

University of Maryland Center on Aging

*Medicare/Medicaid
Integration Project*

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**Collection and Use of Data:
State Operated Managed Care Programs for
Dual Eligibles**

A Technical Assistance Paper of
**The Robert Wood Johnson Foundation
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The Medicare/Medicaid Integration Program

The purpose of The Robert Wood Johnson Foundation Medicare/Medicaid Integration Program (MMIP) is to end the fragmentation of financing, case management, and service delivery that currently exists between Medicare and Medicaid. States will be provided with grant support and technical assistance in their efforts to restructure the way in which they finance and deliver acute and long-term care. Technical assistance will focus on those states that have been awarded grants, but not be limited to grantees. It is recognized that other states and initiatives can benefit from this help. This paper represents one such effort.

The Foundation staff responsible for the program are: Nancy Barrant, Senior Program Officer; James Knickman, Ph.D., Vice President for Research and Evaluation; Pamela Dickson, Program Officer; and Diane Montagne, Program Assistant. The National Program Office (NPO) for the program is based at the University of Maryland Center on Aging under the direction of Mark R. Meiners, Ph.D. The NPO will provide technical assistance and direction for the initiative. Hunter McKay is the Deputy Director for the program.

More information about the MMIP can be obtained from the following locations:

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Executive Summary

As state Medicaid agencies expand their use of managed care, they are increasingly interested in enrolling dual eligibles and those with long term care (LTC) needs. As a result, state and federal policymakers are re-examining their need for information to support program design, program management and ongoing monitoring and evaluation.

Why Collect Data

States uniformly stressed the importance of developing a plan for using data *before beginning data collection efforts*. This enables program managers to either limit collection to data that will be used or prioritize efforts so that limited resources can be devoted to collecting the most useful data first. To aid in the development of that plan, states identified four major reasons for collecting data.

Determining Payment — Program managers, plans and consumers want to make sure that plan payments are neither too high nor too low. If payment is too high the program could fail because it does not adequately contain costs. If payment is too low, the program could fail because either no plan is willing to participate or plans cannot afford adequate care for enrollees.

Consumer Choice of Program and Plan — Program managers, consumers and advocates want to use data to enable beneficiaries to select a plan and delivery system that meets their needs.

Program Management — Program management is the process of ensuring that plans meet the standards states set and that the standards result in the desired outcomes. Programs that serve dual eligibles or integrate acute and LTC are relatively new and few generally accepted performance standards exist. This increases the importance of making sure that the standards actually result in the desired outcome and system improvement.

External Evaluation — Coordinating the program's data collection activities with the needs of any external evaluators at an early stage will save time in the long run and assure a successful evaluation strategy.

Medicaid Data Sources

Understanding what is collected by whom is a first step in developing data systems that allow for program design, monitoring, and research activities examining quality, access and cost.

Complaints/Grievances - Information from complaints and grievances can be used to surface systemic issues that are not (due to limited resources) monitored on a frequent basis. In most

programs, a dual eligible will grieve a plan's decision on a Medicare service to the Medicare system and a Medicaid service to the Medicaid system, making it difficult for either program to get a complete picture of plan performance.

Medical Chart Reviews — Medicaid agencies use medical chart reviews in three ways.

- Plan performance in a specific area can be examined through a sample of charts for enrollees who had certain health events.
- General plan performance can be examined through a sample of charts for a randomly selected group of enrollees.
- Individual charts may be reviewed as part of a complaint/grievance investigation.

Surveys — Consumer and provider surveys can examine satisfaction, provision of care, or program understanding. Surveys of dual eligibles need to accommodate visual and physical impairments.

Utilization — Utilization data provide information about the process used to deliver care and are good predictors of certain outcomes. This data may consist of either a detailed record of each *encounter* an enrollee has with the MCO or *aggregate* data summarizing the overall utilization of an enrolled population. Most Medicaid agencies and many contracted plans do not get data about services provided by Medicare. This makes it difficult for Medicaid agencies to look at how well the delivery system serves dual eligibles.

Care Coordination Tracking Systems — Programs that integrate acute and long term care through care coordination may use systems to track care coordination activities. These systems usually incorporate each enrollee's initial and ongoing assessments, care plan, and social support services. Sometimes they include medical and long term care services information.

Medicare Data Sources

Medicare fee-for-service data includes claims, eligibility, and health assessment data. The claims and eligibility data provide basic demographic and service information. *Medicare managed care plans* may provide encounter data, assessment data, performance measures or satisfaction data, but the availability, consistency and accuracy of the data is mixed.

Section 1876 Risk and Cost-based Plans — Medicare HMOs do not currently provide encounter data, but are now required to do so for some services. Also, all Medicare HMOs must soon begin reporting Medicare-relevant HEDIS performance measures examining effectiveness of care, access to/availability of care, health plan stability, use of services, informed health care choices and health plan descriptive information. Also, the HEDIS functional status measure, Health of Seniors, will be collected from Medicare enrollees. This measure looks at health status over time. Finally, Medicare HMOs must now participate in the Medicare version of the

Consumer Assessments of Health Plans Study (Medicare CAHPs). This study will collect information on beneficiary access, utilization and satisfaction.

PACE (Program of All-inclusive Care for the Elderly) Demonstrations — HCFA has contracted with On Lok PACE (the original PACE site) to develop data collection standards, train all PACE sites in data collection protocols and maintain data for all the sites. Currently, each PACE provider must collect standard data, including: intake, assessment, service utilization and fiscal data. The PACE provider must also maintain complete participant-specific utilization data on-site. While PACE sites contract with Medicare and Medicaid to serve people who are dually eligible, the assessment and other data elements are generic and do not distinguish between Medicaid and Medicare services.

SHMO-I Demonstrations — SHMO-I demonstrations collected both individual and aggregate data. The individual data included: a membership file, a nursing home certifiable file, a comprehensive assessment form file, hospital data, long term care data and health status form data. Aggregate data included membership, case mix, utilization and financial data. The data were used for general reporting, administration and management, and research and evaluation.

SHMO-II Demonstrations — The SHMO-II demonstrations must meet all the encounter data reporting requirements of the Medicare Choice Demonstrations. The Social HMOs must also report HEDIS 3.0 and participate in Medicare CAHPs if they are § 1876 Risk or Cost plans. In addition, a number of assessment forms and protocols have been developed for use in the SHMO-II demonstration sites. An annual survey that includes demographic, IADL and ADL information is administered by a third party. An assessment form is administered once a person has been identified as at risk for services. Finally, geriatric and tracking protocols are part of the overall interventions offered.

Medicare Choices Demonstration — Medicare Choices plans must obtain all clinical information for each health service encounter from their providers and submit encounter records to the Medicare carriers or fiscal intermediary. In addition, Medicare Choices plans that are also § 1876 or Cost plans must report HEDIS 3.0 and participate in Medicare CAHPs.

Medicare Point of Service — In 1995, HCFA developed a Point of Service (POS) option for Medicare risk plans. The POS plan must meet the same data reporting requirements as Medicare risk plans. However, the POS plans must also be able to demonstrate the capacity to manage the POS benefit and its costs. In particular, a POS plan must be able to track who is going out of the plan's network, the types of services received, and the costs of the POS benefit.

Medicaid Agency Experience

The states interviewed for this paper (Arizona, Colorado, Minnesota, Oregon, and Wisconsin) identified five common issues.

Small Numbers of Enrollees — Specialized programs serving dual eligibles or those with LTC needs often have very low enrollment. It is very difficult to produce statistically valid performance measures for small populations. In response, specialized programs emphasize using multiple performance measures and data sources. They also emphasize quality *improvement* since quality improvement does not involve making absolute judgments based solely on reported data, but instead uses data **to** identify and examine areas that need improvement.

Lack of Medicare Information — All of the states expressed a strong preference (due to the relationship between acute and LTC services) for looking at the individual as a “whole person” for program management. Unfortunately, since each of the two systems paying for the services usually has information only about the services it pays for, getting complete information is extremely difficult. Some Medicaid agencies have partially addressed this issue by linking the Medicare and Medicaid claims data. (Note that the linked data still does not include information about services delivered by Medicare managed care plans.)

Reporting Care Coordination Data — Two of the study states developed databases for tracking care coordination activities. These will both help the contractor carry out its duties and the state measure performance.

Utilization Data Validation - Data should be validated before it is used to judge performance. The states reported validating plan utilization data three ways.

- All use a process similar to claims editing. Among other things, this process usually verifies that each record is complete and all codes are valid.
- Two states perform medical chart audits to check for over and under-reporting.
- Two states produce reports that compare plan performance among plans, over time, and between managed care and fee-for-service. Similarly, three states compare data from different sources to detect inconsistencies.

Very Resource Intensive — Although none of the states could provide a firm estimate of resources needed to develop a data system, they generally reported that data collection and use is extremely resource intensive. Even two of the three states that built their data collection system for programs that serve dual eligibles on an existing managed care data collection system reported devoting a high level of resources to this activity.

Emerging Issues

Issues are beginning to appear regarding the collection and use of data.

Confidentiality — As more data is collected and combined in a uniform electronic format the data becomes easier to access. While, for many purposes this is a desirable outcome, if the wrong people gain access it can also do great harm. HCFA, Medicaid agencies and plans already have safeguards in place to protect beneficiary confidentiality. But these may need to be reexamined in light of the creation of new databases.

Need for Compatible and Coordinated Data Collection — Two encounter data reporting systems and data collection systems appear to be emerging: one for Medicaid and one for Medicare. *If these systems are compatible*, they could be used to produce an integrated database containing all the utilization experience of dual eligibles across programs. Of course, the development of an integrated database would require linking state Medicaid data with federal Medicare data, a resource intensive activity. If they are not compatible it will continue to be difficult for either Medicaid or Medicare to gather complete information. Similarly, the growing use of standard data collection instruments (e.g., CAHPS, HEDIS) creates opportunities for coordination. Coordination between Medicaid and Medicare agencies could provide a more complete picture of the care delivered to dual eligibles and maximize resources.

Conclusion

Collecting data is one of the keys to program success. Data is needed for Medicaid agencies to effectively: help beneficiaries select a health plan, help determine plan reimbursement rates, and manage contractors. Programs that enroll dual eligibles or that seek to integrate acute and long term care have even stronger need for data as they are relatively new and must still prove their worth. Unfortunately programs that serve dual eligibles will encounter unique barriers when they seek to collect and use data. Although these tasks will be difficult, there are some promising new developments at the federal level that should help states continue to seek to better care for dual eligibles and others who need both acute and long term care.

Introduction

In recent years both Medicaid and Medicare significantly increased their use of risk-based managed care. In 1994, HCFA estimated that about 7.8 million Medicaid beneficiaries were enrolled in managed care. A National Academy for State Health Policy survey found that this number increased over 50% to about 12-13 million by 1996. During the same two years, the number of Medicare beneficiaries enrolled in TEFRA health plans grew from 2.3 to 4.1 million. Finally, between May 1995 and January 1997 the number of states enrolling older persons, persons with disabilities or both into Medicaid managed care grew from 20 states to 25 states and the District of Columbia.¹ Many members of these populations are dually eligible. (Dual eligibles are people who receive both Medicaid and Medicare.) Specifically, 90-98% of older Medicaid beneficiaries receive Medicare, as do 30-50% of adults with disabilities under age 65.

As Medicaid agencies expand their use of managed care, they are increasingly interested in enrolling dual eligibles. In January 1997, 17 states reported enrolling dual eligibles into managed care and nine reported they were developing such programs.² As a result, policymakers are reexamining their need for information for program design, management and evaluation.

Both the states and the federal government collect and maintain service related information for dual eligibles, but the availability, consistency and reliability of the data varies greatly. States collect and maintain Medicaid fee-for-service claims data; Medicare fiscal intermediaries collect Medicare claims data which is maintained by HCFA. Across states, Medicaid benefits and eligibility criteria differ and reporting and coding conventions vary. Limited encounter information for those in Medicaid or Medicare managed care plans has been collected or used.

With the development of integrated Medicaid/Medicare managed care systems, policymakers are increasingly interested in understanding the clinical and financial interactions of the two programs. This has led to increased interest in using Medicare and Medicaid data in the planning and monitoring of programs for dually eligible beneficiaries. This paper examines:

- Why policymakers, plans and consumers want data about the experiences of dual eligibles in managed care;
- What data is available from both Medicaid and Medicare; and
- What Medicaid agency experience has been in collecting data for programs serving dual eligibles.

¹ Joanne Rawlings Sekunda, *Directory of Risk-Based Programs Serving Older Persons or Persons with Disabilities, Update: January 1997*, (Portland, ME: National Academy for State Health Policy, 1997)

² Ibid. Of the 17 states enrolling dual eligibles, one state (Maryland), ended that practice upon implementation of a new program.

Information Sources

This paper uses three primary sources of information. Two are publications of the National Academy for State Health Policy. The first, *Medicaid Managed Care: A Guide for States, 3rd Edition* edited by Jane Horvath and Neva Kaye, reported the results of a comprehensive survey of all fifty states and the District of Columbia regarding their Medicaid managed care program scope and operations as of June 30, 1996. The second, *The Directory of Risk-Based Medicaid Managed Care Programs Enrolling Elderly Persons or Persons with Disabilities* by Joanne Rawlings-Sekunda, was used to identify the sixteen states that enrolled dual eligibles into risk-based Medicaid managed care programs as of January 1997. Of these sixteen, one state (Iowa) enrolls dually eligible beneficiaries into a non-comprehensive program that provides only mental health and substance abuse programs, while the fifteen remaining enroll dual eligibles into comprehensive programs that provide the full range of acute care, if not LTC.

