspects of care and service that reflect its own goals and stakeholder priorities.

[30] *Medicaid Redesign Team Managed Long Term Care Implementation and Waiver Redesign Work Group Final Recommendations.* October 28, 2011. New York State Department of Health. http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_implement_waiver_rpt.pdf

The new health home measures proposed for the managed long-term care program (see Appendix D), for example, are much more cohesive with New York's ultimate goals than with CMS's Adult Core Measures set.

Measurement Framework

Structural Measures

Existing Measures. To develop these quality measures, states turn to CMS requirements, such as those found within their 1915(c) waiver assurances. Every state that uses 1915(c) authority for long-term care is accountable for specific assurances; no national standards exist that apply to all states. Despite persistent requests that CMS streamline quality reporting, the requirements imposed under various waiver authorities result in most states' collecting quality measurement data from the same providers multiple times. The high-level structural standards within the assurances focus on several domains:

- Level of care: Beneficiaries enrolled under the waiver must have needs consistent with an institutional level of care;
- Service plan: Participants must have a service plan that is appropriate to their needs and must receive the services/supports specified in the plan;
- Qualified providers: Waiver providers must be qualified to deliver services/supports;
- Health and welfare: Participants' health and welfare must be safeguarded and monitored;
- Financial accountability: Claims for waiver services must be paid according to State payment methodologies;
- Administrative authority: The state Medicaid agency must be involved in the oversight of the waiver and is ultimately responsible for all facets of the program.

Gaps in Measures. To address the gaps in current structural measurement approaches, New York's recently released Care Coordination Model Guidelines[31] call for "a quality assurance and performance improvement program which includes a health information system consistent with the requirements of 42 CFR 438.242 and a Department approved written quality plan for ongoing assessment, implementation and evaluation of overall quality of care and services." These types of requirements, and the more specific contract requirements to follow, are a useful starting place for New York. Notably, a key issue when developing structural measures for Care Coordination Models—measuring level of care, as discussed above—is no longer applicable: Care Coordination Models will be responsible for coordinating and delivering care to beneficiaries with *less* than institutional levels of care as long as they require at least 120 days of community-based long-term care services.

[31] Care Coordination Model Guidelines [page 8]. November 15, 2011.
http://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-11-15_care_coord_model_guidelines.pdf

Process Measures

Existing Measures. AARP's Public Policy Institute offers a set of process indicators in its report comparing the 50 states' performance on long-term care.[32] While these measures use publicly available data sets, much of that data is available only at the state level, making health plan comparisons difficult. For New York, those measures derived from OASIS data,[33] which are similar if not identical to many already collected in the state, are useful. Existing process measures for long-term care include:

- Falls assessment;
- Drug regimen reviews;
- Depression screening;
- Influenza vaccinations;
- Pneumococcal vaccinations.

Gaps in Measures. New York State is developing a new tool, the Uniform Assessment System, that it plans to implement in fall 2012. Many of the elements of the system can be used as process measures similar to those above. These could potentially reflect the timeliness and regularity of elements including:

- Mental health assessments;
- Functional assessments;
- Level-of-care determinations.

Outcome Measures

Existing Measures. Many states use measures derived from the OASIS data set. New York currently uses the Semi-Annual Assessment of Members (SAAM), which builds on OASIS data elements. For beneficiaries who use home care and nursing home services, SAAM assesses indicators for which data are easily obtainable. Of particular value when assessing home care services is the percentage of beneficiaries able to remain in their own homes and avoid institutional care.

When measuring outcomes for long-term care recipients, quality-of-life measures, discussed in more detail below, are critical, as this population may not experience any improvements in functional and clinical status. Stability in functional and clinical status may, similarly, be an appropriate outcome for this population. Common assessments include:

[32] Reinhard SC, E Kassner, A Houser and R Mollica. *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* [Executive Summary]. September 2011. AARP, The Commonwealth Fund, and The SCAN Foundation. http://www.longtermscorecard.org/

[33] Centers for Medicare & Medicaid Services. (n.d.) Outcome and Assessment Information Set (OASIS). Baltimore: U.S. Department of Health & Human Services. http://www.cms.gov/OASIS/

- Improvement or stabilization in:
  - Ambulation,
  - Transferring,
  - Bathing,
  - Managing medications,
  - Bladder control,
  - Pain,
  - Breathing;
- Hospitalization rate;
- Discharge to the community.

