CHCS Center for Health Care Strategies, Inc.

Technical Assistance Brief

Quality Measurement in Integrated Care for Medicare-Medicaid Enrollees

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States, with the support of the Centers for Medicare & Medicaid Services (CMS), are working toward improving the integration of care for individuals dually eligible for both Medicare and Medicaid (known as Medicare-Medicaid enrollees or "dual eligibles"). They face several challenges in demonstrating how these new models improve the care provided, including complex methodological issues around appropriate comparison groups and time periods, the need to access data, and the lack of baseline quality measures pertinent to dual eligibles. In addition, many specific challenges exist around choosing the right set of quality and performance measures: many measures are designed for only one system of care, or one subset of dual eligibles, and few standardized measures are available for some of the most important aspects of care, such as the effectiveness of care coordination. These challenges exist whether the state is using a fee-for-service (FFS) or a capitated managed care model to improve care delivery. The Affordable Care Act's new opportunities to integrate care for Medicare-Medicaid beneficiaries heighten state and federal interest in identifying the best approaches to quality measurement.

This brief from the Center for Health Care Strategies (CHCS), created with support from The SCAN Foundation and The Commonwealth Fund, summarizes existing state and federal activities to develop quality of care measures for Medicare-Medicaid enrollees. It is intended to help guide states in developing measurement approaches for proposed integrated programs, whether in capitated or FFS models. It covers how states can assess quality in specific domains of integrated care such as long-term services and supports (LTSS) and behavioral health services, and gather information from beneficiaries on care and services provided by integrated care systems. Finally, it describes how stakeholder input can be used to help define performance measures.

IN BRIEF

States are working to improve the integration of care for individuals dually eligible for both Medicare and Medicaid, but they face several challenges in demonstrating how these new models improve the quality of care. These challenges exist whether the state is using a fee-for-service or a managed care model to improve care delivery. The Affordable Care Act's new opportunities to integrate care for Medicare-Medicaid beneficiaries heighten state and federal interest in identifying the best approaches to quality measurement.

This brief from the Center for Health Care Strategies, created with support from The SCAN Foundation and The Commonwealth Fund, summarizes efforts to develop quality of care measures for Medicare-Medicaid enrollees. It provides guidance to states in developing measurement approaches for proposed integrated programs, including assessment of quality in specific domains of integrated care such as long-term services and supports and behavioral health services. It also describes how performance measures can be shaped by stakeholder input.

Existing State and Federal Approaches to Measurement in Integrated Care in Capitated Arrangements

Pioneering integrated care programs for Medicare-Medicaid enrollees exist at both the national and state level. These programs offer a useful starting point to examine the types of performance measures available to assess the success of integrated care programs. Existing programs have used "standardized measures" developed or endorsed by national organizations such as the National Committee for Quality Assurance (NCQA) or the National Quality Forum (NQF), with technical specifications allowing like comparisons.[1] Some non-standardized, state-specific measures are in use as well. The following section outlines examples of existing performance measurement approaches in select federal and state programs and includes considerations for developing measures for integrated

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care programs. These programs were chosen based on their track record of public reporting of quality measures in integrated care programs.

Medicare Advantage Special Needs Plans

Most integrated care is delivered through state and federal contracts with Medicare Advantage Special Needs Plans, referred to as "Dual Eligible SNPs" or "D-SNPs," that are allowed to limit enrollment to Medicare-Medicaid enrollees. CMS' requirements for Medicare Advantage and D-SNPs offer a starting point for quality of care measures for this population.[2] Because most SNPs are part of larger Medicare Advantage organizations, many of their measures are reported at the larger organizational level, which makes it impossible to detect performance at the SNP level.[3] However, a subset of Medicare Advantage measures must be reported at the SNP population level, and several specific SNP measures are also required. These measures are standardized, reported publicly, and used to encourage performance improvement. Highlighted SNP measures, including select Healthcare Effectiveness Data and Information Set (HEDIS) measures, are listed in Exhibit 1.

A clear advantage to the ongoing use of these measures is the ability to compare plan performance across states and detect change from year to year. However, these measures cannot stand alone for integrated care monitoring, since they do not measure the provision of LTSS, and, with the exception of the few behavioral health measures, are not oriented to the needs of younger Medicare-Medicaid enrollees.

When states consider adding measurement requirements to plan contracts for integrated programs to address LTSS and behavioral health, they weigh the benefit against the burden of the many requirements under Medicare Advantage for SNP, Medicare Advantage-Part C, and Part D measurement.

Minnesota's HEDIS Reports for Medicare-Medicaid Enrollees

Working within a capitated environment, Minnesota's Senior Health Options (MSHO) program illustrates how D-SNP requirements have been used for quality measurement and reporting. SNPs participating in MSHO, which serves Medicare-Medicaid enrollees age 65 and over, are required to report measures for licensing as well as to maintain their contracts with Medicare and Medicaid.[5] Exhibit 2 depicts the complex set of requirements for Minnesota's SNPs.[6] Several of MSHO's measures are reported publicly. The Minnesota Department of Health publishes annual HEDIS reports for each of the state's health plans for all populations enrolled in managed care.[7] In 2011, the health plans' MSHO enrollment sizes ranged from 5,700 member months to over 120,000 member months. All of the plans reported several HEDIS measures, including this subset of Effectiveness of Care, Access, and Use of Services measures:

