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Assessing Success in Medicare-Medicaid Integration: A Review of Measurement Strategies

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IN BRIEF

More and more people who are dually eligible for Medicare and Medicaid are enrolling in integrated care programs. While anecdotal evidence of how these programs benefit individuals is emerging, formally quantifying successes may be challenging. This brief details examples of integrated care success stories from health plans participating in *PRIDE (PRomoting Integrated Care for Dual Eligibles)*, a national effort supported by The Commonwealth Fund. It examines the unique program elements behind these successes and the potential for existing measures – as well as measures currently in development – to accurately assess the performance of integrated care programs.

As of November 2015, more than 500,000 individuals dually eligible for Medicare and Medicaid were enrolled in health plans that integrate benefits across the two programs to provide person-centered primary, acute, and behavioral health care, and long-term services and supports (LTSS).[1,2] Enrollment in these plans – Medicare-Medicaid Plans (MMPs) in the capitated model financial alignment demonstrations and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) – that provide highly integrated care will likely rise as states and the federal government continue efforts to enhance quality of care and life, as well as reduce costs, for this often high-need, high-cost population.

Integrated care programs have invested heavily in person-centered assessments, care plans, and care coordination to support dually eligible individuals who often experience significant medical, behavioral health, and social service needs. For example, since the first of 10 capitated financial alignment demonstrations launched in October 2013, the participating MMPs have hired more than 2,500 care coordinators and strengthened their care coordination infrastructures to better serve enrollees.[3] These care coordinators, working as part of newly formed interdisciplinary care teams, are using data from patient assessments to help implement comprehensive, person-centered care plans and connect enrollees to community-based services and supports.

Anecdotal "success stories" are beginning to show that Medicare-Medicaid enrollees are benefiting from integrated care; however, existing measures may not fully capture how these programs are improving people's lives. This brief, made possible through The Commonwealth

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Fund, introduces two success stories illustrating the positive results possible through better alignment of Medicare and Medicaid. It examines the potential of currently available performance measures to capture the "value" of integrated care. States, health plans, and other stakeholders can use this information to refine quality measurement of these programs.

Identifying the "Value" of Integrated Care

Anecdotal evidence from health plans indicates that both MMPs and FIDE SNPs can effectively integrate care and positively affect members' lives. Integrating Medicare and Medicaid services — including primary and acute care, behavioral health services, and LTSS — and aligning policies and procedures helps Medicare-Medicaid enrollees overcome a fragmented delivery system. To add further value, integrated care programs typically include the following components that are usually not found in Medicare-only or Medicaid-only health plans or fee-for-service Medicare or Medicaid: [4]

- Person-centered, accountable primary care;
- Care management and coordination across all benefits and settings of care;
- Comprehensive provider networks to meet the broad needs of the target population;
- Data-sharing and communication across an individual's providers and caregivers; and
- Financial alignment that blends Medicare and Medicaid funding.

The Center for Health Care Strategies (CHCS) asked the health plans participating in *PRomoting Integrated Care for Dual Eligibles* (PRIDE), a national initiative focused on improving care for dually eligible individuals supported by The Commonwealth Fund, to share member successes. Below are two stories – Melissa from the Commonwealth Care Alliance (Massachusetts) and Frank from UCare (Minnesota) – that demonstrate how integrated care programs helped members through comprehensive, person-centered care and support services.

INTEGRATED CARE SUCCESS STORIES*

Melissa

Melissa, age 42, is highly independent and lives in her own apartment, but nearly ended up in a nursing home. To control her diabetes, Melissa, who is blind, needs daily blood sugar checks and insulin injections, which had been handled through nurse visits. Melissa found out, however, that she would have to check her blood sugar and take insulin herself or move into a nursing home. Unfortunately, neither Melissa's physicians nor home care nurses were able to help her learn to do these tasks.

Integrated Care Intervention: Melissa enrolled in the Commonwealth Care Alliance's (CCA) One Care program – Massachusetts' capitated financial alignment demonstration. During an initial in-home assessment, the nurse care manager found out that Melissa could crochet and use a sewing machine. The care manager concluded that if Melissa could do these activities, she could test her blood glucose and administer insulin – she just needed a good teacher. The care manager immediately reduced Melissa's skilled nursing visits to four per week, and the care manager came the other three days with a plan to teach Melissa self-monitoring.