Gaps in Measures. Despite the many national efforts underway to identify better ways to assess the outcomes of long-term care, the gaps in available measures—especially those reflecting direct value to beneficiaries—are monumental. The measures described below would be of great help as states assess whether their enormous investments are paying off in better outcomes for beneficiaries:

- Meeting individual beneficiaries' goals: For every beneficiary receiving long-term care services, goals are documented within the care plan. Ideally, those goals are individualized—"I would like to be able to attend my grandson's graduation next year," for example. Tracking the percent of beneficiaries able to meet these goals within a given period of time would be a valuable assessment tool;
- Care transition: State and federal officials have long recognized that the misalignments in financing of Medicare and Medicaid can result in inappropriate utilization of expensive institutional services. One opportunity to address avoidable hospital admissions and readmissions is provided by a focus on care transitions. One set of processes to improve care transitions is accompanied by a standard metric, the three-item Care Transition Measure (CTM-3). This National Quality Forum-endorsed measure could be used by the State to assess care management organizations;
- Functional status: Once the new Uniform Assessment System is in place in New York, the data collected via routine assessment could be used to track important outcomes of care. The State will be able to determine, for example, whether beneficiaries of similar functional status have similar service intensity and similar outcomes. This approach could also be used to determine whether beneficiaries' health and functional status is stable, or declining at a slower rate, as a result of enrolling in care management, using a "differences-in-differences" comparison of the pre- and post-enrollment periods. Functional status measures that the National Quality Forum's dual eligibles work group identified as "illustrative" include improvement in ambulation (an OASIS-based measure) and Change in Daily Activity Function, as measured by the Activity Measure for Post-Acute Care.

Quality of Life and Experience of Care: A Special Area of Outcomes Measurement

As described above, the standard Consumer Assessment of Healthcare Providers and Systems (CAHPS) approach does not always capture critical information about high-risk Medicaid beneficiaries, including those who use long-term care services. Stakeholders make the case that measuring quality of life is of more value than the traditional measurement of access to medical services. Quality-of-life measures, recommended by the National Quality Forum (NQF) through its Measurement Application Partnership process for dual eligibles, focus on issues such as whether beneficiaries have control over their environment, choice of living setting, and the ability to direct their own care.[34]

The NQF report also identifies, however, a number of gaps in measurement that are of concern:

> *"Many concepts one might wish to evaluate have not been developed as standardized performance measures. Data at the patient level may exist in other forms, such as consumer surveys or assessments, but performance measures based on that data would need to be developed and tested. Other concepts may not have an obvious data source at this time. Examples include:*
>
> - *World Health Organization's Quality of Life Questionnaire;*
> - *Cross-cutting measures of culturally competent care, compassionate care, continuity of care, and consistency of care;*
> - *Measures of how well a care team functions together; and*
> - *Nontraditional domains of quality: person-centered goals; autonomy, self-efficacy, self-determination; meaning, purpose, and connection; caregiver, household, and community benefits."*[35]

Interviewees for this report recommended a number of model approaches to collecting quality-of-life information from beneficiaries who use long-term care. These include:

- Wisconsin's Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES) survey:[36] Evaluating a broad set of individual experiences, this survey uses person-centered statements such as "I decide where and with whom I live," "I have privacy," and "I feel safe."
- National Core Indicators for Individuals with Developmental and Intellectual Disabilities: Created by a collaborative process and published by the Human Services Research Institute,[37] this survey includes two indicators of choice:

[34] National Quality Forum Measure Applications Partnership. October 1, 2011. *Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries: Interim Report to HHS.*
http://www.qualityforum.org/Setting_Priorities/Partnership/Dual_Eligible_Beneficiaries_Workgroup.aspx

[35] Ibid.

