

# CHCS

Center for  
Health Care Strategies, Inc.

## Resource Paper

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*Integrated Care Program:  
Performance Measures  
Recommendations*

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The Center for Health Care Strategies (CHCS) is a national non-profit organization devoted to improving the quality of health services for beneficiaries served by publicly financed care, especially those with chronic illnesses and disabilities. CHCS advances its mission by working directly with state and federal agencies, health plans, and providers to design and implement cost-effective strategies to improve health care quality.

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## Introduction

Today, more than seven million Americans are defined as "dual eligibles" – low-income people who are elderly or have disabilities and are covered by both Medicare and Medicaid. Most have extensive medical, social, and long-term care needs. Their health care costs are nearly double those of other adults covered by Medicare and eight times higher than Medicaid spending for children. The largely disorganized intersection of Medicare and Medicaid—each governed by its own delivery, financing, and administrative policies—results in misaligned benefit structures, opportunities for cost-shifting, and unresolved tensions between the federal and state governments. Integrating care across service settings and funding streams has great potential for improving the quality, coordination, and cost-effectiveness of care for this population. The creation of Special Needs Plans (SNPs) in the 2003 Medicare Modernization Act (MMA) also offers significant new opportunities to integrate Medicaid and Medicare coverage for beneficiaries who are dually eligible.

Through the *Integrated Care Program*, the Center for Health Care Strategies (CHCS) used resources from the Robert Wood Johnson Foundation (RWJF) to provide grants to five states – **Florida, Minnesota, New Mexico, New York, and Washington** – to develop and/or expand models of care that integrate the financing, delivery, and administration of primary, acute, behavioral health and long-term care services and supports for beneficiaries with chronic conditions who are dually eligible or covered solely by Medicaid. The Integrated Care Program (ICP) is also helping states develop the infrastructure for integrating health care services and contracting with SNPs.

CHCS is using its RWJF resources as well as supplemental grants from Evercare and Schaller Anderson, Incorporated to create a comprehensive technical assistance strategy for this initiative. The states identified three priority areas for technical assistance: (1) *administrative simplification*; (2) *rate setting and risk adjustment*; and (3) *performance measurement*. Expert workgroups are, for each priority area, designing and disseminating standardized, yet flexible, approaches that states and their federal and delivery system partners could tailor to their specific needs. This report outlines a set of recommendations identified by the Performance Measurement Workgroup.

The Performance Measurement Workgroup was charged with recommending a manageable number of performance measures that states could use in their contracts with SNPs for the purposes of assuring the quality of integrated care. This report is divided into four sections:

1. Overview of the current context and need for performance measurement for integrated care;
2. Process followed by the workgroup to identify and make performance measurement recommendations;
3. Recommendations made by the workgroup; and
4. Next steps for states to implement the recommended performance measures for integrated care.

## I: Overview of Performance Measurement for Integrated Care Programs

The performance measures available to purchasers and providers today are unevenly distributed across the acute medical, behavioral health, and long-term care sectors. Quality measures for preventive and acute medical care and common chronic illnesses (e.g., asthma and diabetes) are fairly well developed, in contrast with performance measures related to behavioral health and long-term care. Many sources have documented the need for more comprehensive and holistic measures for people with disabilities and chronic illnesses, but this need is only addressed to a limited extent in current nationally recognized measurement sets such as the Health Plan Employer Data Information Set (HEDIS<sup>®</sup>).<sup>1</sup>

The driving force in health plan performance measurement today is the National Committee on Quality Assurance's (NCQA) HEDIS measures, which are used to evaluate the performance of commercial, Medicaid, and Medicare managed care plans nationally. More than 90 percent of the purchasers of health care services use HEDIS measures to monitor and compare health plan performance (although it is important to note that Medicaid plans report HEDIS data less often).<sup>2</sup> The main criteria for commonly used performance measures are that they be:

- Broadly applicable across populations (in order to ensure sufficient sample sizes);
- Based on scientific evidence that improvements in process lead to improvements in outcomes;
- Actionable; and
- Measurable.<sup>3,4</sup>

For the most part, the HEDIS measures focus on acute medical care, with an emphasis on preventive care screenings and care delivery processes for a few of the most common health conditions and chronic illnesses. While many of these measures are relevant to individuals in integrated care programs, the measures only address a portion of their acute and chronic health care conditions and needs. In addition, there is no comprehensive measurement set that addresses the complexity of health issues and support services common to those in long-term care settings (e.g., consumer transitions between health care settings, care coordination, etc.). Furthermore, none of the existing measures have been tested explicitly for SNPs, which many states intend to use as a vehicle for service integration. As a result, many health plans and researchers specializing in the care of people with chronic illnesses believe that alternative quality measures are needed to accurately assess performance for plans and providers caring for frail elders and people with disabilities.

Unfortunately, long-term care performance measurement is perhaps one of the least developed fields, particularly when it comes to measures that are broadly applicable across all populations that use long-term care services. While measures that target specific populations do exist (e.g., issues related to nursing homes, measures for the developmentally disabled population, measures

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<sup>1</sup> Coleman EA, Smith JD, Frank JC, Eilertsen TB, Thiare JN & Kramer AM. 2002. Development and testing of a measure designed to assess the quality of care transitions. *International Journal of Integrated Care* Vol. 2: 1-8.

<sup>2</sup><http://www.ncqa.org/communications/publications/hedispub.htm>.

<sup>3</sup> EPC Topic Nomination and Selection. 2005. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/epc/epctopicn.htm>.