15 States that Enroll Dual Eligibles into Comprehensive Risk-Based Medicaid Managed Care

Arizona	Georgia	New Jersey	Tennessee
California	Michigan	New York	Utah
Colorado	Minnesota	Oregon	Wisconsin
Florida	Nevada	Pennsylvania	

Finally, to collect more in-depth information about how states that enroll dual eligibles into Medicaid managed care collect and use data, the authors interviewed a number of experts, HCFA representatives, and representatives of five state Medicaid agencies that either enroll dual eligibles or will do so in the near future. The programs and data collection systems in the five states are described in detail later but, a brief description of each program is provided here.

- *Arizona* operates the Arizona Long Term Care Program (ALTCS) which provides Medicaid services to all Medicaid beneficiaries with LTC needs.
- *Colorado* is implementing the Integrated Care and Financing Project. This program is specifically designed to provide both Medicaid and Medicare services to persons who need integrated acute and LTC.
- *Minnesota* operates two programs that serve older persons who are dually eligible.
 - The Prepaid Medical Assistance Program (PMAP) provides Medicaid services to all Medicaid beneficiaries except those who are eligible for Medicaid due to receipt of SSI and are under age 65.
 - The Minnesota Senior Health Options (MSHO) Program provides both Medicare and Medicaid services to dual eligibles over age 65.

- *Oregon* operates a program that provides Medicaid services (except skilled nursing home services for non-Medicare enrollees beyond 30 days) to enrollees. This program offers a risk-based option for all Medicaid eligibles.
- *Wisconsin* operates three programs that serve dual eligibles.
 - The Independent Care (I Care) program provides Medicaid services to people over the age of 15 who live in Milwaukee County and are eligible for Medicaid due to receipt of SSI.
 - The Partnership provides Medicaid services to older Medicaid eligibles who live in Dane and Milwaukee County, as well as, to persons with disabilities who live in Dane County.
 - Wisconsin also operates a PACE (Program of All-inclusive Care for the Elderly) that serves frail elderly persons.

Why Collect Data

Four of the five study states (all except Minnesota) indicated that collecting and using data is an extremely resource intensive process. Even states with existing managed care data collection systems generally found that a great amount of resources was needed to modify the existing system to accommodate new specialized programs, such as programs that serve dual eligibles. Therefore, all study states stressed the importance of developing a plan for using data, *before beginning data collection efforts*. Developing a plan enables state program managers to either limit data collection to data that will be used or prioritize efforts so that limited resources can be devoted to collecting the most useful data first. The first step in developing a plan is to determine the purpose of data collection.

Everyone wants data for one primary reason - *to evaluate program and plan performance*. However, the reasons for wanting that evaluation vary both among and within groups. For example, consumers want this information to help them select the plan or program that best meets their needs. While, program managers want this information to help them select and manage their contractors. Also, data is only truly useful after being turned into information. Collecting data does not, of itself, tell anyone very much about program or plan performance. However, when data is analyzed to, for example, compare the rates of hospitalization due to hypertension among plan enrollees, that data begins to become useful.

This section will both discuss the reasons for collecting data and introduce some specific considerations for programs that serve dual eligibles or integrate acute and LTC. The four reasons for collecting data discussed here are:

- Determining payment
- Consumer choice of program and plan
- Program management
- External evaluation

Determining Payment

Program managers, plans and consumers want to make sure that plans receive payments that are neither too high nor too low. If the payment is too high the program could ultimately fail because it does not contain costs. On the other hand, if payment is too low, the program could fail because either no plan is willing to participate or because plans are unable to afford to adequately care for enrollees. Data plays a key role in determining whether plan payments are appropriate. Also, programs that serve dual eligibles provide contractors with inherent opportunities to shift costs between Medicare and Medicaid. Data is needed to find out whether cost-shifting actually occurs and to help develop means for preventing it.

Capitation payments are the prospective per person per month payments health plans receive in return for providing all covered services to enrollees. Program managers need data to help calculate an appropriate rate, while plans need data to help them calculate how much it will cost to serve enrollees. Medicaid and Medicare payments are usually based on the average per person per month cost to the fee-for-service program of caring for a beneficiary who will be eligible to enroll in the program.

Because the cost of serving an individual dual eligible can vary greatly from the cost of serving the average dual eligible, a number of states are using or considering risk adjusted capitation that adjusts for the frailty and/or health status of individuals. A number of Medicare demonstrations (e.g., Social HMO (SHMO)-H and Medicare+Choices) are also testing risk adjusted capitation. Risk adjustors are typically based either on claims/encounter data or survey/enrollment data. Under the Balanced Budget Act of 1997 (BBA), the Medicare capitation rates paid to Medicare+Choices plans must be risk adjusted for health status by the year 2000. Obviously, program managers need data to calculate the fee-for-service cost and develop risk-adjustors.³

³ Although technical advice for calculating rates for dual eligibles or the populations most likely to need LTC is beyond the scope of this publication there are a number of publications available to those interested in these subjects. One that contains a good discussion of these issues as they apply specifically to programs serving dual eligibles is: Maureen Booth, et al. *Integration of Acute and Long Term Care for Dually Eligible Beneficiaries through Managed Care*, (College Park, MD: University of Maryland, 1997).

In addition to capitation payments, some plans receive risk-sharing payments from either Medicaid or Medicare. These agencies will frequently enter into risk-sharing agreements with plans that serve populations with complex needs, such as dual eligibles, because of the significant variation in cost among individual members of these populations. Risk-sharing gives agencies and plans greater confidence that if the cost of serving those enrolled in the plan does not match the cost of serving those eligible to enroll in the plan, neither the plan nor the agency will suffer financially. There are several types of risk-sharing.⁴

In **stop loss/reinsurance** the plan is usually responsible for an individual enrollee's care until total costs for that individual exceed a pre-determined threshold (\$50,000 for example). After that point the entity sponsoring the stop loss becomes responsible for the cost of caring for the individual.

Risk corridors protect both the plan and the Medicaid or Medicare agency from financial risk on an aggregate basis. In a simple example of this approach, the plan and the agency split any loss or profit that exceeds 25% of revenue from capitation payments on a fifty/fifty basis. In order to create appropriate incentives most agreements have multiple corridors that share profit and loss in different proportions depending on the amount.

Risk pools are typically used to provide plans with protection against adverse selection relative to other contractors. Oregon, for example, uses this approach to accommodate an unequal distribution of pregnant women (and the resulting cost of delivery) in health plans. This State retains a small portion of each capitation payment made to plans during the year, which becomes the 'pool'. At the end of the year the State determines the number of births to Medicaid beneficiaries under each plan. Then the state distributes the money in the 'pool' to plans in proportion to their percent of total Medicaid births.

Medicaid agencies that enter into risk-sharing agreements will need data to calculate the risk-sharing payment. In addition, these states may need utilization data to help them decide if they are paying a fair overall price and to determine if both Medicaid and Medicare continue to pay their "fair share" of the total cost of caring for enrolled dual eligibles.

Another issue that impacts the use of data for calculating payments for dual eligibles is that (as will be discussed in more detail later in this paper) Medicaid agencies do not have complete information about Medicare services provided to dual eligibles. Medicaid agencies can calculate payments without Medicare information. However, the lack of information can increase the difficulty of determining the impact of the program on the overall cost of serving dual eligible enrollees - an issue of concern to both Medicaid and Medicare agencies.

⁴ Again, a technical discussion of risk-sharing is beyond the scope of this paper. For more information please refer to the previously mentioned publication: *Integration of Accute and Long Term Care of Dually Eligible Beneficiaries through Manged Care*. In addition a more general discussion of risk-sharing is presented in: Neva Kaye and Jane Horvath, "Limiting Financial Risk," *Medicaid Managed Care: A Guide for State, 2nd Edition*, (Portland, ME: National Academy for State Health Policy, 1995) vol. III, chap. 3.

Consumer Choice of Program and Plan

Program managers, consumers and advocates are all interested in using data to help beneficiaries select a plan and delivery system that meets the individual's needs. Although enrollment into *Medicare* managed care plans is voluntary, some states require dually eligible beneficiaries to enroll into *Medicaid* managed care plans in order to receive Medicaid services. Of the fifteen states that now enroll dual eligibles into comprehensive risk-based Medicaid managed care:

- six mandate enrollment into comprehensive risk-based managed care;
- two mandate enrollment into managed care, but allow beneficiaries a choice between risk-based and non risk-based managed care programs; and
- ten allow dually eligible beneficiaries to choose between fee-for-service and risk-based managed care.⁵

In the six states that mandate enrollment into comprehensive risk-based managed care, dually eligible consumers need to select a health plan. In addition, in the twelve states that allow dually eligible beneficiaries a choice of delivery systems (fee-for-service and managed care or two types of managed care) beneficiaries need to choose a delivery system. If consumers enroll in a plan that meets their needs they are more likely to be satisfied and thus less likely to complain or seek disenrollment from the plan or program. Because they usually have complex health care needs and are more likely to need long term care, selecting a plan and/or delivery system is a particularly important decision for older persons and persons with disabilities - the two Medicaid eligibility groups to which almost all dual eligibles belong.

Several studies found that when people choose among competing health plans they are most likely to compare plans on service package, enrollee share of payment, and access to current providers. In addition, beneficiaries may want to know how easy it will be to access care within the plan. Therefore, beneficiaries will be interested in plan performance on access measures (e.g. average waiting time for appointments). Also, those with specific health conditions could use information comparing plan performance in treating those conditions. Providing pertinent information to dual eligibles presents a particular challenge as their needs vary greatly among individuals and over time.

Currently, most states report providing only information about service package, enrollee cost-share, and provider network to beneficiaries during the plan selection process. However, there is growing interest among states in providing plan performance information. The BBA will encourage such efforts as it requires states to provide information on plan performance "to the extent available." Information states could provide includes: enrollee utilization, access and

⁵Some states operate both mandatory and voluntary programs. This data taken from: Rawlings-Sekunda, *Risk-Based Directory*, 1997.

health outcome measures, as well as, grievance and complaint information. Due to the complex health needs of many dual eligibles they will probably be more concerned than other beneficiaries about issues such as access to specialists, ability to stay with their own physician and access to durable medical equipment. Providing this information in a meaningful way is a great challenge to Medicaid agencies. The information provided should vary among plans.⁶ The information should also be pertinent to enrollee needs, easy to understand, difficult to misinterpret and a measure that plans can impact. Many of these are difficult requirements to meet.

States are increasingly relying on nationally recognized data collection instruments such as HEDIS.⁷ They may be valuable for plan selection purposes (at least to the extent the measures address the specific concerns of individual dual eligibles) because the measures they include have been developed by consensus between states, employers, plans, and advocates and have been found to meet the requirements of "varying among plans" and "a measure that plans can impact." Using these instruments allows state staff to focus on data collection and validation efforts and deciding how to best present the information.⁸

Of special concern to potential enrollees of programs specifically designed to integrate acute and LTC is the ability to assess how well each plan performs in both areas of service and how well the plan manages the interface between the two. National performance measure sets, such as HEDIS, usually focus on measuring acute and preventive care. Few measures are available for LTC and even fewer are available for measuring coordination between services. Appendix A is a compilation of existing and emerging performance measures for programs serving older persons and persons with disabilities, as of September 1996. In addition, Appendix B contains contract language defining the quality indicators Wisconsin will collect from the I Care program in 1998; some of the "preventable hospitalization indicators," such as "dehydrations" and nutritional deficiencies" may be of particular interest. Finally, Appendix C contains Colorado's proposed measures.

As previously mentioned, to be most useful, the data presented to enrollees must be pertinent to the enrollee's needs and presented in an easy-to-understand format. Given the complex and varying needs of dual eligibles and those requiring both acute and LTC, most programs

⁶ Medicaid Agencies need to collect the same information from each plan to allow comparison, if all plans score the same on a specific measure that information will not help beneficiaries distinguish among plans.

⁷ The Health Plan Employer Data Information Set (HEDIS) is a comprehensive set of health plan performance measures. It includes quality, utilization, financial and membership measures, among others. The latest version (HEDIS 3.0) contains measures appropriate to commercial, Medicaid, and Medicare populations.

⁸ For more information on enrollment and disenrollment in Medicaid managed care, please refer to: Neva Kaye, "Protecting Consumers," *Medicaid Managed Care: A Guide for States 3rd Edition*, (Portland, ME: National Academy for State Health Policy, 1997), vol. II, ch. 3. Also, please refer to Jane Horvath and Neva Kaye, *Enrollment and Disenrollment in Medicaid Managed Care*, (Portland, ME: National Academy for State Health Policy, 1996).

specifically designed to serve these groups rely on face-to-face contact during some part of the enrollment process. This allows the person conducting the enrollment to determine individual needs and present information pertinent to those needs.

Even when enrollment includes a face-to-face encounter, written materials are still important aids to providing information to potential enrollees. Although all of the states interviewed for this project reported that they were still developing written materials that effectively transmit plan performance information to enrollees, they all agreed that information was most effective if presented in a simple (no higher than sixth grade reading level), easy-to-read format.⁹

A final note about written information for dual eligibles. Many elderly persons have vision problems. Given that the majority of dual eligibles are elderly persons, states may need to develop large print materials and use graphics with sharp contrasts.