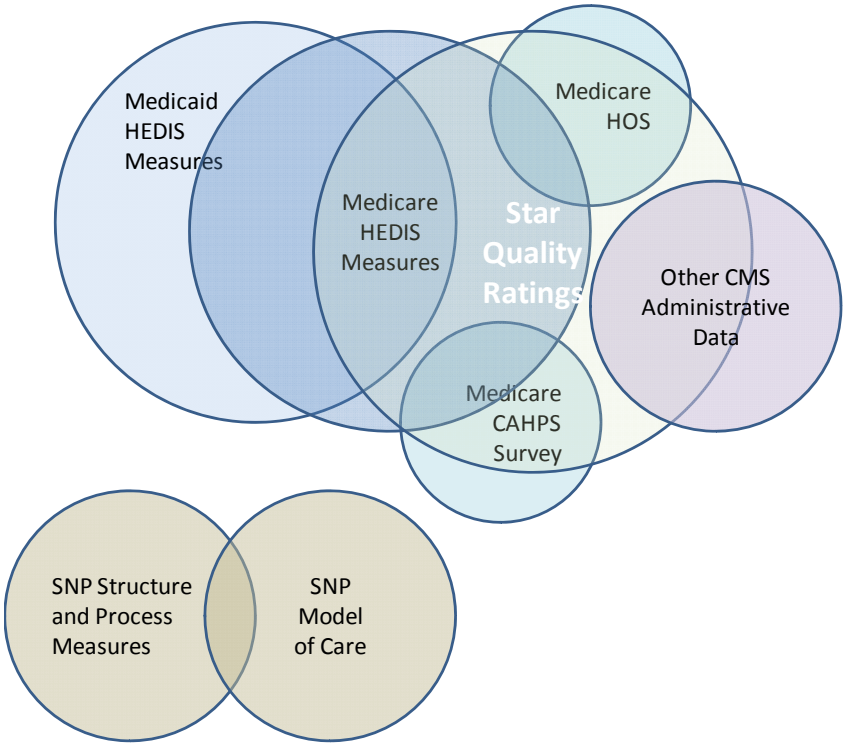
- Use of High-Risk Medications in the Elderly;
- Potentially Harmful Drug-Disease Interactions in the Elderly;
- Annual Monitoring for Patients on Persistent Medications;

***Exhibit 1*: Selected Measures Required for Dual Eligible - SNP Reporting[4]**

Source	Domain	Specific Examples
HEDIS	Effectiveness of Care: ▪ Prevention	▪ Colorectal Cancer Screening ▪ Glaucoma Screening in Older Adults
HEDIS	Effectiveness of Care: ▪ Chronic conditions	▪ Controlling High Blood Pressure ▪ Antidepressant Medication Management ▪ Follow-up After Hospitalization for Mental Illness ▪ Medication Reconciliation Post-Discharge
HEDIS	Beneficiary Reported Outcomes of Care	▪ Medicare Health Outcomes Survey
HEDIS	Care for Older Adults	▪ Advance Care Planning ▪ Medication Review
HEDIS	Utilization	▪ Plan All-Cause Readmissions
CAHPS*	Experience of Care Survey	▪ Getting Needed Care ▪ Getting Care Quickly ▪ Health Plan Customer Service ▪ Getting Needed Prescription Drugs
CMS/ NCQA	Structure and Process Measures	▪ Complex Care Management ▪ Coordination of Medicare and Medicaid ▪ Care Transitions

*CAHPS = Consumer Assessment of Healthcare Providers and Systems

***Exhibit 2*: MSHO Performance Measurement Reporting Requirements**



- Comprehensive Diabetes Care;
- Controlling High Blood Pressure;
- Adult's Access to Preventive/Ambulatory Health Services;
- Use of Services measures for Ambulatory Care, Inpatient Utilization, Mental Health, and Identification of Alcohol and Other Drug Services; and
- Care for Older Adults (SNP-only measure).

The Care for Older Adults set is worth special attention (see Exhibit 3).[8] These measures, specifically designed for SNP plans, should be a good fit for the target population of seniors enrolled in MSHO. The measures require data collection on four critical issues for older adults: (1) documented preferences for advance life support (advance care planning); (2) a systematic review of the entire medication list, including non-prescription drugs; (3) an assessment that covers not only acute medical issues, but also cognitive and functional status; and (4) screening or a management plan for pain. High performance rates on these measures should contribute to better health outcomes and quality of life for individuals.

However, Minnesota officials relayed a lack of support for these measures among their key clinician stakeholders. With the exception of medication review, they are concerned that the measures do not capture the ongoing management of chronic conditions and meaningful communications with care coordinators needed for enrollees 85 years and older.

***Exhibit 3*: Care for Older Adults Results for MSHO Plans, 2011**

Minnesota Senior Health Options Plan	Advance Care Planning	Medication Review	Functional Status Assessment	Pain Screening
Blue Plus	45.8%	74.1%	77.8%	36.0%
Medica	66.9%	93.4%	92.9%	80.5%
South Country	68.4%	88.3%	63.0%	75.4%

In addition to the measures reported by health plans, Minnesota's Department of Human Services uses encounter data to calculate and report HEDIS measures for its contracted plans. The combination of these various approaches contributes to a rich environment for performance measurement for integrated care.

Other Uses of Standard Measures for Medicare-Medicaid Enrollees

In the Medicare Advantage and Medicare Prescription Drug Programs, CMS uses HEDIS and CAHPS (Consumer Assessment of Healthcare Providers and Systems) to report plan ratings. The measures are updated annually, and CMS publishes technical notes explaining the changes.[9] The HEDIS and CAHPS results are published annually via the Medicare Plan Finder.[10] The health plans that perform the best on the selected measures receive an indicator called the "high performing icon."

These measures, along with the Health Outcomes Survey (HOS), are also used by CMS to calculate the "Star" ratings that help guide quality bonus payments to health plans. Unlike Minnesota, however, very few states require local reporting on their enrolled Medicare-Medicaid enrollee population. Thus, the ratings typically represent a combination of dual eligibles along with Medicare Advantage enrollees, who tend to be healthier, have higher incomes, and have less need for assistance with activities of daily living compared to those dually eligible for Medicare and Medicaid.[11]

Non-Standardized Measures in Evaluations

States that have previously implemented integrated care models for Medicare-Medicaid enrollees, including Massachusetts, Arizona, and Texas, have conducted a range of ad hoc evaluations to monitor their programs. While the studies were conducted in a managed care context, the approaches of these states can be helpful in thinking how to evaluate care for FFS beneficiaries as well. The examples below offer approaches to measuring specific topics of interest.