<sup>4</sup> National Quality Measures Clearinghouse. 2006. Agency for Healthcare Research and Quality, Rockville, M.D. <http://www.qualitymeasures.ahrq.gov/about/inclusion.aspx>.

assessing home health care and home and community-based service providers, etc.) none assess the needs and quality of long-term care services for individuals from a broader and more holistic perspective.<sup>5</sup>

Integrated care programs for dually eligible populations with disabilities or seniors are a fairly new concept, and the mainstream measures such as HEDIS are not constructed to measure performance in care transitions and care integration/coordination. Yet these are the very areas that states in the Integrated Care Program hope to impact through enhanced services and contract standards. These programs are being explicitly designed to improve service coordination and integration, reduce the redundancy and cost-shifting that results from separate Medicare and Medicaid funding streams, and to improve the overall health and quality of life of consumers. Although several measures of care coordination and service integration have been developed, they are usually confined to a very narrow target population, such as dually eligible individuals over the age of 55 who are enrolled in the Programs for All Inclusive Care for the Elderly (PACE).<sup>6</sup>

## **II: CHCS Performance Measurement Workgroup**

CHCS convened the Integrated Care Performance Measurement Workgroup to identify and recommend measures that could be implemented by states and health plans that serve people who are dually eligible for Medicaid and Medicare, as well as people with disabilities who receive services solely through Medicaid. The workgroup's goal was to identify a small number of measures that would be broadly applicable across the populations served by the integrated care programs and would add value to the measures health plans are already required to collect under existing state and federal contracts and/or regulations.

The guiding principles under which the workgroup operated (that the recommended measures be manageable in number, broadly applicable, and add value in understanding program performance) acknowledge that performance measurement requires significant resources. The existing performance measurement requirements for plans that serve Medicare enrollees are extensive. The workgroup did not want to add unduly to the burden of data collection since the states participating in the Integrated Care Program are planning to use SNPs or other Medicare Advantage products as one vehicle for integration and would be subject to those performance measurement requirements. (For a list of Medicare-required performance measures, see Appendix 1.) Increasing the reporting burden on states, plans, providers, and consumers too much could have the unintended effect of dissuading plans, physicians, and other providers from participating in the new plan option.

The dual eligible population consists of people with a wide range of special needs and includes the elderly; working age adults; and people with chronic illnesses, developmental disabilities, physical disabilities, and/or psychiatric disabilities. While states may focus on any or all of these subsets of the dual eligible population, the workgroup felt it was important that the measures be broadly applicable to any of the populations states may target in their integrated care programs. Consequently, the workgroup confined its recommendations to those areas that would provide

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<sup>5</sup> The workgroup understands the usefulness of population-specific measures (e.g., measures for people with COPD), but decided to focus on recommending measures that are applicable to a broad population (e.g., care transition measures).

<sup>6</sup> PACE uses funding from Medicare and Medicaid to create interdisciplinary teams of providers that meet seniors' health and social support needs in an adult day care setting. For more information please see <http://www.npaonline.org/website/article.asp?id=12>

states with information that filled in gaps in the existing performance measurement requirements for SNPs. The workgroup felt it would be better to focus more attention on fewer measures until the purchasers, plans, and consumers have a better sense of what is valuable to measure.

### **Overview of the Workgroup Process**

The Performance Measurement Workgroup consisted of 10 individuals with knowledge of the targeted populations, experience in the area of performance measurement, and who represented different perspectives including purchasers, health plans, providers, consumers, states, and health services researchers. (For a complete list of workgroup members, please see Appendix 2.) The workgroup met over a period of three months. The following is an overview of the steps taken by the workgroup to develop its final recommendations:

1. *Established a common framework for eventual recommendations.* The workgroup chose to focus on the need for a limited number of measures that are broadly applicable across populations and programs. In addition, it looked for measures that are easily collected and that add value to existing requirements, particularly those already in existence for Medicare Advantage plans.
2. *Identified all potentially relevant performance measurement domains and located measurement sources for each domain.* The domains and associated measures were gathered from workgroup suggestions, Medicare Advantage requirements, and other sources already in existence. These were then mapped on spreadsheets and distributed to workgroup members. Figure 1 shows a complete list of identified domains. A complete list of the measures identified by the workgroup for all domains can be found in Appendix 3.
3. *Solicited state feedback.* Recognizing the need for a small number of measures that met state needs, the workgroup asked the ICP states to identify the three to five domains that best addressed their performance measurement priorities for integrated care. The states selected five priority domains on which the workgroup then focused: 1) functional status; 2) care coordination; 3) care transitions; 4) behavioral health; and 5) safety/nursing home eligible.
4. *Developed recommendations for state-selected domains.* The workgroup began by identifying measures for the five state-selected domains. It then reached consensus around the specific measures that should be recommended within those domains.

### **Figure 1: ICP Performance Measurement Domains**

- Prevention
- Utilization
- Community Integration
- Care Coordination
- Effectiveness of Care
- Palliative Care
- Behavioral Health
- Functional Status
- Medication Management
- Consumer Satisfaction
- Family/Caregiver Support/Satisfaction
- Access to Care (e.g., timeliness and location)
- Safety
- Health Plan Stability
- Population/Condition Specific
- Self-Direction
- Service Integration/Care Transitions

In recommending the measures for each domain (which are described in the following sections), workgroup members used the criteria in Figure 2 to decide among the many measures they identified.

### Figure 2: Selection Criteria

- What additional information and value will collecting this measure give the program (i.e., will it stimulate continuous quality improvement)?
- How feasible (cost, timing, technology, and resources) is it to implement this measure?
- Can this type of information be collected through existing/easy to access data sources?
- Is this measure scientifically strong (derived from comparable data sources, based on evidence-based standards)? If there are no rigorously tested measures in the domain area, is this measure reasonably strong or does it fill an important role that has been missing to date?
- Would the data collected through this measure be relevant to various stakeholders (Medicaid agencies, health plans, CMS)?
- Are these types of data relevant across health plans?
- Is this something for which the state can hold health plans accountable?