Program and Plan Management

The most frequently cited reason for collecting data in programs that serve dual eligibles is program management. Program management is the process of ensuring that plans meet the standards states set *and* that those standards result in the desired outcomes. The goal of program management is to not only ensure that plans deliver appropriate care to enrolled beneficiaries, but to continually improve the delivery system. Programs that serve dual eligibles or integrate acute and LTC are relatively new. Few generally accepted performance standards exist. This situation increases the importance of focusing program management on making sure that the standards actually result in the desired outcome and system improvement.

The Medicaid managed care delivery system includes plans, enrollees, providers and the Medicaid agency. System operations are laid out in the contract (and subcontracts), the purchasing documents, and other communications between these parties and their representatives. These are all developed in an attempt to turn program goals into performance measures that all parties agree to meet.

⁹ A few studies have examined how to transmit performance information to beneficiaries. Two of particular interest are:

- Lauren A. McCormack, M.S.P.H., et al., “Consumer Information Development and Use,” *Health Care Financing Review*, Fall 1996. This article reports the results of a HCFA funded project that specifically examined effective ways to provide plan performance information.
- Sue Plimpton, *Write It Easy-to-Read, A Guide to Creating Plain English Materials*, (Biddeford, ME: University of New England Health Literacy Center, 1997). The publication provides readers with a conceptual framework for developing materials and exercises that help illustrate its points. Although not specific to performance measures, it does provide good information about ways to make any type of written material easier to read and understand.

Unfortunately, this process does not guarantee that the program will reach its goals. System failure can occur in two areas: (1) the parties do not perform as agreed; and (2) the agreed to performance does not achieve the intended goals. As a result a state needs to build into its system means for: (1) identifying when the delivery system is not achieving its goals; (2) determining why the system is not doing so; and (3) correcting the system (including the means to verify if the correction worked).¹⁰ Data plays a role in all three aspects of program management.

There are many sources of data states can use to identify when the delivery system may not be achieving its goals and to examine potential problem areas to find the cause of the apparent poor performance. These include: utilization and other information provided by plans, complaints and grievances submitted by enrollees and their representatives, discussion with and feedback from consumers and other stakeholders, enrollment and disenrollment information maintained by the Medicaid agency or its contractor, fee-for-service utilization information, medical chart reviews, and other sources outside the managed care system such as birth and death certificates. (These will be discussed in more detail later in this paper.)

Each of these sources produce information that can be used to measure different aspects of program and plan performance. Some, such as grievances, may provide information that is immediately applicable to program management while others, such as utilization, may not provide useful information until enough services have been provided that patterns form. This last point may be a particular concern for programs that serve dual eligibles as the number of enrollees is likely to be small.

Planning for Using Data in Program Management

Program managers will want to develop a plan for using data to identify when the program is not meeting its goals - one that can quickly identify situations in which harm is being done *and* measure progress toward long-term goals. For example, individual grievances may sometimes identify where a health plan is not meeting contract standards, such as lack of adequate homecare services. An annual assessment of the need for and provision of home-care services might better track system performance as a whole. This plan identifies the data program managers want the health plan to regularly produce and the data they want only upon request. Program managers will want their health plan contract to support the data collection plan by-specifying the data the health plan is to provide and the time frame for providing the data (including the maximum time for producing "as-needed" data).

When developing plans for using data, program managers need to consider available resources, the relative importance of program goals, the availability of measures that address these goals, and the time it takes for actions to create measurable changes in performance. Finally, because of the great variety of data, program managers will probably want to work with their data

¹⁰ For more information regarding contractor management, please refer to Neva Kaye, "Contractor Management" *Medicaid Managed Care: A Guide for States*, (Portland, ME: National Academy for State Health Policy, 1997), vol. II chap. 4.

processing staff to create means of more easily identifying system variances. Examples of simple systems of this type include reports that mark individual plan utilization rates that are more than 15% from average or call-tracking systems for enrollee hotlines that identify the ten most often asked questions about each health plan.

Three data issues arise for Medicaid agencies when preparing a plan for using data to manage programs that integrate acute and LTC or serve dual eligibles. (These will be discussed in more detail later in this paper.) First, as previously discussed, dual eligibles are more likely to have LTC, as well as acute and preventive care needs. If program managers are to fully assess a plan's performance they need to measure all three aspects of care. Additionally, managers of programs that integrate acute and LTC will want measures that assess how well the-different types of care are integrated.

The second issue concerns the size of the plan's enrollment. Most programs specifically designed to serve people with complex needs, including dual eligibles, have a small number of enrollees. In small populations, a few events can greatly affect the rates typically used to compare plan performance. Most of these specialized plans have fewer than 1,000 enrollees and many have fewer than 500. For example, Wisconsin's I Care program, one of the largest specialized programs, had 3,178 enrollees as of December 1997 and the Partnership Program has less than 250. In these plans, program managers should be particularly careful to completely examine apparent areas of poor performance before acting on their judgment.

Finally, as previously discussed, Medicaid programs do not receive comprehensive information about Medicare services provided to enrolled dual eligibles, unless the beneficiary receives the Medicare services from the Medicaid health plan. Without the Medicare data, Medicaid agencies cannot assess the over-all provision of care. Similarly, Medicare does not have information about Medicaid services and so is also unable to fully assess plan performance.

Program Evaluation and Research

Many managed care programs for dual eligible beneficiaries are § 1115 demonstration programs under HCFA waiver authority. As a result, many of the programs have been or will be evaluated by outside evaluators. Ideally the data collected for program management and monitoring could also be used for evaluating the impact of the program. However, the data collection needs for program management often differ from the data needs for external evaluation. For example, program managers may be able to use aggregate data to monitor utilization experience whereas evaluators may want more detailed data. Furthermore, to the extent special data collection instruments are developed for the demonstration, evaluators may need to collect similar

information from a control group. Assuring that the data collection instruments are reliable and properly field tested will be important in the design of the evaluation. Coordinating the data collection activities of the program with the needs of the external evaluators at an early stage will save time in the long run and assure a successful evaluation.

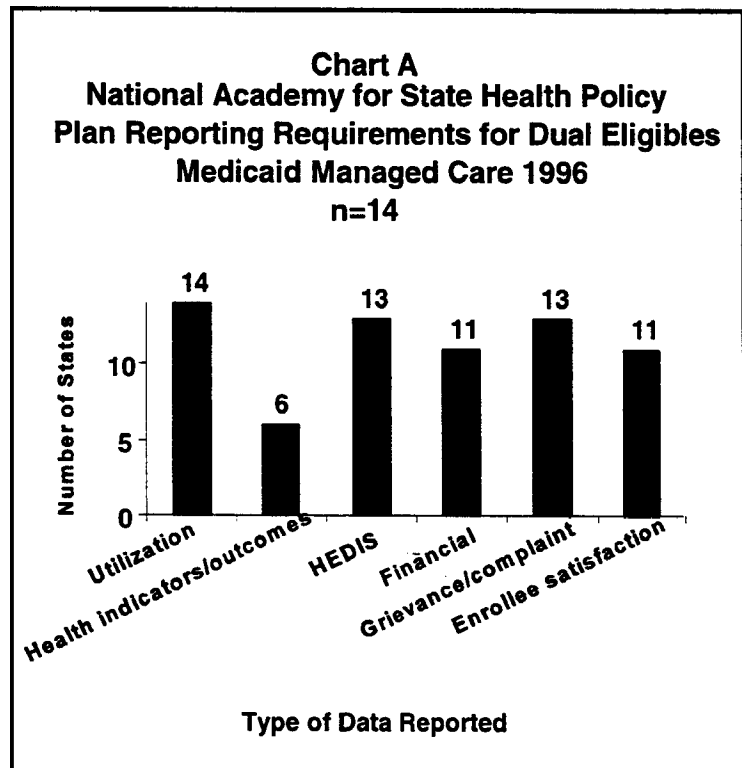
Medicaid Data Sources

Understanding what data is collected by whom is a first step toward developing data systems that support program design, monitoring, and research examining quality, access and cost. This section discusses the most frequently used Medicaid sources, identified in Chart A¹¹. (The next section discusses Medicare sources.)

Complaints/Grievance

Although the primary purpose of complaint and grievance procedures is to resolve individual enrollee or provider complaints,

most program managers also cite the usefulness of these procedures in identifying issues that need further investigation. In particular, complaints and grievances may surface issues that are not (due to limited resources) monitored on a frequent basis. For example, most Medicaid agencies review network adequacy during the contractor selection process, which occurs every 1-2 years. A pattern of enrollee complaints about an inability to see a particular type of trigger an interim review to ensure with network adequacy standards. (This review might, in turn, lead to tightening those standards during the



¹¹ The charts in this section show program status as of June 30, 1996 for the 14 states that enrolled dual eligibles into comprehensive Medicaid managed care programs as of that date. These are the same states identified previously, except Pennsylvania is excluded because it had not yet begun enrollment in its new program as of June 30. Policy information is from the 3rd edition of *Medicaid Managed Care: A Guide for States*.

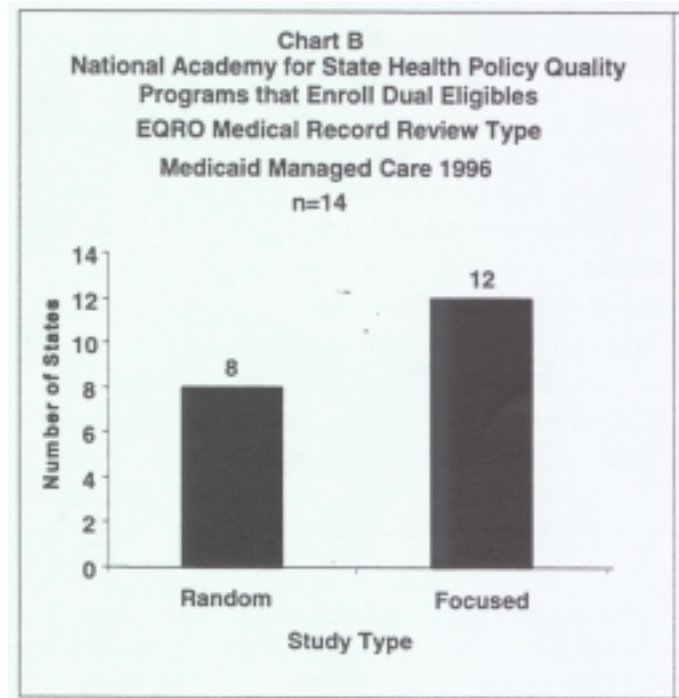
next contractor selection process.) Program managers will want to exercise caution when using this information - not every complaint points to a systemic problem, or even any problem at all.

Most Medicaid agencies require plans to keep logs of complaints and grievances for agency review. Some agencies require the plans to submit the logs for review on a quarterly or annual basis. Others simply require that the plan make the logs available upon request. In either case, program managers specify the items of information a complaint log must include. Some Medicaid agencies require plans to forward copies of all grievances they receive to the agency upon receipt. Others require plans to forward copies on a quarterly or annual basis. In addition to looking for patterns that might require further investigation most Medicaid agencies review this information to ensure that plans meet response timelines and correctly adjudicate issues. Also, most agencies require plans to use this information in their internal quality systems.

In most programs that serve dual eligibles, an individual who wishes to grieve will use the Medicare system for Medicare services and the Medicaid system for Medicaid services. This situation can be confusing for the enrollee who may not be certain of which system to use. From a program management standpoint this means that, frequently, neither Medicare nor Medicaid has a complete picture of plan performance. Of the five case study states, only Minnesota has resolved this issue. Minnesota created a combined Medicare/Medicaid complaint and grievance system. Under its federal waiver this state acts as HCFA's agent to process all complaints and grievances. Short of a combined system, state Medicaid agencies could work with HCFA to develop a method for sharing grievance information.

Medical Chart Reviews

State Medicaid agencies use medical chart reviews extensively as a source of data on plan performance. These reviews may be performed by the state's external quality review organization (EQRO) or the Medicaid agency itself. Medicaid agencies use medical chart reviews in three ways. (1) A sample of charts documenting the care provided to enrollees who had certain health events can provide data about overall plan performance in areas of particular interest. (These are usually referred to as focused reviews.) (2) A random sample of charts can provide data about plan provision of care in general and identify areas that might need more intensive

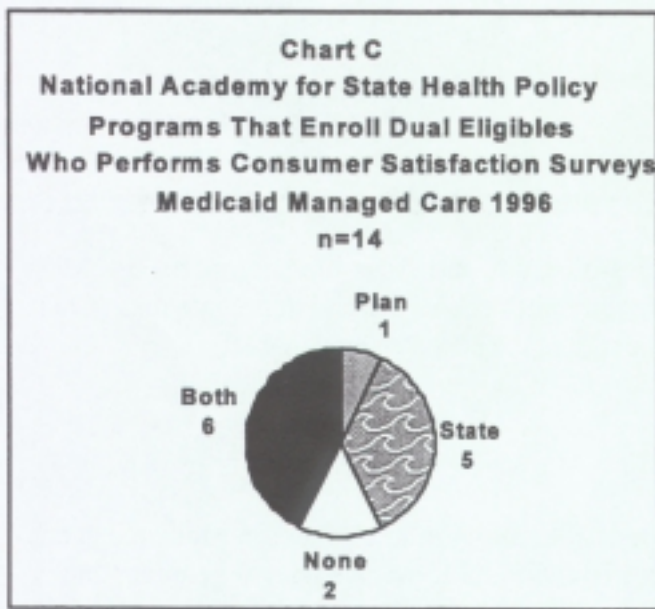


examination. (These are usually called random reviews.) (3) Individual charts may be reviewed not as part of a sample to analyze overall plan performance, but as part of the investigation into an individual's complaint or grievance. Most programs that enroll dual eligibles use both focused and random medical chart reviews (Chart B). All three reviews can also be used to validate plan utilization and health outcome reporting.