Melissa was already doing much of the glucose monitoring herself. The only thing she could not do was get a drop of blood onto the test strip and insert it into the monitor. The care manager helped Melissa visualize the process and explained things clearly. When Melissa became successful at using the glucometer, they switched to focus on injecting the insulin. On the first day, Melissa put her hands over the care manager's hand while she gave the injection. On the second, the care manager put her hands over Melissa's. On the third day, Melissa did the injection herself, giving her a tremendous boost in confidence and soon she was doing both the injections and glucose monitoring. While she had been told how to do these tasks in the past, no one had encouraged and taught her in the same way as CCA's care manager. As Melissa said, "I think I was scared, because I thought I'd get it wrong. [The care manager] had the patience to talk me through it and hold my hand, so I wasn't scared."

Outcome: Melissa now receives two hours of home health aide visits three times weekly for assistance with personal care and homemaking. She manages her diabetes using a talking glucometer supplied by the Massachusetts Association for the Blind and Visually Impaired. A CCA nurse practitioner visits once a month. With this level of monitoring, several urgent health issues including a urinary tract infection and an episode of cellulitis were identified early and successfully treated without a hospital admission. Melissa continues to live independently and has started teaching a knitting class for her apartment complex.

Frank

Frank, age 65, has total hearing loss in addition to several chronic medical conditions including hypertension, hyperlipidemia, obesity, and bilateral osteoarthritis in his knees. Until recently, he lived with his mother, on whom he relied for meals and transportation. When she suffered health issues and moved to an assisted living facility, Frank had to move into an apartment, but he needed help to remain independent.

Integrated Care Intervention: When Frank enrolled in UCare's FIDE SNP through the Minnesota Senior Health Options program, his care coordinator[5] performed an initial assessment and found that he did not have a primary care physician or dentist and had multiple, unmet chronic health care and dental needs. The care coordinator identified a sign language interpreter, and they worked together to assist Frank. The care coordinator located a clinic near Frank's apartment with a pharmacy, lab, and primary and specialty care onsite. She made Frank an appointment and arranged for a sign language interpreter to accompany him. She also arranged for a dental exam, which he had not had in many years, and helped Frank use his transportation benefits to get to appointments. To better manage Frank's medical conditions, his new primary care physician prescribed several medications. Since taking daily medication was new for Frank, the care coordinator helped him obtain a pillbox to track when to take his medications.

To help Frank stay healthy and safe at home, the care coordinator obtained a TTY phone and flashing smoke detector for his apartment and arranged for daily meal delivery through the state's elderly waiver program. She connected him with county services and resources and arranged for a social worker to check in on a bi-weekly basis.

Outcome: Frank adjusted well to his new apartment and the available social activities have reduced his sense of isolation. He is able to get to his physician and dental appointments using transportation and interpreter services and is comfortable arranging his care using the TTY phone. The care coordinator checks in with Frank to ensure that he makes his quarterly primary care physician appointments for routine lab work.

* Members' names and other identifying details have been changed to protect confidentiality.

Before enrolling in integrated care programs, neither Melissa nor Frank had a care manager or care coordinator to assess their needs or develop a person-centered care plan. In Melissa's case, even if she had a care manager assigned by a Medicaid-only health plan, the care manager would not have had the authority to alter the in-home skilled nursing benefit (a Medicare-covered service) as she did in the integrated care program. Melissa's CCA care manager delivered a short-term, intensive intervention that eliminated the need for daily in-home skilled nursing visits and helped to avoid placement in a long-term care facility.

Similarly, by conducting a comprehensive assessment and developing a person-centered care plan, Frank's care coordinator was able to address the totality of his needs. Because the care coordinator was responsible for coordinating both Medicare and Medicaid services and supports, she was able to help Frank access primary medical and dental care as well as equipment, technology, transportation, and home improvements that allowed him to remain independent.

Assessing Performance Measures for Integrated Care Programs

Melissa's and Frank's stories, although anecdotal, begin to demonstrate the value offered by integrated care programs. Current performance measurement tools, however, may not reliably capture these types of successes. Exhibit 1 lists the measurement tools that FIDE SNPs and MMPs must use to gather performance data.