- Nursing Facility Use and Avoidance: Massachusetts' Senior Care Options (SCO) program, an integrated program for seniors built on the capitated model, focused on nursing home avoidance and published several reports on its website.[12] An early program evaluation, conducted by JEN Associates noted, "*…descriptive statistics demonstrate that SCO enrollees in comparison to the control population enter nursing facilities at a lower rate. In addition the time to first nursing utilization is greater and the time spent in a nursing facility episode is less than in the control population. For SCO enrollees that do use a nursing facility there is substantially lower frequency of long term residency.*"[13] Using functional Activities of Daily Living data as an outcome indicator, the evaluation identified that those admitted to nursing facilities were a more frail population. A second year evaluation confirmed findings that SCO enrollees were more likely to stay in the community, using nursing facilities more for extended rehabilitation than end-of-life care. A less thorough study might have missed the factors that led to program success.

- Beneficiary Feedback on Program: Massachusetts's SCO gained valuable beneficiary feedback from an interview-based study conducted by UMass' Center for Health Policy and Research.[14] Unlike standard beneficiary surveys, the interviews were conducted in person in Spanish and Portuguese in addition to English. The 92 interviewees, who averaged 79 years of age, may have had difficulties with a telephone or mail survey even if they had received a survey in their own language. The results were generally positive, with the interviewees having a fairly high level of awareness of SCO and most reporting that they received all necessary services, although very few were aware of the 24/7 access to a nurse care manager.

- Risk-Adjusted HEDIS: A recent Avalere study compared four HEDIS measures for individuals enrolled in Mercy Care, an integrated care plan in Arizona, to national Medicare FFS enrollee data.[15] This analysis is unique in applying risk adjustment factors to measures that are not risk-adjusted in the standard HEDIS calculation to account for potential differences in health status between dual eligibles in the Mercy Care plan and other Medicare enrollees. The results are shown in Exhibit 4.

  Avalere's report noted that although Mercy Care's rates of service use were higher than the national average for the Medicare duals population before being risk adjusted, they were actually lower than the national average after risk adjustment. The report stressed the importance of considering differences in case mix when comparing the outcomes of populations. This was particularly

***Exhibit 4*: Avalere Study Mercy Care vs. Medicare FFS**

HEDIS Measure	Medicare FFS (National)	Mercy Care Plan
Adults' Access to Preventive/Ambulatory Health Services	79%	81%
Inpatient Utilization (discharges per 1,000 member months)	33.4%	23.2%
Inpatient Utilization (days per 1,000 member months)	195.2	110.3
Emergency Department Use (visits per 1,000)	48.8	44.5
All-Cause 30-day Readmission Rate (using HEDIS standard risk adjustment)	0.19	0.15

necessary for Mercy Care because a large proportion of their enrollees were at higher risk than the average Medicare-Medicaid enrollee.[16]

- Public Reporting of Performance Measures: Texas' STAR+PLUS program is now reporting a small set of dashboard measures specific to its integrated program. They include the following innovative measures of integration:[17]
  - Percent of STAR+PLUS members with good access to service coordination;
  - Percent increase in STAR+PLUS members who receive personal attendant and/or respite services through the Consumer Directed Services delivery model;
  - Number of STAR+PLUS members entering nursing facilities; and
  - Number of STAR+PLUS 1915 (c) waiver clients returning to community services.

Financial Alignment Demonstrations for Medicare-Medicaid Enrollees

Since CMS created the mechanism through the ACA to implement Financial Alignment Demonstrations of integrated care for Medicare-Medicaid enrollees, half of the states in the country have seized the opportunity to design new integrated programs. Most states chose to develop either a capitated or managed FFS approach, with a few working on both models. CMS' goals include improving quality of care as well as controlling the rate of cost growth for this high-risk population.[18] State-specific goals include getting better information on Medicare-paid medical services (e.g., hospitalization and prescription drugs) that will help states support beneficiaries to live in the community and avoid costly institutional care. All of the demonstrations will offer new approaches to coordinate care, and most of the capitated models will integrate new benefits, such as mental health and LTSS that are used at a higher rate among the dually eligible population. In developing these new models, state program staff and their many stakeholders are interested in developing measurement strategies that help answer the underlying question: ***Did these new models make a difference to the care and services delivered to beneficiaries and beneficiaries' quality of life?***

The performance measures necessary to answer this fundamental concern need to go beyond the traditional preventive and acute medical care quality measures to address the unique needs of the Medicare-Medicaid enrollee population. In addition to assessing overall costs of care, states and CMS staff are seeking to measure the impact of the demonstrations on four domains:

1. Beneficiaries' quality of life and experiences of care;
2. Changes in LTSS use;
3. Changes in behavioral health service use; and
4. Overall coordination of care.

All states participating in the demonstrations will collect data on a combination of "core" and state-defined quality measures. Appendix 1 lists the core quality measures and Appendix 2 lists the state-specific measures contained in the first three Memorandums of Understanding (MOUs) signed between CMS and Massachusetts, Ohio, and Washington State. The next section outlines considerations for measuring demonstration outcomes within each of the four measurement domains listed above to help guide states and other stakeholders interested in assessing the success of integrated care approaches.

1. Measuring Quality of Life

Measuring quality of life is especially important and increasingly challenging as beneficiaries become more

frail and dependent on services provided by others. Achieving the greatest possible independence, controlling ones' living environment, living pain-free, and engaging with the community as desired are all factors that should be considered in assessing quality of life for this population. Although several tools exist for measuring the quality of life for people with disabilities and those who need LTSS, none are used by states for their existing integrated programs or are required by CMS for SNPs.

Following are potential approaches to assessing quality of life that could be applied to Medicare-Medicaid enrollees. While none cover the many languages spoken by this population, the interview approaches could potentially pair an interviewer with a translator for those whose primary language is other than English.