Issues that Medicaid and other agencies may encounter in performing reviews include: providers use different record formats so reviewers may miss information (particularly immunizations) if they are not careful or do not discuss procedures with office staff; some records may be in use on the date of the visit and thus not available for review; and depending on the service (e.g., personal care) not all information may be kept in the primary care provider's record. Medicaid agencies that wish to conduct medical record reviews are also advised to specify their right to access or require the plan to produce copies of the records (including response time) in their contract and ensure that these requirements are also specified in the plan's contracts with providers.

Surveys

States and plans may survey both providers and enrollees (Chart C). Surveys may examine satisfaction, provision of care (e.g., waiting times for appointments or choice of home health provider), and system understanding (e.g., knowledge of how to access pharmacy services). Surveys may be conducted through the mail, over the telephone or in person. Mail surveys tend to be the least labor-intensive, but have the lowest response rate. Also, short surveys with simple questions are more likely to be returned — especially if provisions are made for non-English speaking enrollees and those with vision problems. Providing multiple choice responses makes tabulation easier and more consistent, but may fail to capture responses that



do not exactly fit the choices. Open-ended questions are more difficult to analyze numerically but will capture information multiple choice questions might miss. All of these factors combine to mean that states need to first think through the purpose of a survey and then design a survey that will meet that purpose.

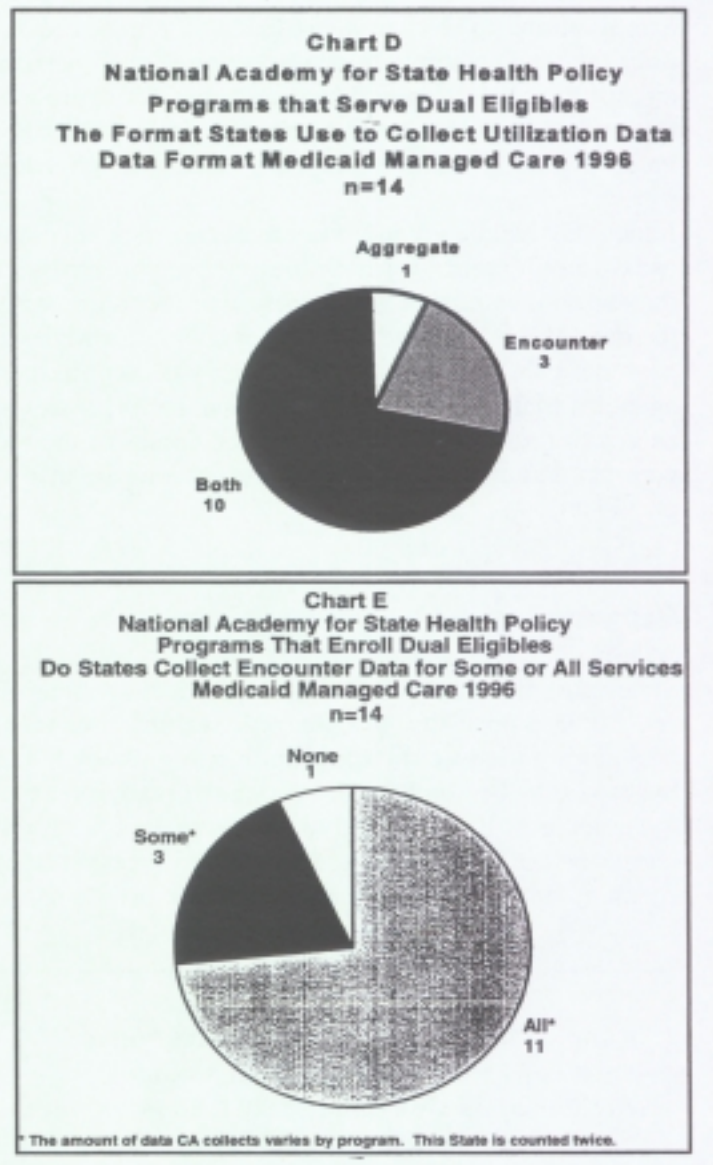
Most dual eligibles are older persons or persons with disabilities, so surveys of dual eligibles need to accommodate visual and physical impairments. Medicaid agencies may wish to consider providing

copies of surveys in large print or black print on yellow background to make them easier for dual eligibles with vision impairments to read. Piloting proposed surveys ensures that they are easily understood by dually eligible enrollees. Finally, Medicaid agencies should consider conducting at least some surveys in-person or over the phone as a means of accommodating potential impairments.

Utilization

Utilization data provide some of the best information about the process used to deliver care and are good predictors of certain outcomes. *Encounter data* provide the same level of detail as claims data (which provider delivered which service to an individual, on what date, to treat what condition).

Aggregate utilization data are counts of particular services provided to individuals or the number of individuals who received particular services. For example, Wisconsin requires its I Care provider to supply both the number of hospitalizations with a primary diagnosis of diabetes the contractor provided during the calendar year and the number of people who were hospitalized with that diagnosis. Medicaid agencies can use both encounter and aggregate utilization data to produce rates that allow cross-plan, cross-program, and cross-time comparisons. Most states with programs that serve dual eligibles require both encounter and aggregate data (Chart D). Most states that collect encounter data collect data for all services (Chart E).



Encounter Data

Of the two formats, encounter data allows the most flexibility in analysis. If a Medicaid agency decides, even years later, that a specific measure is important it may be able to generate that measure from encounter data. Encounter data also offers the state the best means of tracking

services provided to individuals across plans and programs. Unfortunately producing accurate encounter data is technically difficult and can take years. These technical difficulties can result in states and plans spending much time discussing, "Do the rates calculated from encounter data reflect actual utilization?" rather than, "Does the plan provide adequate service?"

The 2nd edition of *Medicaid Managed Care: A Guide for States* explains these technical issues in more detail.¹² However, to summarize, most of the problems are due to differences in data processing systems and codes. Although national standard coding exists for most procedures and diagnosis, there are no such standards for: provider and enrollee identifiers, some procedure codes, provider type codes, place of service codes, etc. Also, the use of global codes¹³ limits the usefulness of some encounter data. Language in the Health Insurance Portability and Accountability Act of 1997 (HIPAA) calls for establishing national unique individual, plan and provider identifiers. Once these are in place, it will be easier for states to collect encounter data.

Aggregate Data

Requiring the plans to calculate their own numbers eliminates much of the discussion about whether utilization rates reflect the actual provision of services and allows Medicaid agencies to more quickly move the discussion to actual plan and program performance. Of course, agencies that rely on aggregate data need to verify that the plans are submitting accurate rates. Wisconsin has a well-developed verification system that relies on the plans submitting more detailed information about the provision of selected services- at least enough information to identify medical records for examination.

The major drawback to aggregate reporting is its lack of flexibility and its inability to track care delivered to an individual across plans and programs. Medicaid agencies relying on aggregate reporting will want to identify the full range of measures they will need from the plan, because if they do not specify the need for a particular measure during the reporting year that agency may be unable to require plans to provide the measure - at least during the current contract period.

As previously discussed, most Medicaid agencies and their plans do not get data about services provided by Medicare, particularly if the dual eligible is enrolled in a Medicare managed care

¹² Nelda McCall, "Collection and Use of Encounter Data in a Capitated Managed Care Program," *Medicaid Managed Care: A Guide for States, 2nd Edition*, (Portland, ME: The National Academy for State Health Policy, 1995), vol. IV, chap. 5.

¹³ Global codes are used by many Medicaid agencies and insurance companies to indicate when a provider has delivered a package of services. For example, a provider may submit a report with one code indicating that it delivered prenatal, postnatal, and delivery services to a woman. In this case the encounter data could not be used to determine either how many prenatal visits the woman had or when these visits occurred.

plan that is not the individual's Medicaid plan. Lack of the Medicare information makes it difficult for Medicaid agencies to look at how well the delivery system serves the individual dual eligible, as well as the population of dual eligibles.

Care Coordination Tracking Systems

Programs that integrate acute and long term care through care coordination may have another source of data. Two case study states (Colorado and Wisconsin) are developing systems to be used by care coordinators to track coordination activities. Such databases usually include the enrollee's initial and ongoing assessments, care plan, and social support. Some also incorporate data about the medical and long term care services enrollees receive. Although these systems are not designed to provide data for program managers both states report that they expect their systems to be a rich source of data regarding plan performance.

Medicare Data Sources

This section identifies the types of Medicare data currently collected (in fee-for-service and in managed care) and how HCFA uses or plans to use the data. This section also discusses some of the new requirements under the BBA for collection of encounter data and their implications.

Fee-For-Service

The Medicare fee-for-service system collects claims and eligibility data, as well as health assessment data.

Claims and Eligibility Data

For a Medicare service provided to a beneficiary in the fee-for-service system, a provider submits a claim for payment to a fiscal intermediary. The intermediary then posts the claim information to a HCFA common working file (the Nearline File) where it is edited and adjudicated for final payment. After final adjudication, the claims become part of a standard analytic file managed by HCFA. This claim information is maintained for a variety of different claim types (e.g., inpatient, outpatient, SNF, home health) and includes detailed information regarding payments, units of service, diagnoses, procedure codes and type of provider. In addition, HCFA maintains beneficiary and demographic information (including whether a person is dually eligible and/or enrolled in a managed care plan) on its enrollment and eligibility files. - Other files have also been constructed from the claims and enrollment data for special purposes (e.g., the MEDPAR file, Provider and Physician summary files). These files

are available for use from HCFA.

Historically, HCFA used Medicare claim and beneficiary information in utilization review, establishment of Medicare payment rates (e.g., the Physician Resource Based Relative Value Scale), development of risk adjustment methods, research and evaluation, and special studies. More recently, some states and HCFA have begun to link Medicare and Medicaid claims data for program planning, research and evaluation purposes. For example, HCFA recently contracted with Mathematica Policy Research to design and test a database on dually eligible beneficiaries and use the linked data to test risk adjusters and study the interaction of the Medicaid and Medicare programs. (State use of the linked data is discussed later in this paper.)

Assessment Data

Uniform assessments are currently conducted for all residents of nursing facilities (regardless of payer source) using the Minimum Data Set (MDS). Rules have been proposed for the use of a standardized assessment (the OASIS) for those seeking Medicare and Medicaid home health care. Following is a brief description of each of the assessment instruments and their uses. Although many of the data components on the two assessments are similar, the exact language and definitions of items are not comparable.

Minimum Data Set (MDS) for Nursing Facilities

The use of a uniform assessment (MDS) is required in all nursing facilities for all residents (Medicare, Medicaid and private residents). This assessment includes socio-demographic information, diagnoses, ADL functioning, and cognitive status. At a minimum, this assessment is completed upon admission, whenever a significant change in status occurs, and annually. For a subset of items, the assessment is completed quarterly. Some states require more frequent assessments. While nursing facilities have been required to complete uniform assessments since 1991, the availability of the data as part of uniform databases varies largely by state.

In October 1996, HCFA released draft rules outlining the automated data processing (ADP) requirements for SNF/NFs. The proposed rules require facilities to encode the MDS in a machine-readable format and be capable of routinely submitting the information in accordance with HCFA specifications. HCFA is installing a standard data system in each state. Upon installation of these systems, nursing facilities will be required to submit the MDS data electronically to the state where it will be maintained and then transmitted to HCFA as part of a national database.

The MDS is one component of a resident assessment instrument (RAI) used to assess residents' needs and to develop a plan of care for each resident. For states participating in the Multi-State Case Mix Demonstration project, the MDS data has also been used to test quality indicators used as part of the licensure and certification process. The MDS data is also used in a number of states to set case mix payment rates for Medicaid. For Medicare, the MDS data has been

used in the Case Mix Demonstration project to set Medicare case mix payment rates. Under the BBA, the MDS data will be used to set Medicare case mix payment rates in nursing facilities.

OASIS Data

In March 1997, HCFA announced proposed rules requiring home health agencies to use OASIS, the Outcomes and Assessment Information Set, to monitor patients' conditions and satisfaction. According to the Notice of Rulemaking, the use of OASIS, "is an integral part of the Administration's efforts to achieve broad-based, measurable improvement in the quality of care furnished through federal programs. It is fundamental in the transition to a quality assessment and performance improvement approach that focuses on stimulating measurable improved outcomes of care and patient satisfaction in the Medicare and Medicaid home health benefits while reducing the burdens on providers."¹⁴ These rules apply to home health agencies participating in the Medicare program, the Medicaid program or both.

Under OASIS, home health agencies must perform a standardized assessment of new patients within 48 hours to determine immediate care and support needs. These agencies then must update this initial assessment continuously until a patient is discharged. Once OASIS has been implemented, HCFA has indicated its intent to require home health agencies to report this data electronically into a national database.