[36] PEONIES project and survey information: http://www.chsra.wisc.edu/peonies/peonies_index.html

[37] Human Services Research Institute. March 2011. *Consumer Outcomes Final Report 2009-10.*
http://www.hsri.org/publication/consumer-outcomes-final-report-2009-10/

- The proportion of people who make choices about their everyday lives, including housing, roommates, daily routines, jobs, support staff or providers, social activities, and what to spend money on; and
- The proportion of people who report having been provided options about where to live, work, and go during the day.

Of note, New York's results show considerable room for improvement on two risk-adjusted items in this survey, the proportion of people who choose the place they live (38%), and the proportion of people choosing the staff who help them at home (68%).

- The Assessment of Health Plans and Providers by People with Activity Limitations: Adaptable to a CAHPS survey, this assessment tool was developed by Dr. Susan Palsbo,[38] whose research with beneficiaries who have limitations in mobility resulted in additional survey questions about accessibility of physicians' offices, communication, and management of pain and fatigue.
- The Behavioral Risk Factor Surveillance System: This surveillance system contains two measures on which New York ranked last among states,[39] both of which might be valuable additions to contractors' quality-of-care surveys for long-term care recipients:
  - Percent of Adults Age 18+ with Disabilities in the Community Usually or Always Getting Needed Support;
  - Percent of Caregivers Usually or Always Getting Needed Support.

Key Issues for New York State Implementation

As New York advances its work of refining a core measurement set for its complex Medicaid beneficiaries, the State must resolve key issues to facilitate a smooth and successful implementation process. Two critical areas raised in interviews are the role of stakeholders in the decision process and data collection and analysis capacity.

Stakeholders' Roles in the Decision Process

New York's Medicaid reform effort is placing a strong emphasis on stakeholder involvement. Many interviewees stressed that this is the best way to ensure that key questions are not answered in a vacuum or without sensitivity to regional differences across the state. There is concern, too, that current State policy attempts to drive change in service delivery faster than the infrastructure can sustain.

[38] Palsbo SE, G Diao, GA Palsbo, L Tang, WF Rosenberger and MF Mastal. September 2010. Case-Mix Adjustment and Enabled Reporting of the Health Care Experiences of Adults With Disabilities. *Archives of Physical Medicine and Rehabilitation* 91(9):1339-1346.e3.

[39] National Center for Chronic Disease Prevention and Health Promotion Behavioral Risk Factor Surveillance System (2009), as cited in Reinhard et al. (see note 2). http://www.cdc.gov/brfss/index.htm

Engaging Beneficiaries and Advocates

Engaging stakeholders to determine their values and priorities is a major component of the design work taking place for Medicare-Medicaid integration. The federal government's approach requires states to reach out to stakeholder groups, including dually eligible beneficiaries, family members, and advocacy organizations. While these groups may not be seen as "subject matter experts," their contribution to the design of new measures is critical. It is their perspective, for example, that pushed the National Quality Forum to consider how to measure quality of life in the measure set for duals.

Once measures are chosen, stakeholders benefit from clear reporting mechanisms. Dr. Ron Jemelka, of Washington's Mental Health Transformation project, shared a behavioral health dashboard designed to monitor the performance of Washington's statewide system of care for individuals with mental illness.[40,41] The dashboard provides a clear and standardized reporting format to communicate proposed measures developed through an intensive stakeholder process.

State Agency Partnerships

In order to build the infrastructure necessary for cross-population quality measurement, state agencies must build partnerships, sometimes sharing resources to link data sets or to share individual-level data reported from contracted entities. State representatives interviewed for this report have long used cross-agency partnerships to support executive-level planning for improved care delivery. New Mexico's experience provides a cautionary tale, however. Its multi-stakeholder effort led by the governor's office established new quality measures, but sometimes left relevant state agencies in the dark. Some agencies reported that they do not always know what is being measured, reported, or improved in their own programs.

Health Plans and Other Care Management Organizations

Health plans expressed a desire for a greater partnership role in the design of quality improvement approaches in New York. One complaint was that measures used in pay-for-performance efforts were not shared with health plans until it was too late to inform providers about their importance. Ideally, of course, plans would be working on multiple fronts to improve quality, but in these tight budgetary times, they have to focus their attention on a select few areas.