EXHIBIT 1: **Performance Measures Required for FIDE SNPs and MMPs**

Measurement Tool	Required for FIDE SNPs? [6]	Required for MMPs?[7,8]
Healthcare Effectiveness Data and Information Set (HEDIS)[9]	Yes, select measures	Yes, select measures
Medicare Health Outcomes Survey (HOS)[10]	Yes	Yes, select measures
Medicare Consumer Assessment of Health Plans and Providers Survey (CAHPS)[11]	Yes	Yes, select measures
Financial Alignment Initiative Core Measures[12]	Not applicable	Yes
Structure and Process Data[13]	Yes	Yes, select measures
State Medicaid LTSS Measures	Yes	Not applicable

Effective performance measures should capture the experiences of integrated care program members across four key areas: (1) implementing needs assessments and person-centered care plans; (2) engaging individuals in their care; (3) addressing LTSS needs; and (4) improving quality of life. Following is an "assessment" of the effectiveness of existing and planned measures in each area:

1. **Assessing an individual's needs and developing person-centered care plans.** Both Melissa and Frank benefited from initial assessments that identified their needs across multiple dimensions. The capitated model financial alignment demonstrations include core measures that capture the completion and timeliness of initial assessments and the documentation of care plan goals.[14] FIDE SNPs have state-mandated reporting requirements related to LTSS assessment and care planning processes. Additionally, new

care management accreditation standards for Medicare Advantage and Medicaid managed LTSS plans under development by the National Committee for Quality Assurance (NCQA) for the Centers for Medicare & Medicaid Services (CMS) may capture activities around assessment and care planning.[15] These measures will assess whether: (1) comprehensive assessments are done; (2) patient goals are documented; and (3) care plans are shared across providers.

- ✓ ***Assessment of Measures:*** *Existing and planned performance measures will capture initial assessment and person-centered care planning activities.*

2. **Engaging individuals in their care.** Melissa's care manager creatively engaged Melissa, providing both education and support to guide her in managing her own medications. Although one of the capitated model financial alignment demonstration core measures looks at benefit and service coordination,[16] this measure does not capture the efforts undertaken by Melissa's care manager to build a relationship and work through care plan goals. Current measurement tools used for FIDE SNPs do not address benefit and service coordination, but the new care management accreditation standards for Medicare Advantage and Medicaid managed LTSS plans under development by NCQA,[17] may better address these activities by assessing whether self-identified goals are documented, tracked, and if progress is made toward achieving the goals.

   - ✓ ***Assessment of Measures:*** *Existing performance measures for integrated care programs, particularly FIDE SNPs, do not appear to address activities undertaken to engage individuals in their care; new measures in development by NCQA may better capture these activities.*

3. **Addressing LTSS needs.** Frank needed supports, such as meal delivery, a TTY phone, and a flashing smoke detector, that, while relatively simple for a care coordinator to arrange, would have been much more difficult to obtain outside of an integrated care program. FIDE SNPs report only select information on LTSS needs, and just a few standardized LTSS-related measures are included in the capitated model financial alignment demonstrations, which mostly pertain to nursing facility-based care rather than home- and community-based services.[18] However, some states, such as New York and Ohio use state-specific measures for their demonstrations that assess nursing facility diversion and overall balance of facility-based versus home- and community-based LTSS.[19] NCQA is developing accreditation standards for plans providing LTSS that will address how plans meet beneficiary LTSS needs, coordinate between LTSS and acute care, and oversee the quality of LTSS providers.

   - ✓ ***Assessment of Measures:*** *Existing performance measures for FIDE SNPs and the capitated model financial alignment demonstrations provide a limited view of health plans' abilities to assess and meet members' LTSS needs. Measures in development may better assess how plans provide LTSS.*

4. **Improving quality of life.** Through enrollment in integrated care programs, both Melissa and Frank were able to remain in their own homes rather than move into nursing facilities and, as a result, likely enjoy a higher quality of life.

   ✓ ***ASSESSMENT OF MEASURES:*** *While the ability of an individual to remain in his or her home can be measured through nursing facility admission data, quality of life is not adequately captured by the performance measures currently used for FIDE SNPs or the capitated model financial alignment demonstrations*.