In the near future, OASIS will hopefully help organize the assessment process around a set of agreed upon, valid and reliable health status measures that are valuable in measuring quality outcomes. Other possible uses of the data include developing reports for internal performance improvement and providing a comparison group for outcome measures. The possibility of using OASIS in monitoring managed care organizations is also under consideration. In the longer run, with the availability of a national database, HCFA envisions using this data to develop standardized risk-adjusted outcome reports or possibly case mix adjusted payment rates for a prospective payment system for home health agencies.¹⁵

The availability of client assessment data including information on consumer ADL levels, cognitive ability, diagnosis and other conditions should provide valuable information to plans and policymakers in assuring and monitoring quality, evaluating outcomes and developing risk adjusters for payments. In the short term, the availability and accessibility of this information will depend on individual state and federal data systems. The nursing facility assessment data systems are being installed at the state and federal level with the goal of maintaining the data as part of a national data base. Programs that serve dual eligibles in nursing facilities should be able to use this information to monitor and assess changes in resident status -by nursing facility

¹⁴ Federal Register Vol. 62, No. 46, March 10, 1997

¹⁵ Ibid

or health plan.. Perhaps of greater interest and greater difficulty is the use of data to track LTC consumers as they transition from home to hospital or nursing facility or any other setting.

The OASIS assessment instrument will allow uniform assessment of all Medicaid/Medicare home health services. While this is important for examining variations and utilization of home health services, the OASIS system, as originally proposed, did not use the same language and definitions as the MDS. Modifications are under consideration to make the two assessments more compatible. Lack of compatibility will limit the ability to examine trends across settings. Also, these assessments do not provide a way to evaluate and assess a p6ison's health status on an ongoing basis because the assessments are only conducted on those using nursing facility or home health services.

Managed Care

The availability, consistency and accuracy of encounter data, performance measures, satisfaction surveys, enrollment data and clinical/assessment data from Medicare managed care plans is mixed and reflects in part the evolution of § 1876 Risk and Cost-based plans and the concurrent implementation of a number of Medicare managed care demonstrations such as PACE, Social HMOs, the Medicare+choices demonstrations and the dually eligible demonstrations being conducted by states under HCFA waiver authority. An assessment of the different reporting requirements and actual and proposed uses of data sets suggests this area is still in development.

Many of the new Medicare reporting requirements (e.g., encounter data, Medicare HEDIS measures and the Medicare CAHPS survey) are prompting discussions about using similar reporting requirements for plans that participate in both Medicare and Medicaid. For example, the requirement that Medicare+Choices organizations report encounter data renews interest in consistency between Medicare and Medicaid encounter reporting. It also raises the question of whether Medicaid and Medicare encounter data for dually eligible beneficiaries could be linked at an operational level (e.g., at the state level, by the fiscal intermediary). As currently envisioned, Medicaid encounter data would be reported to state agencies and Medicare data would be reported to HCFA. While the data could be linked, the time it would take (due to technical difficulties and cost) means that the data may not be available in a timely manner or in a manner that meets the needs of states. The HEDIS and CAHPS (Consumer Assessments of Health Plans Study) reporting requirements for Medicare managed care enrollees raise similar questions about the need for coordination, if not consistency, between Medicare and Medicaid in the reporting, collecting and maybe validation of data.

The following sections provide a brief overview of the types of data required from Medicare managed care plans (either as § 1876 Risk and Cost-based plans or under the BBA) and other Medicare demonstration projects.

Medicare Managed Care Plans (Section 1876 Risk and Cost-based Plans)

Encounter Data

Historically, Medicare HMOs did not need to submit encounter data to HCFA. Under the BBA, HCFA will require Medicare+Choices organizations to submit data regarding inpatient hospital services for periods beginning on or after July 1997 and other services as deemed necessary by HCFA beginning on or after July 1998. The encounter data will be used initially to develop risk adjustment factors for Medicare capitation rates as mandated by the BBA.

HEDIS Data

In 1997, HCFA required all Medicare managed care plans to report those HEDIS 3.0 performance measures relevant to Medicare managed care enrollees for services provided in 1996; some measures require data from previous years as well (Appendix D identifies HEDIS measures collected by enrolled population). Also, those plans with contracts in effect after January 1, 1997 will need to report in 1998 for services provided in 1997. The HEDIS measures plans will report include measures of effectiveness of care, access to/availability of care, health plan stability, use of services, informed health care choices and health plan descriptive information.

In 1997, plans were required to report both summary data and the patient identifier data used to calculate the summary data to the National Committee for Quality Assurance (NCQA). (The summary data was due June 30 and the patient identifier data was due October 31.) HCFA also awarded a contract to the Island Peer Review Organization of Lake Success, NY (IPRO) to audit the validity and accuracy of the data. The goal of this data validation was to determine if the information was accurate and complete.¹⁶

Medicare Beneficiary Satisfaction Survey

Medicare managed care plans must also, as of January 1, 1997, participate in the Medicare version of CAHPS. The Medicare CAHPS will collect information on beneficiary access, utilization and satisfaction. It includes the CAHPS core items and a set of questions developed specifically for Medicare managed care enrollees. The CAHPS survey, for example, asks about a person's personal doctor or nurse, their use of a specialist, the amount and type of services they have used in the last 6 months, their health insurance, and a person's socio-demographic and medical conditions (See Appendix E). HCFA (rather than the plans) will pay a single

¹⁶ Department of Health & Human Services, Health Care Financing Administration, Medicare Managed Care, *Operational Policy Letter #47, New Requirements for Medicare Health Plans in 1997: HEDIS 3.0 Measures and the Medicare Beneficiary Survey* (April 14, 1997).

independent contractor to administer the survey to a sample of enrollees. Participating plans may not administer the same survey instrument until after HCFA releases its data.¹⁷

Health of Seniors Outcome Measure

The HEDIS functional status measure, Health of Seniors, is being produced using the Short Form (SF) 36, a self reporting health status instrument. This is the first outcome measure for the Medicare populations. The Health of Seniors measure looks at an individual's change in health status over a two year period. Independent vendors, certified by NCQA, collected the first year's information in 1997. One thousand beneficiaries per plan were surveyed with a targeted response rate of at least 70 percent. This effort will be repeated two years later. After completing questionnaires for both years, a change in functional health score will be estimated for each individual by subtracting the first year's score from the second. The difference between the scores will be classified as better, same, or worse. Outcome is defined as a change in score and each respondent acts as his/her own "control". Plan to plan risk adjustments will be made based on morbid conditions at baseline, income, household size, social support, education, race and gender. Results will be aggregated for each health plan and reported in 1999.¹⁸

HCFA reports that the HEDIS and Medicare CAHPS data will be used in a variety of ways. The primary audience for the summary data is the Medicare beneficiary, who will now have comparative information to use when choosing among plans. Where applicable, HCFA expects plans to use the data for internal quality improvement. Each plan's summary HEDIS and Medicare CAHPS data will be arrayed and returned to them. These data should help the plans target their quality improvement efforts. The data will also provide HCFA, the Peer Review Organizations and states information useful in monitoring the quality of, and access to, care provided by the plans.

PACE Demonstrations

The PACE demonstration, originally authorized by Congress in 1986, was designed to determine if the community based LTC model developed by On Lok Senior Health Services could be replicated. PACE programs typically enroll frail elderly (usually defined as certified for nursing facilities) Medicaid and Medicare beneficiaries. Services include those funded both by Medicare and Medicaid.

As the PACE program moved beyond its demonstration stage, it developed a PACE PROTOCOL¹⁹ to serve as the basic standard for PACE providers. HCFA contracted with On

¹⁷ Ibid

¹⁸ Ibid

¹⁹ On Lok, Inc, *PACE PROTOCOL Final Version*, (San Francisco, 1995).

Lok PACE to develop data collection standards, train all PACE sites in the data collection protocols and maintain data for all sites.²⁰ While the PACE program serves people who are dually eligible and receives Medicare and Medicaid funding, the assessment and other data elements are generic and do not distinguish between Medicaid and Medicare services.

Under the B.BA, PACE became a permanent program in the Medicaid and Medicare statutes, no longer requiring waivers. The BBA requires PACE providers to (1) collect data; (2) maintain and afford Health and Human Services (HHS) and states access to records including financial, medical and personnel records; and (3) produce reports that the HHS and the states need to monitor the operation, cost and effectiveness of the program. In addition, the PACE provider, HHS and the states will jointly develop and implement health status and quality of life outcome measures. The final data collection requirements will be specified in regulation by HCFA.

According to the PACE PROTOCOL each provider must collect a standard set of data including: (1) intake, assessment and utilization data, coded according to guidelines in the PACE Data Collection Manual; and (2) fiscal data based on a cost center accounting structure provided by HCFA and the state Medicaid agency. The provider must maintain complete participant-specific utilization data on-site updated to one month prior to the present and submit this data to HCFA or its agent. The provider will submit to HCFA and state Medicaid agencies, 45 days after the end of each quarter, quarterly narrative progress reports and program statistical reports including program status, socio-demographic characteristics of participants, health and functional status of participants, and service utilization.

The data collected for PACE covers four major areas (see Appendix F).

- Enrollment data is collected during the intake process, at time of a change, and upon disenrollment or death. This information includes socio-demographic information, prior service use, referral information as well as change in living, marital or other situations.
- Health and functional status assessment information is collected by nurses, social workers, and physicians. This includes information such as ADL and IADL information, behaviors, treatments, informal and formal support services, and medical conditions/problems.
- Service utilization, such as use of home and community based services, primary care and specialist services and outpatient medical services.
- Inpatient utilization relating to inpatient and transitional housing services and informal support information including use of household and non-household services.

²⁰ Kathy-Rice Trumble, R.N., Christina N. Caughlan, *PACE Data Collection Manual*, (San Francisco: PACE/On Lok, 1996).

The data is used to prepare standard reports on client characteristics; evaluate and monitor the project; do cross-site analysis; prepare reports which illustrate the progress of the demonstration; and track census and characteristics of participants. These reports are generated from PC based software provided to each PACE site. In addition, a Fact Book provides a profile of participants at all sites. Finally, the contracted program evaluators used the database in program evaluation.

Social Health Maintenance Organizations-(SHMOs)

SHMO-I Demonstration

The SHMO-I Demonstration, which focused primarily on Medicare-only beneficiaries, included a major data collection effort that involved HCFA, Brandeis University (as the Coordinating Center for the SHMO Consortium) and the evaluation contractors. Individual-level and aggregate data sets were developed and maintained as part of the project. The individual-level data included: (1) a membership file (sex, birth date, enrollment/disenrollment information); (2) a NHC file (information on those who were nursing home certifiable); (3) a Comprehensive Assessment Form (CAF) File; (4) Hospital Data (including in and out of area hospital stays); (5) Long Term Care Data (including information on all home and community based services and nursing home services); and (6) Health Status Form data (self reported for new members). Aggregate data were maintained for monthly membership, case mix and utilization and finances.

As part of the SHMO demonstration, an initial Health Status Form (HSF) and a Comprehensive Assessment Form (CAF) were developed for site use. As a condition of participation, all sites agreed to make utilization and cost data available, but there was no agreement on a reporting format. The reliability, accessibility and completeness of the data varied across site, service and over time. HCFA required quarterly reports of summary information.

The Coordinating Center and the sites developed files with common definitions for all long term care cost and utilization data. The Coordinating Center, the SHMO sites and the evaluation contractors initially worked together in the collection of common data elements and reporting protocols. Eventually, the evaluation contractors developed their own data and reporting requirements for research and evaluation purposes.²¹

The data was collected to meet a variety of purposes including general reporting requirements to HCFA, administrative and management needs of the SHMO sites, and research and evaluation. One of the problems cited was the lack of clarity as to the extent to which the data were being collected for case management versus research purposes. The level of detail on utilization required for management is different from the level of standardization and organization required for research. It was recommended that future efforts include clear definitions of the core set of utilization and expenditure data and a centralized function for

²¹Walter Leutz, et al., *Design of Second-Generation Social Health Maintenance Organization Sites, Final Report*, (Health Care Financing Administration, April 1993).

maintaining accuracy, standardization and protocols for data collection.²² Others recommended "that an information system should be developed at each SHMO that allows creation of uniform data sets including client descriptors and profiles of services used and costs incurred by enrollees. These data are ultimately needed for evaluation and are also necessary for operational management benefits."²³

SHMO-II Demonstrations

The SHMO-II demonstrations must meet all the encounter data reporting -requirements of the Medicare Choices Demonstrations. The Social HMOs must also report HEDIS 3.0 and participate in Medicare CAHPs if they are § 1876 Risk or Cost plans. In addition, a number of enrollment and assessment forms and protocols have been developed for the SHMO- II demonstration sites. A survey is administered by a third party upon enrollment and annually. This survey is comparable to the Medicare beneficiary survey in its core-elements and includes demographic information and information on IADLs and ADLS. In addition, an assessment form is administered once a person is identified as at-risk for services. Geriatric protocols and tracking protocols are also used as part of the overall interventions offered.

The enrollment survey is being used for three primary purposes in the SHMO- II demonstration. First, once the data is collected, it is provided to the SHMO- II demonstration site for use in care planning and identifying those at-risk in the community or who may need a more complete assessment. Second, the data will be used to adjust Medicare capitation rates for certain health conditions. Third, the data will be used as part of the experimental design for the project. A control group will also be assessed using the enrollment survey and the assessment protocols.

Medicare Choices Demonstration

Medicare Choices plans like other Medicare risk plans must report HEDIS 3.0 and participate in Medicare CAHPS. In addition, Medicare Choices plans must obtain all necessary clinical information for each health services encounter and submit encounter records to the designated Medicare carrier or fiscal intermediary — including encounters for out-of-area services. Plans must submit all encounter data as pseudo-claims, identical to fee-for-service claims, following the existing claims process. An encounter is any utilization of specific health care services covered by the plans' benefit packages, including inpatient care, ambulatory visits, lab, durable medical equipment (DME), and pharmaceuticals. Although the claims do not include actual amounts paid, they are "priced" using amounts that would have been paid under fee-for-service. HCFA has contracted with Medstat to validate the encounter data.