[40] Measuring Performance of Washington's Behavioral Health System. The Washington State Behavioral Health Status Report. June 9, 2011. Presentation by Ron Jemelka, PhD, at the 2011 Washington Behavioral Health Conference.

[41] Mental Health Transformation Project. September 2010. *Measures of Statewide Performance for Washington State* [draft]. http://www.healthequity.wa.gov/Meetings/2011/02-10/docs/Tab06c-BH_DSHS2_Handout.pdf

Providers

Sharing data at the provider level has multiple positive effects: interviewees report not only that providers use the information to improve care for individual beneficiaries but also that data-sharing improved the overall collection of quality measurement information. The providers that contract with Union Health Center, for example, found feedback reports—including identification of which patients have six or more medications—helpful. When data indicated problems with management of multiple medications, a health coach was assigned to help the provider manage the patient's care. Union also struggled to identify which clinic patients might need certain services, before they actually used them. Once identified, they could more easily assist those members in managing their health at a lower level of care.

Data Collection and Analysis Capacity

Data Collection Barriers and Challenges

Before integrated quality measurement can be developed as a tool for improving quality of care and quality of life, it is critical that states have the ability to appropriately collect, store, share, and analyze data, which is the driver of quality measurement. Barriers to those tasks include: incompatible data systems; incomplete collection of data; excessive costs; limited storage; and limited accessibility. As discussed earlier, CMS's HITECH program creates incentives to drive "meaningful use" of data. This undertaking is geared toward the creation of compatible data systems to inform providers of the different services an individual is receiving. Since a number of CMS health home quality measures require data from electronic health records, ensuring provider electronic health record capacity is an area of critical importance for New York.

Among state officials interviewed, the ease or difficulty of data collection was cited as the number one driver for quality measurement decisions. In the current economic climate, states are hesitant to require new data collection efforts by health plans, and reluctant to take on new data collection efforts themselves. When data are not readily available, however, it is not possible to accurately identify deficiencies in care. While over 83 percent of Arizona's dual-eligible population is enrolled in managed care, for example, without Medicare data Arizona could not identify all the services these beneficiaries receive. States identified limited resources, costs, and the burden of reporting as considerations in determining measures.

New Mexico's administration has one dedicated employee who receives data reports and disseminates the data to other bureaus in the system. Although New Mexico is sharing data, it has not supported its meaningful cross-department use. Acknowledging this weakness, it has hired a contractor to develop a dashboard, gathering input from the different bureaus to identify important data for inclusion.

Data Analysis Infrastructure

Interviews with state officials found that quality measurement analysis is done both in house and via contractors, depending upon need, regulation, and cost. State Medicaid agencies are required by federal regulations to work with an external quality review organization to disseminate and report managed care quality measurement. These organizations validate quality measurement data collection processes and systems as part of their review. New York's use of its external quality review organization, IPRO, for a focused review of care management outcomes is considered a best practice. IPRO's review of health plans' stratification of members allowed a subsequent analysis of utilization outcomes; this approach could be applied to the new populations enrolled in care management in the future.[42]

Conclusion

New York State is a national leader in developing a vision for Medicaid quality measurement and improvement. Many states are now joining New York in exploring new strategies to improve and measure advancements in care for high-need, high-cost populations. Health reform has accelerated the pace of these efforts and also opened the door to new opportunities, including health homes for beneficiaries with complex chronic conditions; innovative ways to manage behavioral health services and integrate physical and behavioral care; and emerging options for managing and improving long-term care, with the ultimate goal of integrating acute and long-term care services for dual eligibles. In turn, New York is looking for ways to ensure that public dollars continue to provide the best care possible for these high-need, high-cost beneficiaries.

Although it may require years to build the necessary infrastructure to support the goals of the National Quality Strategy, the good news is that the heretofore underdeveloped sets of measures for Medicaid beneficiaries with multiple chronic conditions, behavioral health conditions, and long-term care needs are moving forward at a rapid pace. The current array of quality measures, forms, and reports wastes precious resources and is unsustainable. New York has recognized that a far-reaching and unified system of measurement can and should be the basis for improving quality, increasing accountability, and rationalizing payments. These goals may all be within reach.