In evaluating the proposed measures, the workgroup was particularly interested in whether or not they were applicable across all of the populations eligible to enroll in the various state programs and whether the measures added value by filling in critical gaps in existing performance measurement requirements (such as those for Medicare). In addition, the workgroup focused on measures that could be relatively easy to collect (particularly through administrative data, including utilization data or as an “add on” to a consumer satisfaction survey). The administrative measures were given priority over measures that require separate interviews, medical record review, or review of health plan, case management, or provider data. It is important to note that while the workgroup considered the strength of recommended measures, it did not let that prevent it from recommending measures that have the potential to capture critical information for integrated care programs simply because those measures have not yet been rigorously tested. However, where multiple options were available within a given domain, measures that have been used nationally were selected over those that have not been so validated. Measures recommended by the workgroup for these five priority domains are listed in Section 3. For a comprehensive list of all the recommended measures, including measurement source(s), definitions, and data formats, please see Appendix 4.

## III: Recommended Measures

### *Functional Status*

High quality care for people with chronic conditions should focus on slowing the deterioration of, maintenance of, or optimizing, functional status.<sup>7</sup> Functional status reflects an individual’s

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<sup>7</sup> Institute of Medicine Committee on Quality Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*. National Academy Press. Washington, DC. 2001.

ability to perform activities in the normal course of his/her life to meet basic needs, fulfill usual roles, and maintain his/her health and well-being.<sup>8</sup> Functional assessment is one of the first steps in providing appropriate care for people with numerous and complex health care needs. For integrated care programs, assessing functional status during enrollment and periodically thereafter allows the program to identify the appropriate level of care needs and services for their consumers.

Recommended Measures for Assessing Functional Status	
Measure	Source/Reporting Method <sup>9</sup>
Outcome Assessment and Information Set (OASIS)	Provider Survey
Percentage of members screened to identify impairments in physical and cognitive functioning annually.	NHPG/utilization data

OASIS: Although multiple tools and methods for assessing functional status are being used by states, the workgroup recommends the Outcome and Assessment Information Set (OASIS) developed by CMS. Designed with home health agencies in mind, OASIS is also applicable across service settings and consists of a core set of scientifically tested data points that states can use as a stand-alone functional assessment or as part of a more comprehensive state specific tool, such as the Wisconsin Functional Screen.<sup>10</sup> While the Health Outcome Survey (HOS), which is required for Medicare Advantage, also looks at functional assessment, it does so from the consumer’s perspective. The workgroup felt that OASIS, which looks at functional assessment from a professional’s perspective, complements the existing requirements. However, because OASIS is a survey rather than one single measure, the implementation of OASIS is likely to increase the amount of reporting requirements for plans unless they collect OASIS currently.

*Percentage of members screened to identify impairments in physical and cognitive functioning annually:* This measure comes from recommendations made to the Centers for Medicare and Medicaid Services (CMS) by a group of SNP medical directors working with the National Health Policy Group (NHPG), a national policy and consulting group focused on improving care for high-risk individuals, on developing alternative performance measures for SNPs. The workgroup felt that this was a measure necessary for providing quality care for people with disabilities and chronic illnesses and could be easily captured.

*Measures considered but not selected:* In its evaluation of various functional assessment tools, the workgroup also looked at the World Health Organization’s International Classification of Function (ICF). Although the workgroup thought the ICF’s assessment of consumer participation in community, social, and civic life (which is not a part of the OASIS tool) was valuable, it felt that OASIS was a better fit as it is more commonly used in the United States.

<sup>8</sup> Leidy NK. “Functional status and the forward progress of merry-go-rounds: towards a coherent analytical framework.” *Nurs Res.* 1994;43:196–202.

<sup>9</sup> Explanations of measurement sources can be found in Appendix 5.

<sup>10</sup> For more information on the Wisconsin Functional Screen, please see Appendix 5.

## Care Coordination

People with disabilities and chronic health conditions often require services from numerous providers located in multiple care delivery settings. It is not unusual for a single individual to receive care from multiple providers, specialists, and agencies. That mix of services is often supplemented by informal care provided by friends and family members. Coordinating care delivered by these disparate entities can be challenging for providers, consumers, and payors. While consumers struggle with navigation issues and try to learn which provider is responsible for which aspect of their care, providers and payors struggle with the inefficiencies and redundancies that arise from such a fragmented care system. As a result, care coordination is an essential component of integrated care. However, widely-accepted measurement sets such as HEDIS do not address care coordination. This led to interest from the ICP states in identifying measures in this domain.

Recommended Measures for Care Coordination	
Measure	Source/Reporting Method <sup>11</sup>
Proportion of people reporting service coordinators help them get what they need.	HSRI/Consumer Survey
Percent of people who feel it is a problem to receive advice/assistance from more than one case manager or care coordinator.	Indiana Medicaid Select/Consumer Survey

*Proportion of people reporting that service coordinators help them get what they need:* For the workgroup, the information provided by this measure was the “real test of care coordination,” since the data would serve as a surrogate marker in assessing if a health plan was indeed providing good care coordination. In addition, the workgroup felt that this is relatively easy to measure if added to a consumer satisfaction survey and provides an opportunity for plans to target quality improvement efforts if needed.

*Percent of people who feel it is a problem to receive advice/assistance from more than one case manager or care coordinator:* The second measure requires that plans assess consumer satisfaction with their care coordination experience. The workgroup felt that this measure was necessary to ensure that plans make care coordination seamless for consumers and that consumers are not confused or burdened by a plan’s process for coordinating care.

*An additional area of interest was also identified by the workgroup:*

- Organization monitors continuity and coordination of care that consumers receive and takes actions, as necessary, to ensure and improve continuity and coordination of care.