²² Ibid

²³ Michael Finch, et al., *Design of the 2nd Generation SHMO Demonstration: an Analysis of Multiple Incentives*, (Health Care Financing Administration, July 1991).

The encounter data is used for a variety of purposes. For example, all Medicare Choices plans negotiated with HCFA for a specific payment method to be used during the entire demonstration. Different methods will require different payment calculations and reconciliation processes. A number of the demonstration sites will use diagnostic information from encounter data to risk adjust payments. The encounter data will be used both for setting interim payments and determining interim and final settlements. For research and analytical purposes, HCFA will simulate payments under the risk adjustment system for all participating plans including those that elected alternative payment systems or the existing Medicare system.²⁴

Medicare Point of Service

In 1995, HCFA developed a Point of Service (POS) option for Medicare risk plans. This option allows enrollees to receive certain medical services outside of the provider network as a POS benefit. Since the POS option is available through Medicare risk plans, the same data reporting requirements apply to both the POS and risk benefits. However, POS plans must also be able to demonstrate the fiscal and administrative capacity to manage the POS benefit and associated costs. In particular, a POS plan must be able to track who is going out of the plan's established network, the types of services received, and the costs for the POS benefit. If a plan cannot determine these items, HCFA would conclude that the plan does not have the administrative capacity to guarantee financial soundness. In addition, the enrollee charges for a POS benefit must be separately identified as part of information submitted to HCFA.²⁵

Encounter Data Requirements of the Balanced Budget Act

Under the BBA a new array of providers may participate in Medicare risk contracting under the Medicare+Choices program. Under existing Medicare risk contracting rules, an entity must be a licensed HMO or competitive medical plan in order to participate. The BBA expands the range of eligible entities to include Provider Sponsored Organizations (PSOs) and Preferred Provider Organizations (PPOs). Beginning in 1998, Medicare+Choices organizations (including Medicare risk contractors) must submit hospital encounter data covering the period beginning July 1, 1997. HHS can establish, on or after July 1, 1998, other encounter data reporting requirements for Medicare+Choices plans that transition to the program in 1999.

²⁴ Health Care Financing Administration, Office of Research and Demonstration, *Implementation of Alternate Payment Systems under the Medicare Choices Demonstrations*.

²⁵ HCFA, *Medicare Risk-based Contractor POS Guidelines, (1995)*.

Under the BBA, the Secretary of HHS must submit to Congress by March 1, 1999, a report on a method of risk adjustment for Medicare payments that accounts for variations in per capita costs. The encounter data will provide baseline information that HCFA can use to establish payment amounts for Medicare+Choices plans.

Opportunities for Medicare/Medicaid Coordination

The data collected by Medicare plans can be categorized into two groups: (1) aggregated data that will be used in the longer term at a system level to examine overall plan performance (e.g., performance measures, satisfaction surveys, and utilization); and (2) data- needed to assess an individual's risk/need and provision of services (enrollment, assessment, and care planning data).

The system-wide data (e.g., HEDIS and CAHPS) are being collected as part of national reporting requirements focused on Medicare beneficiaries. These efforts are only beginning to identify and address issues related to the overlap between Medicare and Medicaid. For example, HCFA plans to use an external vendor to administer the CAHPS survey. Medicaid agencies also want to survey Medicaid enrollees. This raises the possibility (and the question of the desirability) of doing a combined (Medicare/Medicaid) survey of dual eligibles.

The individual level data tends to be specific to a plan or a demonstration (e.g., PACE or SHMO-III). While many of the elements in each of these instruments have similar domains (e.g., demographic information, enrollment/disenrollment, health and functional assessment, diagnoses and conditions, social and informal support services) the data collection protocols, definitions and schedule varies among programs. For example, the SHMO-II demonstration collects enrollment data through a telephone survey conducted by an independent third party who provides weekly information to the sites; while, PACE sites collect enrollment data directly through the initial intake process.

As the protocols for enrollment, assessment and care planning for programs that serve dual eligibles are tested and become more widely used, interest is likely to grow in assuring consistency in data elements and collection protocols - at least at the systems level. It may not be possible to achieve that consistency while these programs are still developing, but it may become even more difficult to achieve once reporting requirements are entrenched. A first step toward developing consistent standards is to begin discussing whether (and for which protocols) consistency is desirable. Then, if indicated, the discussion could move to how the information could be used and how data could be shared and disseminated. Even if consistency is not found to be desirable, coordination between federal and state policymakers could provide opportunities for assuring and improving the overall quality of care provided to dual eligibles.

Medicaid Agency Experience

This section of the paper discusses the experiences of Medicaid program managers primarily in the five states interviewed for this paper. This section first describes the program and data collection system in each of the five states, then addresses several issues all five encountered.

State Background and Data Systems

Arizona

In Arizona, all Medicaid beneficiaries, including dual eligibles, must select a Medicaid health plan.

- Those who have LTC needs must join the Arizona Long Term Care System (ALTCS). Under this program one plan provides both acute and LTC services.
- Those who do not have LTC needs must select a health plan that participates in the Arizona Health Care Cost Containment System (AHCCCS). These plans provide all Medicaid services except LTC services.

In both programs, the health plans must pay the Medicaid cost-sharing for those dually eligible beneficiaries who choose to obtain Medicare services within the plan's network but are not required to do so for services obtained outside the network.

Arizona collects extensive financial and utilization data from plans that participate in either program. This State collects utilization data in both aggregate and encounter format. (See Appendix G for a list of the reports Arizona requires, as well as the formats for the aggregate utilization reports.) Finally, Arizona has a client assessment tracking system (care coordination data base) that includes member services plans. Arizona does not request any special reports from the plans about their provision of care to dual eligibles, nor does it analyze encounter data to examine this issue. Arizona does not plan to change its reporting system except to allow the plans to submit encounter data on-line rather than via tape cartridges.

Colorado

In Colorado, all Medicaid beneficiaries, including dual eligibles, may choose to enroll with a health plan, a PCCM provider or remain on fee-for-service. Colorado will soon add a new choice for dually eligible beneficiaries. Under the Integrated Care and Financing Project (ICFP), to be implemented in the spring of 1998, the Medicaid program has contracted with an HMO that is also a Medicare TEFRA cost contractor. This health plan will provide the full range of Medicare and Medicaid health, social and supportive services to enrollees. Services will be coordinated by a multi-disciplinary team.

ICFP enrollees will be subject to a monthly lock-in to the plan's provider network for both Medicaid and Medicare benefit services. Out-of-network reimbursable services are limited to medically necessary emergency services, out-of-area urgently needed services and family planning services. The plan has no payment obligations for other services obtained outside its network. Enrollment in the ICFP is open to all Medicaid eligibility categories. However, it is expected that the vast majority of clients who need and receive integrated services will be dually eligible beneficiaries.

Colorado began collecting encounter data from the plans that participate in its existing HMO program in March 1997. Colorado edits the encounter data through a process similar to claims editing, checking for the types of errors that might be found on a standard fee-for-service claim. (These could include: Are the beneficiary ID, provider ID, procedure code, etc. valid numbers? Is the encounter a duplicate of a previously reported encounter? Is the -procedure code appropriate for the provider type reported on the encounter record?) This process only identifies errors in reported records and cannot identify over- or under-reporting. Nor can this system verify whether the information provided on the record matches the service delivered in the provider's office. Colorado plans to do a medical chart review to validate the completeness and accuracy of the encounter data.

The State will modify its existing encounter data system to permit reporting of additional categories of encounters resulting from the ICFP. It will not ask the ICFP contractor to report care coordination team visits and activities as part of encounter data. Instead, Colorado will use a separate care coordination database for that purpose. This database will include client assessments and plan of care (Appendix H contains a detailed description of the database).

Colorado plans to merge the data from the care coordination database with encounter data. Once the data is merged, the system will identify services specified in the plan of care, but not yet delivered, for follow-up by the care coordination team. Colorado also plans to use this merged data to evaluate plan performance by comparing it with similar fee-for-service claims data. Finally, Colorado established a Quality Assurance Advisory Committee that helped the State define HEDIS-type performance measures for use in the ICFP (Appendix C). The Committee was particularly helpful in identifying measures of how well the program integrated care. Two consumers and several advocates were members of the Committee.

Minnesota

In Minnesota, plans that serve older dually eligible beneficiaries (dually eligible SSI beneficiaries under age 65 are excluded from the managed care program) may have two types of contracts with the State.

- Under the Prepaid Medical Assistance Program (PMAP) contract, plans provide most Medicaid services (nursing home stays are excluded), but do not provide Medicare services.

- Under the Minnesota Senior Health Options (MSHO) contract, plans provide both Medicaid (including nursing home) and Medicare services.

All plans that serve Medicaid beneficiaries must have a PMAP contract. However, plans with PMAP contracts may decide not to contract under the MSHO program.

Most beneficiaries are enrolled with a plan after a presentation by staff from their county of residence. Although county staff present both PMAP and MSHO options for all the plans, most beneficiaries select the PMAP option. If the plan the beneficiary selects also has an MSHO contract, that plan may contact those beneficiaries who qualify for MSHO to find out if the beneficiary would like to be served under the plan's MSHO contract instead of its PMAP contract. (MSHO enrollees must be dually eligible.) Those few beneficiaries who do not select a plan are assigned to a health plan as PMA.P enrollees. Neither PMAP nor MSHO plans are required to pay the Medicaid cost-share for those dually eligible beneficiaries who choose to receive Medicare services outside the plan's network.

Minnesota collects enrollment, financial, rate cell, grievance data and HEDIS measures under both the PMAP and MSHO contracts. This State will also administer the CAHPS survey to MSHO enrollees (although those elderly who reside in a nursing home may have to be excluded because CAHPS has no module for them.) Minnesota currently collects encounter data only for services provided to plans' PNW enrollees, but will soon begin collecting encounter data for services provided to MSHO enrollees. Also, the State is modifying its encounter data reporting system to capture the additional services plans provide under the MSHO contract (home and community based LTC services and nursing home services). Like Colorado, Minnesota validates encounter data via a system similar to a claims editing system.

Minnesota plans to get information about enrollee health status and needs from the screening form that documents the enrollee's nursing home certifiability status for enhanced rate payments for home and community based services. The screening form includes demographic, ADL, and service data. The information from the screening form will be combined with encounter and other information in Medicaid's new MMIS (Medicaid Management Information System).

Oregon

In Oregon, all Medicaid beneficiaries, including dual eligibles, must participate in some form of Medicaid or Medicare managed care.

- Those dual eligibles who choose to receive Medicare fee-for-service must select a Medicaid health plan.

- Those who are members of a Medicare HMO that participates in the Medicaid program may choose to enroll under that plan's Medicaid contract or continue to receive Medicaid on a fee-for-service basis.
- Those who are members of a Medicare IB40 that does not participate in the Medicaid program continue to receive Medicaid on a fee-for-service basis.

In Oregon, Medicaid contracted health plans serve those who receive home and community based and institutional LTC. Plans are only responsible for payment for the first 30 days of skilled nursing home coverage for non-Medicare members.

If the enrollee remains in the nursing home longer than 30 days, the plan continues to provide therapies, durable medical equipment and pharmacy services not covered by the nursing home payment made directly by the State to the nursing home. Plans in Oregon do not have to pay the Medicaid cost-share for those who choose to obtain Medicare services outside the plan's network.

Oregon collects information about grievances and complaints, as well as encounter data from all plans. Since this State enrolls dual eligibles under the same contract as all other Medicaid eligibles, it collects exactly the same data about dual eligibles as other Medicaid beneficiaries. Oregon's encounter data currently includes information on medical, dental, and hospital services.

Like Minnesota and Colorado, this State uses a process similar to claims editing to validate the encounter data the plans submit. Indeed this State uses a modified version of its claims processing system to edit the encounter data. Also, this State validates the data by comparing aggregated encounter data against aggregated data from other sources. For example, the State will compare the number of maternity stays reported in the encounter data to the number of Medicaid eligibles with dates of birth within the encounter data report period.

In addition, Oregon's External Quality Review Organization (EQRO) is currently performing a data validation study by comparing the services identified in randomly selected enrollee medical charts to services reported as encounter data. The EQRO is using a stratified random sample to ensure its review includes records of enrollees who have diabetes, asthma, and depression, as well as neonates. The EQRO study will check for omissions and coding errors in the encounter data. The State is also performing a similar study of dental services. The State anticipates that any errors this study uncovers could be introduced at any one of four points within the system: coding, clinical, data processing system, or encounter definitions. Therefore, the next step will be to identify the source of all identified errors so corrections can be made to the appropriate point within the system.

Currently the encounter data is used mostly to respond to special requests from legislators. However, Oregon plans to set the rates for the next contract period based on encounter data.

Additionally, this State is in the early stages of developing population-based performance indicators. This State believes that it will ultimately find population specific measures more valuable for contractor management than measures designed for the entire Medicaid population. For example, if access to specialists is measured for all enrollees as a group, the measure may fail to detect a problem of access to specialists for a small subgroup of chronically ill enrollees. This State plans to develop these measures using the following process: (1) prepare a series of normalized reports showing plan performance on potential performance measures; (2) review these reports with a cross-functional internal group to identify reporting errors; (3) present the final reports to plan Medical Directors; and (4) work with the Medical Directors to further investigate areas of potential poor performance through multiple avenues, including clinical.

