

Presentation notes for November CMS Alignment: Summary of State Duals Data Project

Duals Data Project with OHSU

Draft overall project purpose: The overall goal of this project is to link Medicare and Medicaid claims for individuals who are dually eligible and to use these data to examine estimates of spending, outcomes, and potential savings gained through Oregon health care reform for duals in coordinated care. OHA is contracting with OHSU to assist OHA in defining evaluation questions, developing and implementing an evaluation plan that will look at the dual eligible Medicaid-Medicare population and Oregon healthcare transformation, including specific comparison of data within CCOs compared to FFS.

A. Assessing the Effects of Coordinated Care Organizations on Dual-Eligibles in Oregon

The goal of this research is to evaluate the extent to which the CCO transformation affects care for dual-eligibles. Despite their high cost and high vulnerability, there is a paucity of evidence about the ways in which new payment models affect this population. Oregon's CCO experiment is an excellent environment for testing an integrated care model. In particular, this research seeks to address the following specific aims:

1. Examine the effect of CCO implementation on health service use among dual-eligibles
2. Examine the effect of CCO implementation on the quality of care among dual-eligibles

Accomplishing the listed aims will provide a robust assessment of the potential for the CCO model to improve the value of care for dual-eligibles.

Proposed Measures: HEALTH SERVICE USE

Any ED visit (low- or high-severity visit), and the number of visits if any Any ED visit for dental problems

Any primary care visit, and the number of visits if any

Any outpatient specialist visits, and the number of visits if any: Cardiology , Gastroenterology, Nephrology, Pulmonary disease, Urology

Any outpatient visits with an Allied Health Professional, and the number of visits if any Physical or Occupational therapy , Audiology or Speech/Language Pathology

Any inpatient hospitalization (excluding psychiatric hospital services)

Any mental health care Outpatient mental health visit

Psychiatric hospitalization

Any use of post-acute care services (home health, skilled-nursing facility, inpatient rehabilitation facility, and long-term care hospitals financed through Medicare)

Any use of long-term care services (home health, group home, foster care, and nursing home care financed through Medicaid)

Proposed Measures: QUALITY OF CARE

Contracted measures:

- Alcohol misuse Screening, Brief Intervention, Referral to Treatment (SBIRT USPSTF)
- Follow-up after hospitalization for mental illness (NQF 0576)

Non-contracted measures All-cause 30-day readmission (HEDIS PCR)

- Congestive heart failure admission rate (PQI 8)
- Chronic obstructive pulmonary disease admission rate (PQI 5)
- Adult asthma admission rate (PQI 15)
- Diabetes short-term complications admission rate (PQI 1)
- LDL-C screening for comprehensive diabetes care (NQF 0063)*

Other measures:

- Use of high-risk medications in the elderly (HEDIS DAE)*
- Disease modifying anti-rheumatic drug therapy for rheumatoid arthritis (HEDIS ART)*
- Annual monitoring for patients on persistent medications (HEDIS MPM)*
- Low-value care (i.e., wasteful health care services providing little or no health benefits) (Schwartz AL, Landon BE, Elshaug AG, Chernew ME, & McWilliams J, 2014):
 - Imaging for nonspecific low back pain
 - Head imaging for uncomplicated headache
 - Head imaging for syncope
 - Arthroscopic surgery for knee osteoarthritis

*Note: These measures require the use of pharmacy claims, requiring additional data validation and linkage to other files.

Proposed Primary independent variables will be the type of Medicaid health plan for each dual eligible enrollee, including Medicaid managed care (MCO or CCO) and fee-for-service (FFS), as well as time period (pre- and post- CCO implementation). Note: Both MCO and CCO will be termed “managed care” hereafter.

Proposed Other variables will include enrollee demographic and health characteristics such as age, sex, race, living arrangement (community vs institution), rural or urban residence, neighborhood characteristics (including % of high school graduates and % poverty in each dual-eligible’s ZIP code of residence), Medicare eligibility group (age 65 or older, end-stage renal disease, and disability), Medicaid eligibility group (SSI, poverty, medically needy, section 1115 waiver, and special income limit and other), Medicare health plan (Medicare Advantage vs FFS), and presence of physical and behavioral health conditions. Physical health conditions will be assigned using the Chronic Illness and Disability Payment System (CDPS); behavioral health conditions will be assigned using Ettner behavioral health categories. Both the CDPS and Ettner methods are established diagnostic classification systems. **3**

B. CMS Innovator Accelerator Program for Beneficiaries with Complex Needs (BCN)

Track B - State Agency Partnerships (SA): Partner with other state agencies to address the needs of specific BCN populations by building capacity to connect services across silos and link data across state agencies.

Oregon main areas of support or interest : This project targets IAP BCN goal 1 to enhance state capacity to use data analytics to better serve the dual eligible BCN population. We also want to build more sophistication in our ability to look at data to inform policy and our partnerships with our Coordinated Care Organizations, D-SNPs and other work with affiliated Medicare Advantage plans to ultimately address additional work in areas 2 and 3.

What we hope to gain for Oregon from this experience: The technical assistance and support will enhance our overall statewide capacity to track and monitor outcomes for dual eligibles and further additional policy and program work to impact this BCN population. Specifically we look to gain: assistance with the integration of multiple datasets, database consolidation, creation of consistent interpretation of data fields across different databases, assistance to develop/find solutions for gaps associated with missing or inconsistent data, assistance with programming and complex algorithms that may be required to read and use the data for integration, developing protocols for cleaning and linking data sets.

For more information: <http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/beneficiaries-with-complex-needs/beneficiaries-with-complex-needs.html>