Although more of a guiding principle than an actual measure (the recommendation comes from the proposed NCQA 2007 accreditation standards), the workgroup felt that it was important for plans participating in integrated care programs to hold monitoring and improving care coordination as a key priority. As a result, the workgroup felt that this should be included, not necessarily

<sup>11</sup> Explanations of measurement sources can be found in Appendix 5.

as a performance measure, but as an element states could include in their external quality review organization (EQRO) contracts for health plan performance monitoring.

*Measures considered but not selected:* Additional care coordination measures considered but not selected by the workgroup included: whether consumers can identify their care coordinators; whether care plans are shared by all care providers; and whether consumers thought their care coordinators were competent and knowledgeable. Although important, these measures were not selected because the workgroup felt that the other measures recommended by the workgroup could collect more useful data – e.g., it may be more constructive to know if the care coordinator helps the consumer get what he or she needs than if the care coordinator can be identified or if care plans are shared.

### Care Transitions

The term “care transitions” refers to the movement of people between health care settings as their conditions and care needs change during the course of a chronic or acute illness. According to the American Geriatrics Society, transitional care is designed to ensure the coordination and continuity of health care as consumers transfer between different locations or different levels of care within the same location.<sup>12</sup> Care transitions are an important part of both care coordination and service integration and, as a result, an integral aspect of integrated care programs.

Recommended Measures for Care Transitions	
Measure	Source/Reporting Method <sup>13</sup>
<p>Quality of preparation for post-hospital care from the patient’s perspective:</p> <ul style="list-style-type: none"> <li>▪ The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.</li> <li>▪ When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.</li> <li>▪ When I left the hospital, I clearly understood the purpose for taking each of my medications.</li> </ul>	Care Transition Measures(CTM)/ Consumer survey

The workgroup felt strongly that states and health plans need to assess the quality of preparation for post-hospital care from the consumer’s perspective because workgroup members felt that it was a critical area to measure for dual eligibles and other persons with disabilities and/or chronic conditions in both a consumer- and outcomes-oriented way. This measure, which consists of a three-question consumer survey called the Care Transition Measure (CTM), was developed by researchers at the University of Colorado Health Sciences Center to assess the quality of care transitions from the consumer’s perspective. In fact, CTM scores have demonstrated significant linkages with a consumer’s return to a hospital or emergency room after discharge.<sup>14</sup> CTM is currently being piloted by PeaceHealth, an integrated health system with locations in Alaska, Oregon, and Washington. As a result, the workgroup felt it was a valid measure that was relatively easy to collect and relevant for plan quality improvement purposes.

<sup>12</sup> <http://www.caretransitions.org/definitions>

<sup>13</sup> Explanations of measurement sources can be found in Appendix 5.

<sup>14</sup> “One Patient, Many Places: Managing Healthcare Transitions.” HMO Workgroup on Care Management. February 2004.

*Measures considered but not selected:* Other care transitions measures considered but not recommended by the workgroup included: whether consumer medications were reviewed within 24 hours of discharge/transition; and whether a member of the health care team communicated with the consumer within 72 hours of discharge/transition. While the workgroup felt that these were important measures, there was some question as to the method and ease of data collection required for implementation so they were not put forth as recommendations.

### **Behavioral Health**

Studies have shown that behavioral and physical health are very much connected; individuals with physical problems are more likely to have mental health problems and vice versa. In California’s Medicaid managed care program, beneficiaries with physical disabilities or mental disability were five times more likely to have two or more chronic conditions.<sup>15</sup> In addition, an institutional bias remains in the area of behavioral health, because those who reside in the community have difficulty accessing the behavioral health system (aside from medications) despite persistent need. Whether or not people with long-term care needs are able to access this type of care can have a profound impact on the success of their overall health care. In the past, behavioral health has been carved out of most Medicaid managed care programs. Yet truly integrated care, as CHCS defines it, includes behavioral health. Several ICP states are interested in including behavioral health in their programs.

<b>Recommended Measures for Behavioral Health</b>	
<b>Measure</b>	<b>Source/Reporting Method<sup>16</sup></b>
<p>Ability to access behavioral health services quickly:</p> <ul style="list-style-type: none"> <li>▪ In the last 12 months did you need counseling or treatment right away?</li> <li>▪ In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?</li> <li>▪ In the last 12 months, not counting times you needed counseling or treatment right away, did you make any appointments for counseling or treatment?</li> <li>▪ In the last 12 months, not counting times you needed treatment right away, did you get an appointment for counseling or treatment as soon as you wanted?</li> </ul>	ECHO/consumer survey
Rate of readmission to psychiatric hospitals within 30 days and 180 days.	NOMS/utilization data

*Ability to access behavioral health services quickly:* This measure, which comes from the Experience of Care and Health Outcomes Survey (ECHO),<sup>17</sup> consists of four questions that are directly posed to the consumers. The workgroup felt that these questions could yield important access

<sup>15</sup> Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disability and Chronic Condition: Project Overview. <http://www.chcf.org/documents/policy/MediCalDisabilitiesQualityAcctOverview.pdf>

<sup>16</sup> Explanations of measurement sources can be found in Appendix 5.

<sup>17</sup> A supplemental item from the CAHPS survey.

and health outcome data that are currently missing from HEDIS measures and the Health Outcomes Survey (HOS), a consumer-focused outcomes survey designed specifically for Medicare managed care, and required under Medicare Advantage. In addition, the workgroup felt this measure was relevant across stakeholders and could be easily collected by plans via a CAHPS-like tool or methodology. ECHO is also a nationally-recognized measurement set. However, it is important to consider that the term “right away” (as used in the ECHO measure) may be subject to varying degrees of interpretation based on a consumer’s clinical state (i.e., consumers with severe mental illness may need to access services within several hours whereas a consumer with moderate depression may need to access within a week).