Behavioral Risk Factor Surveillance System Survey The AARP Scorecard[19] uses two questions from the Behavioral Risk Factor Surveillance System survey to assess quality of life for those living in the community who indicate they have a disability:

- *How often do you get the social and emotional support you need?*
- *In general, how satisfied are you with your life?*[20]

Home- and Community-Based Service (HCBS) Experience Survey This CAHPS-like survey has been supported by CMS: it has gone through cognitive testing, but not field-testing for general use. It includes a set of questions on Community Inclusion and Empowerment.[21] The development of this survey resulted in alternative wording for people who have difficulty using response options about the frequency of a particular event ("always/sometimes/never"), which was found to be an issue for a significant portion of the population. The survey also includes new questions on the quality of HCBS that previously were not collected in a standardized way across states. Sample questions include:

- *When you want to, how often can you get together with these family members who live nearby?*
- *When you want to, how often can you do things in the community that you like, such as shopping or going out to eat?*
- *Do you need more help than you get now from [personal assistance/behavioral health staff] to do things in your community?*
- *Do you take part in deciding what you do each day – for example, what you do for fun at home or in your community?*
- *Do you take part in deciding when you do things each day – for example, deciding when you get up, eat, or go to bed?*

Medicare Health Outcomes Survey This survey includes a set of questions taken from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System survey that measure "Healthy Days."[22] One question in the Healthy Days Symptoms Module is:

- *During the past 30 days, for about how many days did PAIN make it hard for you to do your usual activities, such as self-care, work, or recreation?*

Other surveys include questions about comfort as a key indicator of quality of life. The Quality of Life Scale for Nursing Homes developed by Rosalie Kane, for example, includes a comfort scale. Questions are specific to the perception of cold, noise, pain, and whether residents get a good night's sleep.[23]

National Core Indicators (NCI) This set of measures was developed for people with intellectual and developmental disabilities through a collaboration of the National Association of State Directors of Developmental Disability Services and the Human Services Research Institute.[24] The NCI include topics linked to quality of life, such as choice and control of caregivers. Examples of questions posed to family members about the individual receiving services include:

- *Does your family member participate in community activities?*
- *Do you feel that services and supports have made a positive difference in the life of your family?*
- *Overall, do you feel that your family member is happy?*

Personal Experience Outcomes iNtegrated Interview and Evaluation System (PEONIES) Wisconsin developed its PEONIES survey to assess quality of life for people using LTSS.[25] This resource-intensive survey tool uses a semi-structured interview to assess quality of life through the following outcomes:

- *I decide where and with whom I live.*
- *I make decisions regarding my supports and services.*
- *I work or do other activities that are important to me.*

- *I have relationships with family and friends I care about.*
- *I decide how I spend my day.*
- *I am involved in my community.*
- *My life is stable.*
- *I am respected and treated fairly.*
- *I have privacy.*
- *I have the best possible health.*
- *I feel safe.*
- *I am free from abuse and neglect.*

The importance of gathering quality of life information directly from beneficiaries and their chosen representatives cannot be overstated. As the NQF Measures Application Partnership report points out, "*The measurement strategy should promote a broad view of health and wellness, encouraging the development of a person-centered plan of care that establishes goals and preferences for each individual. Ideally, that care plan and its goals would form the basis for measurement.*"[26] Documenting progress towards those preferences is best done by gathering information from the beneficiary.

2. *Measuring Long-Term Services and Supports*

As mentioned above, states have not collected and reported information on HCBS quality in standardized ways, which poses a challenge for adding such measures to the evaluation of the Financial Alignment Demonstrations. Institutional measures of long-term care, such as those reported for nursing facilities in the CMS Nursing Home Compare website,[27] only apply to individuals living in institutional settings. Others are limited to certain providers, such as measures used in the Home Health Compare website.[28] Absent standard measures, the demonstrations may look to the states' unique measures. Examples of state-developed measures described in a recent report by Truven Health Analytics on managed LTSS include: (1) timeliness of initiating community-based LTSS; (2) timeliness of completing level of care assessments; (3) nursing facility or other institutional admissions; (4) maintenance of community transition; (5) receipt of services authorized in the care plan; and (6) member-centeredness of care plan.[29] A recent report from Mathematica Policy Research and the AARP Public Policy Institute offers a summary of state-established performance measures for managed LTSS programs. LTSS measures cited include: (1) changes in functional status; (2) percent of beneficiaries who receive a timely assessment and care plan; and (3) number of beneficiaries who have received home safety evaluations.[30]

States' HCBS programs operated under CMS waiver authority include "assurances" that provide a common platform for states to develop LTSS measures. The assurances require states to collect and report on the structural aspects of the program, such as timeliness of service, provider qualifications, and financial accountability, but also include monitoring of the health and welfare of beneficiaries. Many of these are appropriate to track for individuals dually eligible for Medicare-Medicaid who use LTSS.

Massachusetts' CMS-approved MOU for its Financial Alignment Demonstration offers an example of how a state can incorporate LTSS considerations into an integrated care performance measurement approach. The state included the following LTSS measures in the core set of measures required for its capitated plans:[31]

- Percent of High Risk Residents with Pressure Ulcers (Long Stay);
- Risk Stratification Based on LTSS or Other Factors; and
- Self-Direction (measures training for care coordinators on self-direction).

Care transitions, included in Massachusetts' core set of measures, represent a critical opportunity to identify and avoid gaps in care that often occur during shifts from one setting of care to another. The NQF's Measure Application Partnership (MAP) Dual Eligibles Workgroup recommended the Three-Item Care Transition Measure (CTM3), which was endorsed by NQF.[32] This measure of preparation for hospital discharge is a helpful tool for assessing coordination of care. The Structure and Process measures also include care transitions measures (see discussion of Measuring Coordination of Care below).