[42] IPRO, for the New York State Department of Health, Office of Health Insurance Programs. September 29, 2010. *Use of Clinical Risk Groups to Enhance Identification and Enrollment of Medicaid Managed Care Members in Case Management.* Lake Success, NY: IPRO.

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Appendix A: Interviewees

State Officials Interviewed

Arizona

Kim Elliot, PhD, CPHQ
Administrator, Clinical Quality
Division of Health Care Management, Quality Assessment & Performance Improvement Strategy
Arizona Health Care Cost Containment System

Kristin Frounfelker
Behavioral Health Administrator
Division of Health Care Management
Arizona Health Care Cost Containment System

New Mexico

Kim Carter
Behavioral Health Program Manager
Behavioral Health Services Division
New Mexico Human Services Department

Ellen Teresa Costilla, LISW, MSW, MPA, CIR-A
Program Manager, CoLTS
Medical Assistance Division Long Term Services & Support Bureau
New Mexico Human Services Department

Crystal Hodges, HSD, MAD
Administrative Operations Manager, CoLTS
Medical Assistance Division Long Term Services & Support Bureau
New Mexico Human Services Department

Angela Medrano
Bureau Chief
New Mexico Long Term Care Services and Supports
New Mexico Human Services Department

Victoria Parrill
Program Manager
New Mexico Aging and Long-Term Services Department

Cathy Sisneros
Bureau Chief, CoLTS
Medical Assistance Division Long Term Services & Support Bureau
New Mexico Human Services Department

Lesley Urquhart, CPHRM
Procurement Manager
Medical Assistance Division
New Mexico Human Services Department

New York

Foster Gesten, MD
Medical Director
New York State Department of Health

Linda Gowdy
Director, Bureau of Continuing Care Initiatives, Office of Continuing Care
New York State Department of Health

Mark Kissinger
Deputy Commissioner
Office of Long Term Care
New York State Department of Health

Vallencia Lloyd
Director, Division of Managed Care
New York State Department of Health

Pat Roohan, MS
Director, Division of Quality and Evaluation
New York State Department of Health

Oregon

Tina Kitchin, MD
Medical Director
Seniors and People with Disabilities
Department of Human Services

Pennsylvania

David K. Kelley, MD, MPA
Chief Medical Officer
Pennsylvania Department of Public Welfare

Washington

David Mancuso, PhD
Senior Research Supervisor
Washington State Department of Social and Health Services

Jeff Thompson, MD, MPH
Chief Medical Officer
Washington State Department of Social and Health Services

Additional Experts Interviewed

AARP
Dr. Susan Reinhard, RN, PhD
Senior Vice President for Public Policy

Aetna
Coleen Kivlahan, MD, MSPH
Chief Medical Officer, Aetna Medicaid

The Anderson Group
Robert B. Atkins, MD
Chief Medical Officer

Association for Community Affiliated Plans
Mary Kennedy
Vice President, Medicare

Deborah Kilstein, RN, MBA, JD
Director, Quality Management and Operational Support

Blue Cross Blue Shield of Massachusetts Foundation
Kate Nordahl
Director
Massachusetts Medicaid Policy Institute

Burns and Associates
Gretchen Engquist, PhD
Subject Matter Expert

CareOregon
David Labby, MD, PhD
Medical Director

Centers for Medicare & Medicaid Services
Marsha Lillie-Blanton, DrPH
Vice President, Health Quality, Evaluation and Health Outcomes

Karen E. Llanos
CHIPRA Quality Demonstration Grants Project Officer

Anita Yuskauskas, PhD
Technical Director for HCBS Quality

Columbia University
Susan Essock, PhD
Director of the Division of Mental Health Services & Policy Research
Department of Psychiatry

Community Health Plan of Washington
Betsy Jones, MBA, MSW
Director of Product Development

George Mason University
Susan Palsbo, PhD
Affiliate Professor
Center for the Study of Chronic Illness and Disability

Healthfirst
Rebecca Schwietz
Vice President, Clinical Performance Management

Pat Wang, JD
President and CEO

Manatt Health Solutions
Deborah Bachrach, JD
Special Counsel, Health Care Transaction and Policy