Finally, like the other case study states, Oregon wants to begin combining data from several sources to get a more complete picture of the services provided to Medicaid enrollees. This State is focusing on meshing local and Medicaid data, as well as, data about services provided by other State agencies. For example Oregon plans to eventually combine information about the services enrollees receive from the Senior Services Agency with encounter data.

Wisconsin

In Wisconsin, dually eligible beneficiaries may join a health plan or remain on fee-for-service. This State operates a comprehensive risk-based program that serves TANF (AFDC) eligibles throughout the State. In addition, this State operates three programs specifically designed to serve the elderly or adults with disabilities (those most likely to be dually eligible).

- The Independent Care (I Care) program coordinates primary, acute and social services for people in Milwaukee who are over age 15 and receive Medicaid due to their SSI eligibility.
- There are four Partnership contractors. (The first two listed also contract with the State under the PACE program described in the previous section on Medicare data sources.) One contractor serves elderly Medicaid and dually eligible beneficiaries in Milwaukee County, a second serves elderly beneficiaries in Dane county, the third serves beneficiaries with physical disabilities in Dane County and the fourth serves both the elderly and persons with physical disabilities in western Wisconsin. Elderly beneficiaries who participate in the Partnership program must be certified as nursing home eligible. This program uses a multi-disciplinary team headed by a nurse practitioner who acts as a care coordinator of all Medicaid and Medicare services, as well as social support services. Wisconsin submitted a waiver requesting Medicare capitation for the contractors, but this has not yet been approved. In the meantime, the Partnership operates under a partial capitation from the Medicaid program.

None of the programs are limited to serving dual eligibles, although almost all of the older beneficiaries who participate in the Partnership program are dually eligible. Finally, Wisconsin

requires plans to pay the Medicaid cost-share for Medicare beneficiaries who obtain Medicare services out-of-network.

Wisconsin collects financial, grievance, utilization, and health outcome data from plans that participate in any of its programs. This State requires the plans that serve AFDC enrollees to provide aggregate utilization information, backed up by lists of enrollees who received certain services and "recipient histories" (recipient histories are abbreviated encounter records of all services some enrollees receive). This State also performed a medical chart review to validate the data reported for AFDC enrollees. Additionally, Wisconsin has already combined its Medicaid utilization data with data about the services provided by its Home and Community Based Waiver Program and is working to match the Medicare fee-for-service claims data to

Medicaid utilization data. This State ultimately intends to add information about services provided by community organizations that are not paid for by Medicare or Medicaid. The State is making these efforts to get a more complete picture of all services provided, including diagnostic and acuity levels. Wisconsin feels that complete information on all services is critical to effectively serving the population, measuring plan performance and setting rates.

The data collection systems used for the two programs that serve dual eligibles are very different from each other. Wisconsin is taking these different approaches because it believes that they can learn lessons from both approaches that will help them design a combined approach in a few years.

I Care Program Data Collection - The I Care program's data collection system is similar to that used for the AFDC population. In fact, prior to 1998, Wisconsin used the same system for I Care. However, in 1998, I Care will begin using a system specifically designed for the population. The primary difference between the old and new reports is that the aggregate data the plan must now report better reflects the needs of the population. For example, I Care will no longer report EPSDT or most pregnancy related measures because the population the program serves includes no one under the age of 15 and a low percentage of women of child bearing age.

The new reporting requirements were based on Continuous Quality Improvement (CQI). The goal of the new system is to select measures that are of interest to both the State and the I Care contractor. For example, the financial reports showed that inpatient, emergency room, and drug utilization were driving I Care costs. Therefore, the new reporting system focuses particular attention on these issues. The contractor needs the information to help control costs and the State can use this same information to measure the contractor's performance. State staff can then provide this information back to the contractor along with a fee-for-service comparison. In other words, under this system, the information reported to the state will be a by-product of the information the plan needs and the State will be able to make the information more useful to the plan by adding information to the data it receives from the plan. Wisconsin believes that this

will help make sure that the data the contractor reports is accurate.

Under this new system, Wisconsin also plans to examine ambulatory care and community-based LTC. (The contractor does not provide nursing home care beyond the first 90 days.) The State plans to use outcomes to examine these new areas. For example, the number of avoidable hospitalizations, nursing home admissions, and institutional admissions will be examined. (An avoidable hospitalization or nursing home admission is one that could have been avoided through appropriate preventive care, acute care, or LTC. For example, a hospital admission with a primary diagnosis of dehydration might have been prevented if the enrollee had received some sort of home-care.)

This new system will also help Wisconsin monitor enrollment. The contractor must report the results of their outreach contacts and the number of assessments completed within 60 days of enrollment. In addition, there are plans to monitor disenrollments by diagnosis to see who is choosing to leave the program.

Partnership Program Data Collection - The data collection system for the Partnership program developed differently. In 1998, the Partnership program begins using an automated case management system designed by the "Partnership Academy." (The Partnership Academy is a non-profit organization established jointly by the Partnership contractors to help them develop tools that will be useful to all three contractors). This system will track utilization, care coordination and cost. Information from the case management system will be reported to the State in the form of three files (see Appendix I for specifications).

- The "Intake File" lists all approved and denied applicants. For each individual the file will summarize the information collected as part of the enrollment application process (source of referral, date of enrollment, reason for delayed enrollment, reason for denial of the application, reason the individual decided to enroll in the program, etc.). In addition, the Intake File will record information about where those denied enrollment ultimately received services. (This information is gathered through a telephone survey.)
- The "Enrollment File" lists all people who enroll in the program. For each individual the file will contain enrollment and disenrollment dates, Medicare status, and information on living arrangement and the enrollee's medical status at enrollment (e.g., Barthel score).
- The "Event File" identifies each occurrence of 51 reportable events. Reportable events include: acute hospital admission, physical therapy, social services visits, and dentition status. For each event the file will include information similar to an encounter record.

The contractors provide this information to the Medicaid agency as e-mail or on a floppy disk. Once the system is running, the State proposes to do on-site audits to validate the information.

The Partnership program plans to perform an enrollee survey during 1998. The survey's

purpose will be to find out what drove the enrollment decision and determine enrollee satisfaction.

Use of the data collected under both programs - Wisconsin intends to use the information collected in both programs for rate setting and contractor management. In addition Wisconsin is designing a report, similar to the HMO fee-for-service comparison report it produces for the AFDC population, for use in these two programs. (Several pages of this report are included as Appendix J.) Like its AFDC counterpart this report will be distributed to legislators, advocates, tribes, and community based organizations that might be interested in program performance. The new report will use more graphics and other techniques to make the document more "user friendly." Even so, this State does not plan to distribute this report to consumers because of its complexity and length.

Instead, Wisconsin is developing a separate consumer report card to provide plan performance information to potential enrollees. (Of course, the full report will be available to anyone who requests it.)

State Data Reporting Issues and Solutions

This section discusses the five common issues identified by the case study states.

- The impact of the small number of people enrolled in most programs specially designed for people with complex needs, including dual eligibles.
- The impact of the Medicaid program's lack of information regarding Medicare services provided to individual beneficiaries.
- The need to develop a means for contracted plans to report care coordination data.
- The importance of and techniques for data validation.
- The great amount of resources most states report devoting to data collection and use.

Small Numbers of Enrollees

Both Arizona and Oregon enroll those who are eligible for both Medicaid and Medicare as well as those who are only eligible for Medicaid into the same plan, under the same contract. These States reported that they do not produce separate data reports for dual eligibles, partially because very few enrollees are in any one plan. Even those states with programs specifically targeted to dual eligibles or populations with complex needs use the data cautiously. For example, although Minnesota collects HEDIS measures from PMAP plans and will do so from MSHO plans, the number of enrollees in the MSHO program is so small that the measures will not be statistically valid. Due to this issue, states cannot judge plan performance based solely

on aggregate performance measures in programs with small numbers of enrollees. Since dual eligibles are a small portion of the Medicaid population, this means that programs that serve only dual eligibles will need to emphasize the use of multiple performance measures and data sources to identify potential poor performance areas. These programs will also need to emphasize quality improvement over quality assurance.

Using multiple measures and data sources gives Medicaid agencies more confidence in their judgment of plan performance. In other words, if two enrollees complain about how long they have to wait to see a specialist in a particular plan, an avoidable hospitalization of one of the plan's diabetic patients occurs, and the plan performs retinal exams for a smaller percentage of diabetic patients (even though the measure is not statistically valid), the Medicaid agency can be fairly confident in identifying diabetic care as a potential area of poor performance. On the other hand, if only one of these events occur, the Medicaid agency would be less confident in identifying diabetic care as an area of poor performance.

States will need to emphasize quality improvement over quality assurance because quality assurance depends on being able to judge performance against an absolute "gold standard". Under quality assurance, the Medicaid agency sets minimum standards--of performance. In turn, this means that the agency must be certain that if a plan fails to meet the standard it is due to poor performance and not the result of an inability to adequately measure performance. As previously discussed, the small number of enrollees in most programs (much less plans) designed to specifically serve dual eligibles or people with LTC needs, makes it extremely difficult to produce statistically valid performance measures. Therefore, quality assurance is less valuable in managing contractors in these programs than it is for other programs.

Quality improvement, however, involves identifying an area of potential poor performance, working with the plan(s) to find out why performance appears to be poor and how to improve it, making changes, then remeasuring performance to make sure that performance actually

improved. In other words, quality improvement uses data as part of a system to improve care, not judge plan performance against absolute standards. This makes quality improvement very valuable for managing contractors in programs with small numbers of enrollees, such as those designed for dual eligibles.

Lack of Medicare Information

All five states expressed a strong preference for looking at the individual as a "whole person" for program management. However, dual eligibles receive most of their acute care from Medicare and most of their LTC from Medicaid. Unless information from the two systems can be combined neither Medicaid nor Medicare program managers will be able to look at the "whole person," which is absolutely necessary given the interrelationship between acute and LTC services. (Appropriate Medicaid-funded LTC can prevent some Medicare-funded hospitalizations.) Unfortunately, because two systems pay for the services, getting complete

information about all the care provided to an individual is extremely difficult. (Of course, it may remain important to track which program paid for specific services within the combined data.) Other aspects of program information, such as grievances and complaints, are also usually segregated by payment system, again making examination of overall plan performance difficult.²⁶

This situation is also true under fee-for-service, but since the fee-for-service system is designed mostly to pay claims, not measure access and quality, the lack of information does not prevent the system from achieving its purpose. However, once the State decides to enroll dual eligibles into Medicaid managed care the primary purpose of the data collection system turns from payment for individual services to measuring contractor performance. At that point the Medicare utilization data becomes invaluable because the state needs the information to measure overall performance and establish a historical performance baseline. As the program is implemented, plans frequently report difficulty coordinating the care of individuals because they may not be aware of the services Medicare provides.

The completeness of the utilization data varies depending on the enrollee's managed care enrollment status. This is important not only because the plan needs the information in order to better manage the enrollee's care, but also because the plan is the Medicaid agency's primary source of utilization data. If the plan cannot obtain complete data about services provided to an enrollee, the Medicaid agency is also unlikely to do so. Incidentally, the five study states all reported that Medicaid plans provided data about both Medicaid and Medicare services provided to dual eligibles.

- *If a dual eligible is on Medicare and Medicaid fee-for-service, the Medicaid agency will receive "cross-over" claims²⁷ from the Medicare claims payment system at least for services where Medicaid pays a portion of the cost of providing the service. This gives the Medicaid*

²⁶ For more information on these issues, please refer to three other publications available from The National Academy for State Health Policy.

- Volumes I and H of the two volume series "Protecting Low Income Beneficiaries of Medicare and Medicaid in Managed Care."
 - Volume I by Paul Saucier and Robert Mollica covers *Contracting Arrangements, Beneficiary Choice, Enrollment and Disenrollment, and Tracking*.
 - Volume II by Robert Mollica, et al. covers *Coordination of Benefits, Payment Mechanisms and Quality Management*.
- Robert Mollica, Paul Saucier and Neva Kaye, "Special Considerations for Programs that Service The Elderly and Persons with Disabilities," *Medicaid Managed Care: A Guide for States, 3rd edition*, vol. IV.

²⁷ When a provider bills Medicare for a service that is covered by both Medicare and Medicaid, the federal Medicare agency pays its portion of the claim and then passes enough information to the state Medicaid agency so that it can pay its share of the cost of the service. The information passed from the Medicare to the Medicaid agency is frequently referred to as a *cross-over claim*. These claims provide some information about the Medicare services provided to Medicaid beneficiaries, but less information is provided about each service than that normally found on a Medicaid claim form. Moreover, only information about those services covered by *both* programs is passed by this system..

agency some information about some services Medicare provides to dual eligibles. However, Medicaid agencies will not receive information about all Medicare fee-for-service services. Colorado and Wisconsin, among other states, have begun to obtain tapes from HCFA containing information on all services provided to dual eligibles by Medicare fee-for-service so that they can create a database that contains information about all Medicare and Medicaid funded services.