Additionally, as part of the demonstration, states are required to track a utilization measure of institutional versus community-based care for beneficiaries who qualify for institutional level of care. Finding the right approach to that measure may prove challenging, as again, state approaches to measuring "rebalancing" are not standardized. The AARP Scorecard[33] uses a spending measure to assess the provision of community-based care: *Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities*. The scorecard, however, notes the limitations in using a single measure and

suggests three supplemental "choice of setting" indicators:

- The proportion of Medicaid LTSS spending that pays for HCBS;
- The proportion of new Medicaid LTSS beneficiaries who receive HCBS; and
- The percentage of HCBS users in publicly funded programs who direct their own services.[34]

These LTSS-sensitive measures are equally important in the evaluation of both capitated and managed FFS models. As more Financial Alignment Demonstration MOUs are posted publicly, a consensus on a state and federal measurement approach to LTSS integration may emerge as later-signing states adopt and refine the measures proposed by early-signers. States may also look to the state-specific measures included in approved state MOUs to inform their own state-specific LTSS measures.[35]

3. *Measuring Behavioral Health*

Medicare-Medicaid enrollees have a disproportionate need for both mental health and substance use treatment compared to Medicare-only enrollees.[36] Many health plans and providers that have traditionally served Medicare and commercial enrollees do not have experience with screening, assessment, and referral for these behavioral health services. As a result, many Medicare-Medicaid enrollees go without needed services. Thus, measures that reflect appropriate screening and referral are important, as well as measures of improved overall quality of mental health and chemical dependency services.

Whether states use a capitated or managed FFS approach in their demonstrations, measures of behavioral health can be applied. For example, the NQF MAP Dual Eligibles Workgroup considered appropriate measures for Medicare-Medicaid enrollees with behavioral health needs, and recommended two measures as ready for implementation:[37]

- Screening for Clinical Depression and Follow-Up Plan; and
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

In developing its MOU, Massachusetts chose to include these NQF MAP recommendations, as well as these three additional measures pertinent to behavioral health that states might also consider:[39]

- Follow-up After Hospitalization for Mental Illness;
- Antidepressant Medication Management; and
- Unhealthy Alcohol Use: Screening and Brief Counseling.

California's Financial Alignment Demonstration, which carves out most behavioral health from the capitated set of services, has nonetheless sought input from stakeholders on the best measurement approach for shared accountability for behavioral health service delivery.[40] Among the measures proposed by California for stakeholder input are these placeholders signaling the state's openness to new approaches to behavioral health:[41]

- Behavioral Health Shared Accountability Process Measure (Year 1);
- Behavioral Health Shared Accountability Enhanced Process Measure for Evidence of Data Sharing and Joint Care Planning (Year 2); and
- Reduction in Emergency Department Use for Seriously Mentally Ill and Substance Use Disorder Enrollees (Year 3).

As officials in states using managed FFS and capitated models begin to develop performance measures for carved-out approaches to behavioral health, it may be helpful to review the evaluation of the Serious Mental Illness (SMI) Innovations Project in Pennsylvania.[42] The evaluators found improvements in utilization, and also measured whether the projects met pilot goals,

***Exhibit 5*: Physical and Behavioral Health Measures for Pennsylvania's SMI Innovations Project**

Outcomes Measures	Performance Measures
▪ Emergency visits (rate per 1,000 members per month) ▪ Mental health re-hospitalizations (rate per 1,000 members per month) ▪ Readmissions within 30 days	▪ Stratification of at least 90 percent of members into risk groups and annual re-stratification ▪ Patient-centered care plans ▪ Notification of at least 85 or 90 percent of admissions within one business day of responsible entity learning of admission ▪ Prescriber notification of at least 85 or 90 percent of medication refill gaps for atypical antipsychotics leading to a medication possession ratio of < 0.8[38]

reported as certain performance metrics (Exhibit 5).

4. *Measuring Coordination of Care in Capitated Arrangements*

CMS requires that SNPs undergo an evaluation of their care management systems via an NCQA review of required Structure and Process measures. The three categories of Structure and Process measures most pertinent to evaluating whether health plans deliver integrated care to Medicare-Medicaid enrollees are shown in Exhibit 6.

NCQA has begun sharing its plans to test new Structure and Process measures for the Medicare-Medicaid enrollee population. This will help to address the gap in the appropriate measurement of care coordination that has been a source of frustration for both state and federal officials.

In addition to the collection and reporting of the above types of measures, health plans participating in capitated model Financial Alignment Demonstrations will be required to submit their Model of Care documents to CMS. These Model of Care documents will be evaluated by NCQA, and may be reviewed by state staff involved in the demonstration. These models of care are generally hundreds of pages long, including detailed descriptions of assessment and care planning processes for enrollees, as well as provider and staff training and the health plans' monitoring of the models' success in improving the delivery of services.

Of note, the Government Accountability Office (GAO) released a report in September 2012 that examined the models of care submitted by several D-SNPs in 2012.[44] The GAO noted that CMS does not require D-SNPs to use or report on standardized measures in the models of care, which would make it possible for CMS to compare D-SNPs' effectiveness and evaluate how well they have done in meeting

Exhibit 6: **Structure and Process Measures Relevant to Integrated Care**[43]

Measure Name	Measure Content
SNP 1: Complex Case Management	The organization coordinates services for members with complex conditions and helps them access needed resources. Elements include: ▪ Identifying Members for Case Management ▪ Access to Case Management ▪ Case Management Systems ▪ Frequency of Member Identification ▪ Providing Members with Information ▪ Case Management Assessment Process ▪ Individualized Care Plan ▪ Informing and Educating Practitioners ▪ Satisfaction with Case Management ▪ Analyzing Effectiveness/Identifying Opportunities ▪ Implementing Interventions and Follow-up Evaluation
SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and, where possible, prevents unplanned transitions. Elements include: ▪ Managing Transitions ▪ Supporting Members through Transitions ▪ Analyzing Performance ▪ Identifying Unplanned Transitions ▪ Analyzing Transitions ▪ Reducing Transitions
SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for members. Elements include: ▪ Coordination of Benefits for Dual Eligible Members ▪ Administrative Coordination of D-SNPs ▪ Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos) ▪ Service Coordination ▪ Network Adequacy Assessment

their goals across plans. The report recommended that CMS systematically evaluate D-SNP performance to hold plans accountable and compare performance across plans and to inform the implementation and reporting requirements of the Financial Alignment Demonstrations. In addition, the GAO also stated that moving to a standard set of performance and outcome measures should pose minimal administrative burden to the plans and might, in some cases, be less burdensome and no more costly than what some D-SNPs currently collect.