Tony Fiori, MA
Senior Manager

NASUAD
Mike Cheek
Senior Director for State Services

National Committee for Quality Assurance (NCQA)
Sarah Scholle, MPH, DrPH
Assistant Vice President, Research and Analysis

New York University
John Billings, JD
Associate Professor
Wagner School of Public Service

Northeast Health
John Collins, MD, FACP
Chief Medical Officer, Executive Vice President

Union Health Center
Karen Nelson, MD, MPH
Medical Director and CEO

UnitedHealthcare
Anna Scott, PhD, MBA, PAHM
Vice President, Quality Management, Medical Home

University of Washington Medical Center
Jürgen Unützer, MD, MPH, MA
Professor and Vice Chair, Psychiatry and Behavioral Sciences, and Chief of Psychiatry

Visiting Nurse Service of New York
Robert Rosati, MD
Vice President of Clinical Informatics

Appendix B: Existing Measurement Sets Used for New York Medicaid Populations

Adults Living with Illness Measures[43]

- Use of Imaging Studies for Low Back Pain
- Adult BMI Assessment
- Annual Dental Visit
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Medical Assistance with Smoking Cessation
- Flu Shot for Adults
- Controlling High Blood Pressure
- Cholesterol Management for Patients with Cardiovascular Conditions
- Use of Appropriate Asthma Medications—Three or More Controller Dispensing Events for People with Asthma Ages 5-50
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation
- Comprehensive Diabetes Care
- Drug Therapy for Rheumatoid Arthritis
- HIV/AIDS Comprehensive Care (New York State–specific, with no national comparison)
    - Engaged in Care
    - Viral Load Monitoring
    - Syphilis Screening

Behavioral Health Measures

- Antidepressant Medication Management
- Follow-up After Hospitalization for Mental Illness

CAHPS (Consumer Assessment of Healthcare Providers and Systems)

- Getting Care Needed
- Getting Care Quickly
- Customer Service
- Rating of Health Plan
- Shared Decision-Making

Care Coordination

- Wellness Discussion
- Rating of Overall Health Care
- Getting Needed Counseling or Treatment
- Rating of Counseling or Treatment

[43] See http://www.health.state.ny.us/health_care/managed_care/reports/eqarr/2010/about.htm

Appendix C: Proposed Measures in the New York State Plan Amendment for Medicaid Health Home Program for Individuals with Chronic Medical and Behavioral Health Conditions

Clinical Outcomes

- Inpatient Utilization—General Hospital/Acute Care
- Use of Appropriate Medications for People with Asthma
- Cholesterol Testing for Patients with Cardiovascular Conditions
- Comprehensive Diabetes Care (HbA1c test and LDL-c test)
- Annual Monitoring for Patients on Persistent Medications (ACE/ARB and Diuretics)
- Antidepressant Medication Management
- Follow-up Care for Children Prescribed ADHD Medication
- Comprehensive Care for People Living with HIV/AIDS
- Proportion of Schizophrenia Patients With Long-Term Utilization of Antipsychotic Medications
- Proportion of Patients with Bipolar I Disorder Treated with Mood Stabilizer Medications During Course of Bipolar I Disorder Treatment
- Persistence of Beta-Blocker Treatment after Heart Attack
- Stable or Improved Functional Status
- Follow-Up after Referral

Experience of Care

- CAHPS for Medical Home or Health Home

Quality of Care

- Case Management Structure and Process Measures
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Chlamydia Screening in Women
- Colorectal Cancer Screening
- Medical Assistance with Smoking and Tobacco Use Cessation
- Follow-up After Hospitalization for Mental Illness
- Follow-up After Hospitalization for Substance Abuse
- Follow-up After Hospitalization for Medical Illness