*Rate of readmission to psychiatric hospitals within 30 days and 180 days:* The workgroup also recommended that states look at the rate of readmission to psychiatric hospitals, a measure that is part of the National Outcomes Measurement Set (NOMS) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The workgroup felt this measure was important in assessing the effectiveness of care provided and constituted easily captured, “hard data” that would be relevant across plans.

*Measures considered but not selected:* Other measures considered but not selected in this domain included: perceived improvement in functioning and treatment penetration rates. The workgroup found them to be duplicative of measures currently required for Medicare Advantage plans and felt that they did not provide the plan/state with critical or missing data or add significant value.

### ***Safety/Nursing Home Eligible***

People who are dually eligible face multiple and complex obstacles maintaining their physical and emotional health status. Many dually eligible people reside in the community, but can quickly be put in imminent risk of hospitalization or institutional placement when changes in health condition, the availability of support systems, or the lack of home and community-based services (such as personal assistance or home-delivered meals) occur. A frail elder’s physical disability creates additional risk for falls and slower healing time. Further, cognitive disabilities prevalent in this population (e.g., dementia or Alzheimer’s) can impact an individual’s ability to adhere to treatment or to identify or report abuse. Due to these complexities, finding appropriate or accurate ways to measure the access to or quality of health care dual eligibles receive can be very difficult.

The workgroup considered the following measures for this domain:

- Number of home safety evaluations conducted;
- Percent of participants reporting they feel safe;
- Degree to which safety is improved; and
- Number of persons age 75 or older and those at risk for falls have been asked at least annually about the occurrence of falls and treated for related risks.

However, because these measures would not provide any new information—e.g., the measures did not address target issues, were not applicable to all of the included populations, etc.—the workgroup decided against recommending any of the measures. Although the workgroup recognized the need and importance of safety within integrated care programs, and nursing home eligible populations in particular, recommending a set of measures that are not value-added would not best use state or plan resources. Rather, the group felt that the performance measure-

ment environment for this domain is such that further research is required to develop and test new measures that would more adequately evaluate the safety of dual eligibles and people with disabilities and/or chronic conditions. As such, this will continue to be an area of exploration for future integrated care work undertaken by CHCS.

#### **IV: Next Steps for States**

This document was designed to serve as a resource for states at any point in the development and implementation of an integrated care program. For states currently in the process of thinking about or developing such a program, the recommended measures could be integrated into an RFP or contracting process. States with existing integrated care programs could use the recommended measures to supplement current state measurement requirements. Regardless of where a state is along the program development/implementation continuum, it is important to note that all of the recommendations made may not be suitable for all integrated care programs and should be adopted/adapted as appropriate.

It is critical that states evaluate their own integrated care program priorities, internal resources, and existing Medicare Advantage requirements to determine what additional measures they are interested in and capable of collecting, if any. To facilitate this process, states may want to look at the measures they are currently collecting and/or plan to collect and how that information is used to monitor and improve performance. This careful review will help ensure that states are only requiring plans to report on measures that have the most value and are actually used. States are also urged to have their draft performance measurement plan reviewed by stakeholders critical to their successful implementation—especially consumer, provider, and plan representatives. States should feel free to adopt as few or as many measures as they are able, and in a timeframe that best suits their individual needs. For example, if a state is not yet comfortable with incorporating new measures into its existing requirements or wants to start with Medicare Advantage requirements and build from there, it could consider adopting these measures six months, a year, or even two years from now. States may also want to consider rolling out any or all of these measures slowly or on a staggered timeline before making them a mandatory requirement. In addition, the Centers for Medicare and Medicaid Services (CMS) is planning to develop new performance measures for SNPs as part of an overall quality strategy that will also include SNP reporting at the plan level; the measures recommended in this document may also serve as a bridge for states in the interim.

Due to the nature and complexity of the conditions that members of integrated care programs face, states have the responsibility to enhance state capacity ability to appropriately assess the type and level of care that members receive. Performance measurement represents a significant opportunity for states to assess the quality of care provided and create a more effective health care system that will improve the experience and outcomes of consumers of publicly financed care. By implementing measures that are specific to the needs of people with disabilities and chronic conditions, states are better equipped to create an integrated care system that promotes accountability for itself and its health plans, and ensures quality health care for all its members.

## **Appendix 1: Required HEDIS Measures for Medicare Advantage Reporting for Summary Data<sup>18</sup>**

### **Effectiveness of Care**

Colorectal Cancer Screening

Breast Cancer Screening

Osteoporosis Management in Women Who Had a Fracture

Controlling High Blood Pressure

Beta Blocker Treatment After A Heart Attack

Persistence of Beta Blocker Treatment After a Heart Attack

Cholesterol Management After Acute Cardiovascular Events

Comprehensive Diabetes Care

Follow-up After Hospitalization for Mental Illness

Anti-depressant Medication management

Glaucoma Screening in Older Adults

Medicare Health Outcomes Survey

Management of Urinary Incontinence in Older adults (collected through HOS)

Physical Activity in Older Adults (collected through HOS)

### **Access to/Availability of Care**

Adults' Access to Preventive/Ambulatory Health Services

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Claims Timeliness

Call Answer Timeliness

Call Abandonment

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<sup>18</sup> These are the current HEDIS reporting requirements for Medicare Advantage. It is important to note, however, that CMS is planning to require SNPs to report on a subset of HEDIS measures. For more information on the current Medicare Advantage quality requirements see <http://www.cms.hhs.gov/Manuals/Downloads/mc86c05.pdf>.