Health plans will undergo readiness review prior to entering into three-way contracts with CMS and the states. Areas to be evaluated include the plans' processes and procedures for beneficiary assessment, care coordination, enrollment, and enrollee and provider communications among others.[45] The readiness review will include system testing, provider network review, and desk and on-site review of their capacity to serve the beneficiaries enrolled.

Data-gathering efforts across these critical domains will contribute to the overall evaluation of the demonstrations. CMS has contracted for a national evaluation that will synthesize information across states (see Exhibit 7 for more information about demonstration evaluation activities). The national evaluation team, led by Research Triangle Institute, will also be responsible for measuring changes in utilization and cost-savings, in addition to quality of care and services.

Stakeholder Input on Quality Measures in the Demonstrations

States and CMS have aggressively sought stakeholder feedback to help shape the Financial Alignment Demonstrations, but most of the input states have received has been on program design, beneficiary protections, and benefits, rather than on quality measures. Now that three states have published their MOUs with a core set of quality measures, stakeholders in other states can evaluate these three states' measurement approaches and consider whether the measures cover all the important aspects of performance under the demonstrations.

California has directly requested stakeholder input on its proposed quality measures. The state held a series of public meetings on quality and evaluation that culminated in a proposed measure set published for comment on its website.[46] Exhibit 8 includes examples of feedback from California stakeholders including both general and specific comments, many of which could be helpful for FFS programs as well.[47]

The comments in Exhibit 8 reflect stakeholders' concerns and hopes for the demonstration. California also held an LTSS Summit in which stakeholders were given the opportunity to brainstorm quality measurement priorities.[48] In Washington, focus groups were held with stakeholders that also proved useful for state officials' thinking about which approaches resonated with people not enmeshed in policy work. Other states may look to these states' examples and encourage their own stakeholders to comment on performance measures for their new programs.

***Exhibit 7*: Evaluation of the Financial Alignment Demonstrations**

Independent Evaluation by Research Triangle Institute

Separate from the performance measurement activities undertaken by states, the Financial Alignment Demonstrations will include an evaluation led by Research Triangle Institute (RTI). Both state-specific analyses and a meta-analysis across states are planned. Evaluation topics will include:

- Beneficiary health status and outcomes;
- Quality of care provided across care settings;
- Beneficiary access to and utilization of care across care settings, satisfaction and experience;
- Administrative and systems changes and efficiencies; and
- Overall costs or savings for Medicare and Medicaid.

The RTI evaluation team will have access to plan-reported measures and will use encounter data to calculate additional measures. The evaluation will use both qualitative and quantitative approaches such as:

- Conducting site visits; qualitative analysis of program data; focus group and key informant interviews;
- Tracking changes in utilization, cost, and quality measures;
- Evaluating the impact of the demonstration on cost, quality, and utilization measures; and
- Calculating savings attributable to the demonstration.

Exhibit 8: Stakeholder Feedback on California's Proposed Quality Measures

Examples of Stakeholders' General Comments

- Suggestions for Year 1:
  - Use more process-oriented measures;
  - Measure whether beneficiaries have lost any services they had received before, and if so, why and for how long; and
  - Measure establishment of care plans and hospitalization notification.
- Suggestions for Years 2 and 3:
  - Transition to outcome measures;
  - Apply customer satisfaction tools;
  - Measure timeliness of referrals and appointments;
  - Reflect social model values and priorities (e.g., consumer control, social participation, caregiver support) in measures; and
  - Measure changes in emergency department and inpatient utilization.
- Suggestions for consumer survey questions:
  - Do consumers understand their rights and benefits?
  - Do consumers know who to contact if they have questions/concerns/need to appeal a care decision?
  - Are consumers involved as much as they would like in treatment/service plan decisions?

Examples of Stakeholders' Comments about LTSS Measures

- Consider the Agency for Healthcare Research and Quality's HCBS measures, especially see those related to consumer choice about provider and services.[49]
- Use process measures for beneficiaries determined at risk for LTSS: (1) proportion who received comprehensive assessment (including cognitive); (2) reassessment; and (3) care plan in place.
- For the frail seniors in community settings (those with mobility limitation, incontinence, dementia, etc.), measure the incidence of skin ulcers, falls, abuse, significant weight loss, dehydration, and medication errors.
- Examples of specific suggestions for LTSS measures:
  - Degree to which consumers experience an increased level of functioning;
  - Unmet need in ADLs/IADLs;
  - Participants reporting unmet need for community involvement;
  - Degree to which health status is maintained and improved;
  - Degree to which consumers report that staff are sensitive to their cultural, ethnic, or linguistic backgrounds;
  - Degree to which consumers felt they were respected by staff;
  - Percent of caregivers usually or always getting needed support; and
  - Proportion of people with disabilities receiving preventive health care visits.
- Examples of specific suggestions for nursing facility measures:
  - Care Transition Record Transmitted to Health Care Professional;
  - Percent of High Risk Residents with Pressure Ulcers (Long Stay);
  - Pneumococcal vaccination for long-stay residents;
  - Percent of long-stay residents whose need for help with daily activities has increased;
  - Percent of residents (short-stay and long-stay) who have moderate to severe pain;
  - Percent of long-stay residents who were physically restrained; and
  - Percent of long-stay residents who are more depressed or anxious.

Examples of Stakeholders' Comments about Measures of Mental Health and Substance Use Treatment

- Implement positive measures of mental health recovery:
  - Dimensions: Health, Home, Purpose (meaningful activity) and Community (relationships and social networks). Example: Mental Health America's Milestones of Recovery Scale.
- Tailor traditional D-SNP measures to the subset of the population with serious and persistent mental illness, e.g.:
  - Medication adherence for beneficiaries with depression tailored for individuals with bipolar disorder;
  - Weight gain and obesity applied to individuals taking atypical medications for psychotic disorders.
- Use recovery based outcomes:
  - Increased independence in housing;
  - Increased income/employment and avoiding institutions (jails, nursing homes and hospitals);
  - Engagement in meaningful activity;
  - Adequate social support.
- Measure utilization of services:
  - Psychiatric hospitalizations (reflects unmet needs);
  - Outpatient mental health care (including those who are only receiving psychotropic medications but do not require continued therapy).
- Year 1 measures:
  - Percentage of behavioral health/substance use members with integrated (medical/behavioral) care plan;
  - Percentage of behavioral health/substance use members under Care Management;
  - Percentage of behavioral health/substance use members completing a health risk assessment.
- Years 2 and 3 measures:
  - Psychiatric bed days;
  - Emergency department utilization rates;
  - Readmission rates;
  - Medication adherence.