Appendix D: New York's Proposed Measures for Managed Long-Term Care

Measures	Data Source	Specifications
Nursing Home Admissions	Semi-Annual Assessment of Members (SAAM)	Percentage of enrollees who had one or more nursing home admissions in a six-month period
Reason for Nursing Home Admissions	SAAM	Percentage of admissions for: • Therapy Services • Permanent Placement • Unsafe at Home • Other • Unknown
Emergency Department Visits	SAAM	Percentage of enrollees who had one or more hospital ED visits in a six-month period
Emergency Department Visits During Baseline and Follow-up Periods	SAAM	Percentage of enrollees who had one or more hospital ED visits during the baseline and follow-up periods
Falls Requiring Emergency Department Visit	SAAM	Percentage of enrollees who had an ED visit as a result of a fall or accident at home
Hospital Admissions	SAAM	Percentage of enrollees who had one inpatient admission in a six-month period
Hospital Readmissions	SAAM	Percentage of enrollees who had more than one inpatient admission in a six-month period
Hospital Admissions for Selected Reasons	SAAM	Percentage of all admissions that were for: • Rate 1: Falls • Rate 2: Diabetes • Rate 3: CHF • Rate 4: Respiratory Problems
SAAM Index (ADLs, Incontinence, Cognitive)	SAAM	Percentage of enrollees whose overall ADL, incontinence, and cognitive functioning improved or remained the same between the baseline and follow-up periods
ADL Composite: Percent Stable or Improved on Seven Activities of Daily Living: Ambulation, Bathing, Transferring, Dressing (upper body), Dressing (lower body),Toileting, Feeding/Eating	SAAM	Percentage of enrollees whose overall ADL status improved or remained the same between the baseline and follow-up periods
Urinary Incontinence: Percent Stable or Improved	SAAM	Percentage of enrollees whose incontinence or need of a catheter improved or remained the same between the baseline and follow-up periods
Frequency of Incontinence	SAAM	Percentage of enrollees whose frequency of urinary incontinence improved or remained the same between the baseline and follow-up periods
Frequency of Pain	SAAM	Percentage of enrollees whose level of pain remained the same or improved between the baseline and follow-up periods

Continued on next page

Appendix D: New York's Proposed Measures for Managed Long-Term Care (cont'd)

Measures	Data Source	Specifications
Advance Directives: Satisfaction with Health Home, Providers, and Care	New York State Department of Health Managed Long-Term Care (NYS-DOH-MLTC) survey Note: The Uniform Assessment System, once implemented, will replace self-reporting per the MLTC survey.	Percentage of enrollees who: • Discussed appointing someone to make health care decisions • Have a legal document appointing someone to make health care decisions • Have a copy of the legal document
Depressive Feelings	SAAM	Percentage of enrollees whose feelings of depression remained the same or improved between the baseline and follow-up periods
Satisfaction with Health Home	NYSDOH-MLTC survey	Biennial survey administered by NYSDOH through its external quality review organization
Depressive Feelings Reported or Observed	SAAM	Percentage of enrollees who have expressed depressive feelings, a sense of failure, hopelessness, thoughts of death, or suicide
Cognitive Functioning	SAAM	Percentage of enrollees who are alert, require prompting, need assistance in answering, are not oriented, or are delirious
Confusion	SAAM	Percentage of enrollees who are alert, require prompting, need assistance in certain situations, are not oriented, or are totally dependent
Anxiety	SAAM	Percentage of enrollees who are anxious none of the time, less than daily, daily, or all the time, or not responsive
Memory Deficit	SAAM	Percentage of enrollees who fail to recognize familiar people/places, cannot recall events of past day, or have significant memory loss requiring supervision
Oral Medication Management	SAAM	Percentage of enrollees whose ability to independently manage oral medications remained the same or improved between the baseline and follow-up periods
Health plan has asked to see prescriptions/over-the-counter medicines	NYSDOH-MLTC survey	Biennial survey administered by NYSDOH through its external quality review organization
High Risk Factors and BMI Assessment	SAAM	Percentage of enrollees who, in the last six months, have had selected risk factors: smoking, underweight, overweight, obesity, or alcohol or drug dependency
Flu Shots	SAAM	Percentage of enrollees who had a flu shot in the past year
Falls: Number	SAAM	Percentage of enrollees who had one or more falls in the last six months
Falls: Medical Intervention	SAAM	Percentage of enrollees who required medical attention following a fall
Oral Medication Management	SAAM	Percentage of enrollees whose management of oral medications was assessed
Satisfaction with Care Manager; Timeliness of Care Manager	NYSDOH-MLTC survey	Biennial survey administered by NYSDOH through its external quality review organization

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