## **Health Plan Stability**

Practitioner Turnover

Years in Business/Total Membership

## **Use of Services**

Frequency of Selected Procedures

Inpatient Utilization—General Hospital/Acute Care

Ambulatory Care

Inpatient Utilization—Non-acute Care

Mental Health Utilization- Inpatient Discharges and Average Length of Stay

Mental Health Utilization—Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services

Chemical Dependency Utilization—Inpatient Discharges and Average Length of Stay

Identification of Alcohol and Other Drug Services

Outpatient Drug Utilization (for those with a drug benefit)

## **Health Plan Descriptive Information**

Board Certification

Total Enrollment by Percentage

Enrollment by Product Line (Member Years/Months)

## Appendix 2: ICP Performance Measurement Workgroup Members

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### Appendix 3: Complete ICP Measures Matrix

The following matrix contains all of the measures identified for each of the 17 domains initially considered by the Performance Measurement Workgroup. For information on measurement sources, please see Appendix 5.

Domain	Measures Identified by ICP Workgroup	Source
<b>Prevention</b>	Degree to which health status of consumers is maintained or improved.	CARF
	Hospitalization Rates for Preventable Conditions <ul style="list-style-type: none"> <li>▪ Dental Conditions</li> <li>▪ Vaccine Preventable Conditions</li> <li>▪ Iron Deficiency Anemia</li> <li>▪ Nutritional Deficiencies</li> <li>▪ Bacterial Pneumonia</li> <li>▪ Cancer of the Cervix</li> <li>▪ Convulsions</li> <li>▪ Dehydration</li> <li>▪ Gastroenteritis</li> <li>▪ Hypoglycemia</li> <li>▪ Kidney Infection</li> <li>▪ Pelvic Inflammatory Disease</li> <li>▪ Angina</li> <li>▪ Asthma</li> <li>▪ COPD</li> <li>▪ CHF</li> <li>▪ Diabetes</li> <li>▪ Grand Mal and Other Epileptic Conditions</li> <li>▪ Hypertension</li> <li>▪ Tuberculosis (pulmonary and non-pulmonary)</li> </ul>	AHRQ
	Hospitalization Rates for Care Coordination Sensitive Conditions in People with Impaired Mobility <ul style="list-style-type: none"> <li>▪ Bowel Impaction</li> <li>▪ Urinary Tract Infections</li> <li>▪ Pressure Ulcers</li> <li>▪ Autonomic Dysreflexia</li> </ul>	Palsbo
<b>Utilization</b>	Nursing Home Admissions and Length of Stay	Multiple
	Emergency Room visits	Multiple
	Rate of hospital readmissions within 7 days and 30 days	Multiple
	Proportion of individuals supported through the HCBS waiver program compared to the total number of persons who receive Medicaid long-term care services	HSRI
<b>Community Integration</b>	Community Tenure	Palsbo
	Percent of consumers who are at imminent risk of nursing home placement who are served with community-based services	FL Aging
	Length of time spent in the community	CARF
	Degree to which consumers experience an increased independence in living	CARF
	Degree to which consumers report housing situation is better	CARF
	Degree to which adults live in residences they own or lease	CARF
	Degree to which a consumer’s housing situations improve as a direct result of	CARF

	service or intervention	
	Rate of member discharge to the community	NQF
	Proportion of people who participate in everyday integrated activities in their community	HSRI
	Proportion of HCBS waiver participants who receive supports in a home of their own	HSRI
<b>Care Coordination</b>	Members identified for case management	ACOVE
	Process to assess and support needs of members in case management	ACOVE
	Member satisfaction with case management	ACOVE
	Proportion of members who can identify person responsible for care coordination across settings.	NHPG
	Proportion of members that report they are easily able to get in touch with their care coordinator/case manager	AXIS
	Frequency of contacts with care coordinator/case manager	AXIS
	Degree to which individual care plans are shared with all care providers as well as the member	NHPG
	Proportion of people reporting that service coordinators help them get what they need	HSRI
	Proportion of people reporting that their care managers are knowledgeable and competent.	HSRI, PACE
	Proportion of people who receive care/assistance from a case manager or care coordinator	IN Medicaid Select
	Proportion of people who feel it is a problem to receive advice/assistance from more than one case manager or care coordinator.	IN Medicaid Select
	Rate of care coordinator turnover	WI Family Care
	Degree to which organization monitors the continuity and coordination of care that members receive and takes action, as necessary, to ensure and improve continuity and coordination of care.	NCQA
	Degree to which consumers found it easy to get someone from Medicaid to help coordinate their care among different providers or services	CAHPS PWMI
<b>Effectiveness of Care</b>	Improvement in pain interfering with activity	NQF
	Improvement in status of surgical wounds	NQF
	Improvement in dyspnea	NQF
	Improvement in urinary incontinence	NQF
	Increase in number of pressure ulcers	NQF
	Emergent care for wound infections, deteriorating wound status	NQF
	Emergent care for hypo/hyperglycemia	NQF
<b>Palliative Care</b>	Proportion of members who have signed advance directives	NHPG
	Proportion of members who have discussed trajectory of disease and treatment options with providers	NHPG
	Proportion of members for whom palliative care was provided in a setting of their choice	NHPG
	Proportion of members for whom a palliative care plan was developed	NHPG