Promising Work Underway

Several promising efforts are underway nationally that support the work of state and federal officials in developing performance measures for programs integrating care for Medicare-Medicaid enrollees. In addition to the NQF MAP Dual Eligibles Workgroup, the AARP Scorecard is revisiting the measure set for its next edition. Both efforts rely on the contribution of scores of volunteers, who provide their expertise to consider best practices and available measures. NCQA is also beginning to explore specific measurement approaches for dual eligibles enrolled in managed care, which may result in an improved set of Structure and Process measures.

Another project that may contribute to the development of performance measures for Medicare-Medicaid enrollees includes "Promoting Integrated Care for Dual Eligibles" supported by The Commonwealth Fund.[50] In this project, a small number of high-performing health plans that serve individuals who are dually eligible will be engaged in a consortium, with the goal of identifying best practices and thinking about how to better expand such models.

Finally, CMS recently published a solicitation for researchers to test new measures in three areas: (1) continuity of information and care from hospital discharge to the outpatient setting; (2) continuity between mental health provider and primary care provider (PCP); and (3) items that may be added to the CAHPS survey addressing language-centered care, cultural competence, physical activity, healthy eating, and caregiver strain.[51] Enhanced focus on these areas of measurement offers great promise for improving integrated care programs not only in capitated models but in all delivery systems, including emerging FFS models.

Conclusion

The good and bad news about the heightened attention to Medicare-Medicaid enrollees in the Affordable Care Act is that many eyes are now on state and federal officials as they design new programs and develop methods to evaluate those programs. It can be a bit uncomfortable to have so much attention when a program is still in the design phase because there are many unanswered questions about the collection and sharing of data needed to measure success. The promising news is that funding is being dedicated to evaluation both within states and at the national level, as well as helping states to think about how to improve care and services for the beneficiaries they care about.

For example, in the GAO report mentioned above, the authors observed that CMS has neither formally evaluated the sufficiency and appropriateness of the care that D-SNPs provide nor assessed their effectiveness in integrating benefits and coordinating care for dual-eligible beneficiaries. GAO provided several recommendations to CMS, including that CMS require D-SNPs to explicitly describe in their Models of Care how they will evaluate services and increase accountability, and collect and report standard performance and outcome measures to CMS that are relevant to the enrolled population.[52] In addition, GAO suggested that this performance information should be made available to the public and that CMS should evaluate D-SNPs' ability to provide sufficient, appropriate care to Medicare-Medicaid plan enrollees.

These recommendations for the use of standard measures, which would support state-to-state comparison regardless of demonstration design, are already being incorporated in the MOUs between states and CMS and in the planned evaluation. CMS has made it clear to states that stakeholder involvement does not end with input into the design, and that transparency and sharing of information will be required throughout the demonstration. California and its prospective contractors took the unusual step of making the heath plan Models of Care available publicly, along with health plan responses to questions about the use of quality measures for improving care and services. This is a good starting place for engaging stakeholders in the critical dialogue about performance measurement for integrated care.

APPENDIX 1: Core Quality Measures Used by States Participating in Financial Alignment Demonstrations[1]

Measure	Description	Measure Steward/ Data Source
Antidepressant Medication Management	Percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS
Initiation and engagement of alcohol and other drug dependence treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA/HEDIS
Follow-up after hospitalization for mental illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS
Screening for clinical depression and follow-up care	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS

[1] Note that these CMS-required core measures were taken from the Memorandum of Understanding (MOU) between CMS and the Commonwealth of Massachusetts. For additional details see: "Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the Commonwealth of Massachusetts." Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf. The MOU between CMS and the State of Ohio includes one additional core measure: "Health Status/Function Status" that is defined as the percent of members who reports their health as excellent. See: "Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the State of Ohio." https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OHMOU.pdf. The MOU between CMS and Washington State lists two additional two core measures not included by either Massachusetts or Ohio: Ambulatory Care-Sensitive Condition Hospital Admission and Ed Visits for Ambulatory Care-Sensitive Conditions. See: "Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the State of Washington." http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf.

Measure	Description	Measure Steward/ Data Source
SNP 1: Complex Case Management	The organization coordinates services for members with complex conditions and helps them access needed resources. Element A: Identifying Members for Case Management Element B: Access to Case Management Element C: Case Management Systems Element D: Frequency of Member Identification Element E: Providing Members with Information Element F: Case Management Assessment Process Element G: Individualized Care Plan Element H: Informing and Educating Practitioners Element I: Satisfaction with Case Management Element J: Analyzing Effectiveness/Identifying Opportunities Element K: Implementing Interventions and Follow-up Evaluation	NCQA/HEDIS
SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for members. Element A: Coordination of Benefits for Dual Eligible Members Element B: Administrative Coordination of D-SNPs Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos) Element D: Service Coordination Element E: Network Adequacy Assessment	NCQA/HEDIS
Care Transition Record Transmitted to Health Care Professional	Percent of Demonstration participants discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or to the health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI
Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS

Measure	Description	Measure Steward/ Data Source
SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions. Element A: Managing Transitions Element B: Supporting Members through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions Element E; Analyzing Transitions Element F: Reducing Transitions	NCQA/HEDIS
CAHPS, various settings including: - Health Plan plus supplemental items/questions, including: - Experience of Care and Health Outcomes for Behavioral Health (ECHO) - Home Health - Nursing Home - People with Mobility Impairments - Cultural Competence - Patient Centered Medical Home	Depends on Survey	AHRQ/CAHPS
Part D Call Center – Pharmacy Hold Time	Part D Call Center – Pharmacy Hold Time	CMS/Call Center data
Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	CMS/Call Center data
Part D Appeals Auto–Forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.	IRE