- *If a dual eligible is on Medicare fee-for-service and in a Medicaid managed care plan,* states usually pass on the Medicare cost-sharing responsibility to the dual eligible's Medicaid plan. Non-plan providers are supposed to bill Medicare for the Medicare share-of-cost and the Medicaid plan for the Medicaid share-of-cost. The Medicaid share-of-cost for a Medicare service is generally quite small. Only Arizona reported they were confident that providers routinely bill Medicaid plans for this small amount of money. If the provider does not bill the Medicaid plan:
 - the plan *would not* have any information about the service provided;
 - the Medicaid agency would not receive a cross-over claim since the provider was to bill the plan so, the Medicaid agency *would not* have any information on the service provided;
 - Medicare would know about the service because they would receive a bill from the provider but, the only way for the plan or the Medicaid agency to access that information is through the tape matching process discussed earlier.
- *If a dual eligible is enrolled in the same plan for both Medicare and Medicaid, two situations could exist.*
 - *If the dual eligible's plan operates under a Medicare risk-contract, the beneficiary cannot go out of the plan's network for either Medicaid or Medicare services. The plan will have complete information about both Medicare and Medicaid services provided to the individual beneficiary.*
 - *If the dual eligible's plan operates under cost-based reimbursement, the beneficiary can go out of the plan's network to obtain Medicare services. The plan will not have complete information about the Medicare services provided to the individual. HCFA pays for out-of-network Medicare services directly and then provides the Medicare plan an aggregate report of the services provided outside the plan's network. However, this report does not detail which Medicare beneficiary received what Medicare service. As a result, the plan cannot identify which services were provided to dual eligibles versus Medicare only*

beneficiaries, much less identify all the Medicare services provided to an individual.

- *If the dual eligible is enrolled in two separate plans, one for Medicare and one for Medicaid, two situations could exist.*

- *If the Medicare plan has a risk contract, the enrollee cannot go outside the plan's network for Medicare services, nor would the Medicaid plan*

share in the cost of providing the services. In this case, the Medicare plan would have data about all Medicare services and the Medicaid plan would have data about all Medicaid services, but neither plan would have complete information about both types of services.

- *If the Medicare plan operates under cost-based reimbursement, neither the Medicare nor the Medicaid plan would have complete information about Medicare services provided to the individual beneficiary, due to the beneficiary's ability to go outside the Medicare plan's network.*

Essentially the **only** situation in which the plan will have complete information is when the dual eligible receives Medicare and Medicaid services from the same plan and uses only the plan's provider network. Additionally, if the enrollee belongs to a Medicaid plan and is on Medicare fee-for-service, the Medicaid plan may have complete data about Medicaid services and the Medicare services for which Medicaid pays a portion of the cost — if the Medicare provider bills the Medicaid plan for that portion of the cost.

As previously mentioned, Medicaid agencies are partially addressing this issue by linking HCFA's Medicare claims and enrollment data with Medicaid claims data. Colorado and Massachusetts used linked data in their I 1 15 waiver applications to support cost neutrality computations and proposed rate setting methods for both Medicaid and Medicare. Wisconsin plans to use its linked data for a similar purpose. In addition, this State intends to use linked data to help gauge the affect of the new LTC system it is piloting on both Medicare and Medicaid services. Maine used its linked data to analyze program design options and further study the clinical interaction of the two programs. Other New England States are using linked data to profile characteristics of the dually eligible populations in their states for program planning.

The new encounter data requirements for Medicare plans established by the BBA show some promise for helping resolve this issue. If Medicare encounter data is compatible with that collected by the Medicaid agency, the Medicaid agency may be able to link Medicare and Medicaid encounter data, like some now link the Medicare and Medicaid fee-for-service claims data. If a Medicaid agency were to link all four data sets (Medicare claims and encounter, as

well as, Medicaid claims and encounter) that agency would have a complete picture of all the Medicare and Medicaid services provided to dual eligibles.

Reporting Care Coordination Data

Many of the programs specifically designed for dual eligibles or other populations with complex needs emphasize the integration or coordination of acute, preventive and LTC. If states are to know if either care coordination or integration fulfills its promise to better serve

beneficiaries with complex needs, Medicaid agencies will need to measure the effectiveness of care coordination in addition to health outcomes and the provision of the individual types of care. Otherwise, the agency will not be able to identify whether plan performance is tied to its ability to coordinate all three types of services.

Two of the three states (Colorado and Wisconsin) operating programs specifically designed to serve dual eligibles or other populations with complex needs developed new databases for tracking care coordination activities. They believe the care coordination databases will be absolutely necessary both to help the contractor carry out its responsibilities and the State measure plan performance. Both databases were designed primarily for the first purpose. For example, Colorado's system will identify any services specified in an enrollee's plan of care that are not actually provided within a specified time so that the care coordination team can correct the situation. Both states advised others with similar programs to gather this information.

Utilization Data Validation

All five states emphasized the importance of validating utilization and other data. If plans appear to be performing well, but consumers and program managers do not believe the data the measures are based on, they will discount plan performance. Conversely, if plans do not appear to be performing well, the plan may argue that the appearance is a result of state data collection and aggregation methods not actual performance. Validating data (and reports generated from data) and making sure that those who use the data trust the validation process is a key to successfully using data.²⁸

²⁸ Although the issue of data validation existed in fee-for-service, that system was primarily designed to pay claims correctly, not to measure performance. It focused on finding errors in claims presented for payment. Under managed care, a Medicaid agency is more concerned with making sure the data completely and accurately represents the services provided so the agency can be sure it is accurately measuring performance. Also subcontracting (and subcapitated) arrangements under managed care create more opportunities for inaccuracy as the data frequently passes through a number of hands (and coding conversions) before reaching the Medicaid agency.

The five states reported using three methods to validate data. All five use a process similar to claims editing for encounter data. This process checks that the coding on each record is valid and in the required format. Among many other items, these processes also usually check to make sure that all required information is on the record, that the reported procedure and diagnosis code are compatible, and that the record is not the duplicate of one already processed. As all five states pointed out, a claims editing type of function ensures all reported individual records are "clean" and complete. However, it cannot check for over- or under-reporting of services.

State program managers report using two techniques to validate utilization data completeness. Oregon and Wisconsin report performing medical chart audits to check for over- and underreporting. (Colorado plans to use medical chart reviews once the program is implemented.) Similarly, Wisconsin plans to do on-site audits of assessments and other records entered into its new care coordination database.

Arizona, Oregon, and Wisconsin use different data sources and reports to validate each other. Two produce reports comparing performance among plans (Arizona and Wisconsin), over time (Arizona and Wisconsin), and between managed care and fee-for-service (Wisconsin). (The executive summary and several pages from Wisconsin's annual report are included as Appendix J.) These states follow-up with plans to determine if variations are due to reporting error before using the reports to examine performance. Similarly, Arizona produces aggregate reports from encounter data that match aggregate reports the plans themselves produce for the State. If the two reports differ Arizona follows up with the plan to correct the discrepancy. Finally, Wisconsin verifies the aggregate data it receives from the plans in two ways. First this State asks for a list of enrollees who have received certain types of services, then State staff both:

- verify that the number of people the plan reported as receiving these services matches the number of names submitted; and
- use this information to select medical records to review to make sure that the person identified as receiving the service actually did so.

Very Resource Intensive

Four of the five study states indicated that collecting and using data is an extremely resource intensive process. Even two of the three states (Colorado and Wisconsin) that built their data collection system for programs that serve dual eligibles on existing managed care data collection systems reported devoting high levels of resources to data collection. (Although, as discussed in the earlier section on encounter data, the new HIPAA requirements may make it easier to produce "clean" encounter data, thus reducing the amount of resources needed.) Unfortunately, none of the study states could provide a firm estimate of resources needed to develop a data system, but several states provided some helpful information.

Arizona does not have a separate data collection system for programs that serve dual eligibles.

This State's encounter data collection unit has 13 staff, responsible for collecting and analyzing encounter data, as well as producing special reports. To place this in context, Arizona has operated a managed care program since 1984 and currently has 29 contractors (20 AHCCCS, 8 ALTCS, and 1 behavioral health contractor). These contractors serve:

- 360,000 AHCCCS enrollees;
- 24,000 ALTCS enrollees; and
- 26,000 Behavioral Health enrollees.

Colorado reported that rate-setting and proving budget neutrality (as required under the I 1 15 waiver) required the equivalent of one high level Medicaid staff person to work full-time for about one year. In addition to this staff person, HCFA paid at least one subcontractor to assist in data processing. Also, the plan that will participate in the new program produced several special reports from its internal data at no cost to the State.

However, this State felt the issues have now been thought through so that fewer false starts will occur in future. As a result, Colorado believes that states developing similar programs will need less resources.

Minnesota alone reported that although developing the PMAP data collection system was resource intensive, developing the MSHO system was not because few changes were needed to the PMAP system to accommodate the new MSHO system.

Oregon, like Arizona, does not separately collect data about services provided to dual eligibles. This State reports that it devotes six staff to encounter data collection. These staff are responsible for working with the plans to make sure they understand the requirements, validating the data, and working with the plans to improve the quality of the data. In addition, about 30 systems staff spend part of their time gathering and analyzing encounter data. This State also reported that it needed more resources during development than it does now that the system has been operating for a few years. To place Oregon's resources in context, as of June 1996, Oregon reported that its comprehensive risk-based managed care program- served 298,474 beneficiaries and its PCCM program served 11,065.

Wisconsin reported that the Medicaid program devoted a full-time data processing staff person to each program, depending on the size and uniqueness of the new program. Policy Analyst and Medical Consultant time were also needed. This State found it needed this additional staff even though it learned much about a number of issues, such as how to validate data, from its existing data collection system. Wisconsin believed that more resources needed to be devoted to data collection and use during the first years of a new program but, that fewer resources would be needed as the program matured and State staff learn what is important

Emerging Issues

Several new issues are beginning to appear regarding the collection and use of data.

Confidentiality is rapidly emerging as a national issue, as more data is collected and combined in an uniform electronic format that is relatively easy to access and understand. For many purposes ease of access is a desirable outcome. Certainly combining data about Medicaid and Medicare services gives program managers and plans a more powerful tool to help them better serve plan enrollees. Unfortunately, if the wrong people gain access to the data it can also do great harm. For example, if a person's HIV positive status were to become known that individual could be ostracized from the community. HCFA, Medicaid agencies and plans already have safeguards in place to protect beneficiary confidentiality, but these may need to be re-examined in light of the creation of new databases.

Another issue is that, as with the current fee-for-service system, it appears that two encounter data reporting and collection systems are emerging: one for Medicaid and one for Medicare. If *these systems are compatible*, policymakers could create an integrated database representing all the utilization experience of dual eligibles across programs. On the other hand, if as in some state Medicaid agencies and among the PACE sites, information about Medicare and Medicaid services are combined into a single database that does not identify which program's payment covered the service, rate setting and evaluation of cost savings and shifting may become difficult. Also, if plans report Medicare encounters to both Medicaid and Medicare, it may complicate the potential of merging the two sets of services as Medicaid agencies will need to unduplicate the Medicare services in the combined database. These issues will be particularly prominent in those areas where Medicare and Medicaid benefits overlap (e.g., home health and SNF/NF level of care).

A final issue relates to the use of assessment data. The assessment level data currently collected in the fee-for-service system (MDS data and the proposed OASIS data) have not yet been used in any systematic way as part of managed care programs for dually eligible beneficiaries. One cause is that although MDS and OASIS are proposed as uniform assessment instruments for Medicare and Medicaid, they are still oriented to certain providers of service (NF and home health agencies) and not compatible across settings or across the LTC system. Furthermore, states use state-specific assessment instruments for Medicaid LTC services that may or may not be compatible with either the NMS or OASIS.

Conclusion

Collecting data is one of the keys to Medicaid managed care program success. Data is needed for Medicaid agencies to effectively: help beneficiaries select a health plan, help determine plan reimbursement rates, and manage contractors. Programs that enroll dual eligibles or that seek

to integrate acute and long term care have even stronger needs for data as they are relatively new and must still prove their worth. Unfortunately programs that serve dual eligibles will encounter unique barriers in collecting and using data. Primary among these barriers is the difficulty of obtaining complete data about both Medicare and Medicaid services provided to enrolled dual eligibles. The need to develop a new or modify an existing system to capture care coordination data and measure the effectiveness of such services is also a difficult, but - necessary task. Finally, since the population of dual eligibles is so small states will need to modify the way they use the data, particularly by focusing on quality improvement over quality assurance.

Although these tasks will be difficult, promising new developments at the federal level should help states seeking to better care for dual eligibles and others who need both acute and long term care. The HIPAA calls for the establishment of a national system of unique identifiers for patients, plans, and providers. Collecting encounter data should be easier once these requirements are in place. Medicare is moving to collect HEDIS measures and perhaps encounter data, from Medicare plans. If the new encounter data is shared with states and plans it could go a long way toward enabling states to judge overall contractor performance. Finally, both Medicare and Medicaid are participating in the QISMC program. This will, hopefully, result in more uniform quality improvement activities in both programs.

List of Appendices

- A. A Compilation of Existing and Emerging Performance Measures for Programs Serving Older Persons and Persons with Disabilities, as of September 1996
- B. Wisconsin I Care: Contract Language for Quality Indicators
- C. Colorado ICFP HEDIS-like Measures
- D. HEDIS Measures Reported for Specified Populations
- E. CAHPS Medicare Managed Care Questionnaire
- F. Data Collected for PACE
- G. Arizona Reporting Requirements
- H. Colorado Care Coordination Database Description
- I. Wisconsin Encounter Data Reporting for PACE and Partnership
- J. Wisconsin HMO/Fee-for-Service Comparison Report - Sample Pages

Please note that appendices are not included in this electronic version. To obtain the full report please email: SL139@umail.umd.edu