<b>Behavioral Health</b>	Rate of readmission to psychiatric hospitals with 30 days and 180 days	NOMS
	Unduplicated number of persons served by substance abuse programs.	NOMS
	Perceived improvement in functioning	ECHO
	Ability to get mental health services quickly	ECHO
	Degree of functional impairment in service recipients due to substance abuse	CARF
<b>Functional Status</b>	Percentage of members screened to identify impairments in physical and cognitive functioning annually.	NHPG
	Percent of new service recipients whose ADL assessment score has been maintained or improved	FL Aging
	Percent of new service recipients whose IADL assessment score has been maintained or improved	FL Aging
	Improvement in ambulation/locomotion	NQF
	Improvement in bathing	NQF
	Improvement in transferring	NQF
	Improvement in management of oral medications	NQF
	Functional Assessment of ADLs/IADLs	OASIS
	Functional Assessment of ADLs/IADLs/Social Supports/Community Integration/etc	ICF
<b>Medication Management</b>	Percent of consumers who receive drug regimen review at least annually.	ACOVE
	Emergent care for improper medication administration, medication side effects	NQF
	Degree to which health plan has a process to address annual assessment of medication use and misuse, non-compliance with medications, monitoring adverse drug events and polypharmacy, etc.	NHPG
<b>Patient Satisfaction</b>	CAHPS for People with Mobility Impairments	CAHPS
<b>Family/Caregiver Support/Satisfaction</b>	Degree to which providers routinely communicate with family and informal caregivers	NHPG
	Degree to which families/caregivers are included in care planning process consistent with patient preferences	NHPG
	Degree to which health plans/providers provide caregiver education, training and support	NHPG
	Caregiver satisfaction	NHPG, PACE
	Proportion of families who report they are informed about the array of existing and potential resources in a way that is easy to understand	HSRI
	Proportion of families who report that staff are respectful of their choices and decisions	HSRI
	Proportion of families who report that services/supports are available when needed, even in a crisis.	HSRI
	Proportion of families who feel that services and supports have helped them to better care for their family member living at home	HSRI
<b>Care Transitions</b>	Member of health care team communicates with patient within 72 hours of discharge to a new setting	NHPG
	Patient medications reviewed within 24 hours of discharge/transition	NHPG

	Medical Records are transferred within * hours to new setting	NHPG
	Number of enrollees by place of disposition after discharge from skilled nursing facility	MassHealth SCO
	Readmission rate to skilled nursing facility	MassHealth SCO
	Degree to which members feel that their preferences were taken into account in planning health care needs when leaving the hospital	CTM-3
	Degree to which members feel that they had a good understanding of their self-management responsibilities when leaving the hospital	CTM-3
	Degree to which members feel that they clearly understood the purpose of taking each of their medications when leaving the hospital	CTM-3
<b>Access to Care</b>	Convenience of service locations for consumers	CARF
	Convenience of appointment times for consumers	CARF
	Length of time to schedule first appointment	CARF
	Degree to which people identified with physical health problems obtain appropriate services	CARF
	Proportion of persons age 18 and over who receive services compared to the estimated number of adults with a developmental disability in a state's population	HSRI
	Proportion of persons age 18 and over who receive residential services compared to the number who need such services	HSRI
<b>Safety/Nursing Home Eligible</b>	Number of home safety evaluations conducted	NHPG
	Percent of participants reporting they feel safe	CHCS
	Degree to which safety is improved	CARF
	Number of persons age 75 or older and those at risk for falls have been asked at least annually about the occurrence of falls and treated for related risks	NHPG, ACOVE
<b>Self Direction</b>	Degree of consumer involvement in the planning, design, delivery, and evaluation of services	CARF
	Degree of active consumer participation in decisions concerning their treatment	CARF
	Degree to which consumers receive information to make informed choices	CARF
	Degree to which consumers report that staff are sensitive to their cultural, ethnic, or linguistic background	CARF
	Degree to which consumers believe they were respected by staff	CARF
	Degree to which consumer reports that they live in a choice of their choosing	CARF
	Degree to which consumers experience an increased level of social support	CARF
	Degree to which consumers feel they can manager their day-to-day lives	CARF
	Degree to which people are informed about available resources in the community	CARF
	Proportion of people who make choices about their everyday lives including: housing, daily routines, jobs, support staff or providers, and social activities	HSRI
	Proportion of people who control their own budgets	HSRI
	Proportion of individuals who direct their own services	HSRI
<b>Other</b>	Degree to which linguistic accommodations are made	CARF

## Appendix 4: ICP Recommended Measures

Domain	Measure	Definition	Source*	Data Format	Nationally Recognized Measurement Set/ State or Organization Specific Examples
<b>Behavioral Health</b>	Ability to get behavioral health services quickly	<ul style="list-style-type: none"> <li>▪ In the last 12 months did you need counseling of treatment right away?</li> <li>▪ In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted?</li> <li>▪ In the last 12 months, not counting times you needed counseling or treatment right away, did you make any appointments for counseling or treatment?</li> <li>▪ In the last 12 months, not counting times you needed treatment right away, did you make get an appointment for counseling or treatment as soon as you wanted?</li> </ul>	ECHO	Consumer Survey	Nationally Recognized Measurement Set
	Effectiveness of behavioral health services	Rate of readmission to psychiatric hospitals within 30 days and 180 days.	NOMS	Utilization Data	Nationally Recognized Measurement Set
<b>Care Coordination</b>	Effectiveness of care coordination services	Proportion of people reporting that service coordinators help them get what they need.	HSRI	Consumer Survey	Minnesota Disability Health Options
	Effectiveness of care coordination services	Percent of people who feel it is a problem to receive advice/assistance from more than one case manager or care coordinator.	Indiana Medicaid Select	Consumer Survey	Indiana, North Carolina, Arizona
<b>Care Transitions</b>	Quality of preparation for post-hospital care from the patient's perspective	<ul style="list-style-type: none"> <li>▪ The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.</li> <li>▪ When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.</li> <li>▪ When I left the hospital, I clearly understood the purpose for taking each of my medications.</li> </ul>	CTM-3	Consumer Survey	Pilot testing underway in Alaska, Oregon, and Washington.
<b>Functional Status</b>	Rate of consumer functional assessment	Percentage of members screened to identify impairments in physical and cognitive functioning annually.	NHPG	Utilization data	Multiple States and Managed Care Organizations
	Activities of Daily Living/Instrumental Activities of Daily Living	Functional Assessment Tool.	OASIS	Provider Survey	Nationally Recognized Measurement Set

\* For more information on sources of measurement sets, please see Appendix 5.