Refining Performance Measures for Integrated Care Programs

It is important for state and federal partners to demonstrate the success of integrated care programs serving dually eligible individuals. As illustrated above, existing performance measures examine many, but not all aspects of integrated care. A number of efforts are underway to develop new measures to fill in the gaps. NCQA's new care management accreditation standards for LTSS plans are one example of this work.[20] The National Quality Forum's (NQF) Measures Application Partnership[21] recently described the development of the National Core Indicators Aging and Disability survey, which will assess the impact of LTSS for seniors and individuals with physical disabilities.[22]

Another effort to establish LTSS performance measures is the Home and Community Based Services Experience of Care Survey, being developed by Truven Health Analytics for CMS, which is designed to: (1) be suitable for individuals with physical, intellectual, cognitive and developmental disabilities; (2) focus on participant experience, not just satisfaction; (3) address dimensions of quality valued by individuals receiving LTSS; and (4) align with existing CAHPS tools. [23]

In addition to work at the national level, several state-specific efforts could lead to promising new measures, including:

- Texas' Delivery System Reform Incentive Package program is using an assessment of functional status for complex chronic conditions;[24]
- Massachusetts' financial alignment demonstration, One Care, is using a state-specific measure of quality of life, and the state's Behavioral Health Partnership, which provides integrated medical and behavioral health care for Medicaid enrollees, includes a measure of 'healthy days' using the World Health Organization's Quality of Life Assessment survey;[25]
- Minnesota's alternative model financial alignment demonstration is combining Medicare and Medicaid CAHPS questions about member involvement in decision making about care and satisfaction with questions about care coordination; and[26]
- Washington State, in its Adult Behavioral Health Performance Measure project, is using the "brief" version of the World Health Organization's Quality of Life survey and its measures of physical, emotional, and social health, as well as autonomy and safety.[27]

In addition, while the following tools are not endorsed by NQF, and not specifically aimed at measuring the performance of integrated care programs, they provide rich data sources for states: Wisconsin's Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES);[28] the Money Follows the Person Quality of Life Survey;[29] and National Core Indicators collected through the Developmental Disability Consumer Survey. Finally, other resources can be found in the Disability Rights Education and Defense Fund/National Senior Citizens Law Center's *Guide for Advocates: Identifying and Selecting Long-Term Services and Supports Outcome Measures*.[30]

Conclusion

As illustrated in this brief, there is anecdotal evidence to show that integrated care programs are benefiting members like Melissa and Frank, both in terms of health status and quality of life. While existing performance measures are able to assess many aspects of integrated care programs, there are opportunities to more fully examine the experience of care and quality of life of the individuals enrolled. Additional measures examining care coordination and care management may be needed to more effectively assess the successes and shortcomings of integrated care programs in achieving desired outcomes.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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ENDNOTES

[1] Integrated Care Resource Center. "Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, November 2014 to November 2015." November 2015. Available at: http://www.chcs.org/media/ICRC-MMP-Enroll-by-State-November-2015.pdf.

[2] Centers for Medicare & Medicaid Services. "SNP Comprehensive Report." November 2015. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2015-11.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending.

[3] Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office. Memorandum to Financial Alignment Demonstration States, July 16, 2015. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAExtensionMemo071615.pdf.

[4] Ibid.

[5] UCare uses the term "care coordinator" rather than "care manager."

[6] Centers for Medicare & Medicaid Services. "SNP Quality." Available at: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNPQuality.html.

[7] For a complete description of the performance measures used in the financial alignment demonstrations, see: Zainulbhai S, Goldberg L, Ng W, and Montgomery A. "Assessing Care Integration for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative." The Commonwealth Fund, March 2014. Available at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/mar/1724_zainulbhai_care_integration_dual_eligibles_ib.pdf.

[8] For the longer-term, CMS is considering a quality ratings strategy for health plans participating in the financial alignment demonstrations based on the star rating system. See: Centers for Medicare & Medicaid Services. "Medicare-Medicaid Plan Quality Ratings Strategy." November 6, 2015. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalMMPQualityRatingsStrategy110615.pdf.

[9] National Committee for Quality Assurance. "HEDIS and Performance Measurement." Available at: http://www.ncqa.org/HEDISQualityMeasurement.aspx.

[10] Centers for Medicare & Medicaid Services and Health Systems Advisory Group. "Medicare Health Outcomes Survey." Available at: http://www.hosonline.org/.

[11] Agency for Health Care Research and Quality. "CAHPS Surveys and Tools to Advance Patient Centered Care." Available at: https://www.cahps.ahrq.gov/.

[12] Lind A. "Quality Measurement in Integrated Care for Medicare-Medicaid Enrollees." Center for Health Care Strategies, January 2013. Available at: http://www.chcs.org/resource/quality-measurement-in-integrated-care-for-medicare-medicaid-enrollees/.

[13] National Committee for Quality Assurance. "Special Needs Plans." Available at: http://www.ncqa.org/Programs/OtherPrograms/SpecialNeedsPlans.aspx.

[14] Zainulbhai, op cit.

[15] The now retired NCQA structure and process measure SNP 1: Complex Care Management contained two elements that reflected the existence of an assessment tool and care plan process, not the completion of an assessment or care plan. See: National Committee for Quality Assurance. "Medicare Special Needs Plans Performance Results: Structure & Process Measures Reporting Year 2012." September 20, 2013. Available at: https://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Downloads/SandP_2012_SNP_Performance-Report_09_20_2013.pdf.

[16] Lind, op cit.

[17] National Committee for Quality Assurance. "Medicare Special Needs Plans Performance Results: Structure & Process Measures Reporting Year 2012." September 20, 2013. Available at: https://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Downloads/SandP_2012_SNP_Performance-Report_09_20_2013.pdf.

[18] Zainulbhai, op cit.

[19] Ibid.

[20] National Committee for Quality Assurance. "Medicare Special Needs Plans Performance Results: Structure & Process Measures Reporting Year 2012." September 20, 2013. Available at: https://www.cms.gov/Medicare/Health-Plans/Medicare-Advantage-Quality-Improvement-Program/Downloads/SandP_2012_SNP_Performance-Report_09_20_2013.pdf.

[21] The Affordable Care Act required the U.S. Department of Health and Human Services to contract with NQF to assist with the development of quality measures. NQF convened the Measure Applications Partnership, a public-private partnership, to provide input through multi-stakeholder groups. For more information see Appendix A in: National Quality Forum, Measure Application Partnership. "2014 Input on Quality Measures for Dual Eligible Beneficiaries." August 2014. Available at: http://www.qualityforum.org/Publications/2014/08/2014_Input_on_Quality_Measures_for_Dual_Eligible_Beneficiaries.aspx.

[22] Ibid.

[23] Hayes Seibert J. "Maximizing Data Quality in HCBS Experience of Care Survey Data Collection Efforts." Truven Health Analytics, February 2015. Available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/downloads/maximizing-data-quality.pdf.

[24] Texas Health and Human Services Commission. "Tools and Guidelines for Regional Healthcare Partnership Participants." Available at: https://www.hhsc.state.tx.us/1115-waiver-guideline.shtml.

[25] World Health Organization. "The World Health Organization Quality of Life (WHOQOL). Available at: http://www.who.int/mental_health/publications/whoqol/en/.

[26] Minnesota Department of Human Services. "Minnesota's Demonstration to Integrate Care for Dual Eligibles." http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_163573.

[27] University of Washington. "World Health Organization Quality of Life Instruments (WHOQOL-BREF)." Available at: http://depts.washington.edu/seaqol/WHOQOL-BREF.

[28] University of Wisconsin, Center for Health Systems Research and Analysis. "Personal Experience Outcomes – Integrated Interview and Evaluation System (PEONIES)." Available at: http://chsra.wisc.edu/peonies/.

[29] Sloan M and Irvin C. "Money Follows the Person Quality of Life Survey. Prepared for Centers for Medicare and Medicaid Services (CMS)." Washington, D.C.: Mathematica Policy Research, Inc., 2007. Available at: http://www.mathematica-mpr.com/~/media/publications/PDFs/health/MFP_QoL_Survey.pdf.

[30] Disability Rights Education and Defense Fund/National Senior Citizens Law Center. "Guide for Advocates: Identifying and Selecting Long-Term Services and Supports Outcome Measures." January 2013. Available at: http://dredf.org/2013-documents/Guide-LTSS-Outcome-Measures.pdf.