## Appendix 5: Measurement Sources

Acronym	Measurement Source	Link
ACOVE	Assessing Care of Vulnerable Elders Quality Indicator Library	<a href="http://www.acove.com/QI/Acove.hta">http://www.acove.com/QI/Acove.hta</a>
AHRQ	Agency for Healthcare Research and Quality	<a href="http://www.ahrq.gov">http://www.ahrq.gov</a>
AXIS	AXIS Healthcare Consumer Satisfaction Survey	<a href="http://www.chcs.org/usr_doc/axis_survey.pdf">http://www.chcs.org/usr_doc/axis_survey.pdf</a>
CAHPS PWMI	Consumer Assessment of Healthcare Providers and Systems People with Mobility Impairments Item Set	<a href="http://www.cahps.ahrq.gov/content/products/PWMI/PROD_PWMI_Intro.asp">http://www.cahps.ahrq.gov/content/products/PWMI/PROD_PWMI_Intro.asp</a>
CARF	Commission on Accreditation for Rehabilitation Facilities	<a href="http://www.carf.org/pdf/PerIndMo.pdf">http://www.carf.org/pdf/PerIndMo.pdf</a>
CTM-3	University of Colorado Health Sciences Center's Care Transitions Measures- Core Set	<a href="http://www.caretransitions.org/documents/CTM-3.pdf">http://www.caretransitions.org/documents/CTM-3.pdf</a>
ECHO	Experience of Care and Health Outcomes Survey	<a href="http://www.cahps.ahrq.gov/content/products/ECHO/PROD_ECHO_Intro.asp">http://www.cahps.ahrq.gov/content/products/ECHO/PROD_ECHO_Intro.asp</a>
Fl Aging	Florida State Plan on Aging FY 2005-FY 2006: Performance Measures, Outputs, and Standards	<a href="http://elderaffairs.state.fl.us/english/StatePlan/docs/00.pdf">http://elderaffairs.state.fl.us/english/StatePlan/docs/00.pdf</a>
HEDIS	Health Plan Employer Data Information Set	<a href="http://www.ncqa.org/programs/hedis/">http://www.ncqa.org/programs/hedis/</a>
HOS	Medicare Health Outcomes Survey	<a href="http://www.hosonline.org/surveys/hos/download/HOS_2005_Survey.pdf">http://www.hosonline.org/surveys/hos/download/HOS_2005_Survey.pdf</a>
HSRI	National Core Indicators developed by Health Services Research Institute and the National Association of State Directors of Developmental Disability Services	<a href="http://www.hsri.org/docs/NCI_RevisedPhaseV_Indicators.doc">http://www.hsri.org/docs/NCI_RevisedPhaseV_Indicators.doc</a>
ICF	International Classification of Function	<a href="http://www3.who.int/icf/checklist/icf-checklist.pdf">http://www3.who.int/icf/checklist/icf-checklist.pdf</a>
IN Medicaid Select	Indiana Medicaid Select Performance Measure	<a href="http://www.medicaidselect.com">http://www.medicaidselect.com</a>
MassHealth SCO	MassHealth Senior Care Options Performance Measure	<a href="http://www.mass.gov/masshealth">http://www.mass.gov/masshealth</a> Click on "People Who Need Long-term care" under "Programs and Services"
NCQA	National Committee for Quality Assurance Recommendations for 2007 Accreditation Standards	<a href="http://www.ncqa.com">http://www.ncqa.com</a>
NHPG	Performance Indicators recommended to CMS by National Health Policy Group	<a href="http://www.gmu.edu/departments/chpre/snp-leadership/NHPGOverview.pdf">http://www.gmu.edu/departments/chpre/snp-leadership/NHPGOverview.pdf</a>

NOMS	National Outcomes Measurement Set developed by the Substance Abuse and Mental Health Services Administration (SAMHSA)	<a href="http://www.nationaloutcomemeasures.samhsa.gov/.outcome/index.asp">http://www.nationaloutcomemeasures.samhsa.gov/.outcome/index.asp</a>
NQF	National Quality Forum National Voluntary Consensus Measure for Home Health Care	<a href="http://www.qualityforum.org/docs/home_health/webHHpublic09-23-05.pdf">http://www.qualityforum.org/docs/home_health/webHHpublic09-23-05.pdf</a>
OASIS	Outcome and Assessment Information Set	<a href="http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#">http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#</a> Instrument located in “Part I Appendices/Appendix B”
PACE	Program for All-Inclusive Care for the Elderly Performance Measure	<a href="http://www.cms.hhs.gov/PACE/Downloads/reviewguide.pdf">http://www.cms.hhs.gov/PACE/Downloads/reviewguide.pdf</a>
Palsbo	Indicators/Measures recommended by Margaret Mastal and Susan Palsbo in the CHCS publication “Measuring the Effectiveness of Managed Care for Adults with Disabilities.”	<a href="http://www.chcs.org/usr_doc/CCOMeasures_final.pdf">http://www.chcs.org/usr_doc/CCOMeasures_final.pdf</a>
WI Family Care	Wisconsin Family Care Performance Measure	<a href="http://www.dhfs.state.wi.us/ltcare/">http://www.dhfs.state.wi.us/ltcare/</a>
WI Functional Screen	Wisconsin Functional Assessment Tool	<a href="http://www.dhfs.state.wi.us/LTCare/FunctionalScreen/Index.htm">http://www.dhfs.state.wi.us/LTCare/FunctionalScreen/Index.htm</a>