Measure	Description	Measure Steward/ Data Source
Part D Appeals Upheld	How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal. This measure is defined as the percent of IRE confirmations of upholding the plans' decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100.	IRE
Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 days.	Medicare Advantage Prescription Drug System (MARx)
Part D Complaints about the Drug Plan	How many complaints Medicare received about the drug plan. For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS/CTM data
Part D Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS/Administrative data
Part D Members Choosing to Leave the Plan	The percent of drug plan members who chose to leave the plan in 2013.	CMS/Medicare Beneficiary Database Suite of Systems
Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS/PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan

Measure	Description	Measure Steward/ Data Source
Part D High Risk Medication	The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS/PDE data
Part D Diabetes Treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS/PDE data
Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS/PDE data
Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS/PDE data
Part D Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are	CMS/PDE data
Plan Makes Timely Decisions about Appeals	Percent of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage.	IRE
Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.	IRE
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.	CMS/Call Center data
Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed

Measure	Description	Measure Steward/ Data Source
Consumer governance board	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements.	CMS/State defined process measure
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. In the last 6 months, how often did your health plan's customer service give you the information or help you needed? In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS
Assessments	Percent of Enrollees with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure
Individualized Care Plans	Percent of members with care plans by specified timeframe.	CMS/State defined process measure
Real time hospital admission notifications	Percentage of hospital admission notifications occurring within specified timeframe	CMS/State defined process measure
Risk Stratification Based on LTSS or Other Factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS/State defined process measure
Discharge follow up	Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit	CMS/State defined process measure
Self-direction	Percent of care coordinators that have undergone State-based training for supporting self-direction under the Demonstration.	CMS/State defined process measure
Care for Older Adults – Medication Review	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/HEDIS
Care for Older Adults – Functional Status Assessment	Percent of plan members whose doctor has done a functional status assessment to see how well they are doing activities of daily living (such as dressing, eating, and bathing).	NCQA/HEDIS

Measure	Description	Measure Steward/ Data Source
Care for Older Adults – Pain Screening	Percent of plan members who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS
Diabetes Care – Eye Exam	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/HEDIS
Diabetes Care – Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	NCQA/HEDIS
Diabetes Care – Blood Sugar Controlled	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	NCQA/HEDIS
Rheumatoid Arthritis Management	Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS
Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HOS
Plan all-cause readmissions	Percent of enrollees discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS
Comprehensive medication review	Percentage of beneficiaries who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance
Complaints about the Health Plan	How many complaints Medicare received about the health plan. Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS/CTM data

Measure	Description	Measure Steward/ Data Source
Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS/Beneficiary database
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in 2013.	CMS
Getting Information From Drug Plan	The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost. -In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? -In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? -In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? -In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?	AHRQ/CAHPS
Rating of Drug Plan	The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs. -Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?	AHRQ/CAHPS

Measure	Description	Measure Steward/ Data Source
Getting Needed Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan. -In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? -In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?	AHRQ/CAHPS
Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists. • In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?	AHRQ/CAHPS
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care. • In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	AHRQ/CAHPS
Overall Rating of Health Care Quality	Percent of best possible score the plan earned from plan members who rated the overall health care received. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	AHRQ/CAHPS

Measure	Description	Measure Steward/ Data Source
Overall Rating of Plan	Percent of best possible score the plan earned from plan members who rated the overall plan. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	AHRQ/CAHPS
Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.	NCQA/HEDIS
Colorectal Cancer Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS
Cardiovascular Care – Cholesterol Screening	Percent of plan members with heart disease who have had a test for bad (LDL) cholesterol within the past year.	NCQA/HEDIS
Diabetes Care – Cholesterol Screening	Percent of plan members with diabetes who have had a test for bad (LDL) cholesterol within the past year.	NCQA/HEDIS
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	NCQA/HEDIS
Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	CMS/HOS

Measure	Description	Measure Steward/ Data Source
Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS/HOS
Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS
Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS
Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS
Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS
Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS

AHRQ = Agency for Healthcare Research and Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; CTM = Care Transition Measure; HEDIS = Healthcare Effectiveness and Data Information Set; IRE = Independent Review Entity; LTSS = Long-term Services and Supports; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; PDE = Prescription Drug Event; SNP = Special Needs Plan

APPENDIX 2: State-Defined Quality Measures for Financial Alignment Demonstrations [2]

Measure	Description	Measure Steward/Data Source	MA	OH	WA
Tracking of demographic information	Percent of all Demonstration participants for whom specific demographic data is collected and maintained in the ICO Centralized Enrollee Record, including race, ethnicity, disability type, primary language, and homelessness, in compliance with contract requirements.	CMS/State defined process measure	X	X	
Documentation of care goals	Percent of Enrollees with documented discussions of care goals.	CMS/State defined process measure	X	X	
Access to an IL-LTSS Coordinator	Percent of Enrollees with LTSS needs who have an IL-LTSS Coordinator.	CMS/State defined process measure	X		
Ensuring physical access to buildings, services and equipment	ICO has established a work plan and identified individual in its organization who is responsible for ADA compliance related to this Demonstration.	CMS/State defined process measure	X		
Access to Care	Percent of respondents who always or usually were able to access care quickly when they needed it.	AHRQ/CAHPS	X		
Documented Discussion of Member Rights and Member Choices for Providers	Percent of members with documented discussion of their rights and choices for providers.	MassHealth	X		
Screening for Preferred Language	Percent of members who are screened for their preferred language.	MassHealth	X		
Wait Time for Interpreter	Percent of members who need an interpreter and always wait fewer than 15 minutes for the interpreter.	MassHealth	X		
Frequency of Ongoing Prenatal Care	Proportion of pregnant women with expected number of prenatal visits.	NCQA/HEDIS	X		
Documented Discussion of Care Goals	Percent of members with documented discussion of care goals.	MassHealth	X		
Enrollees with LTSS Needs who have an IL-LTSS Coordinator	Percent of members with LTSS needs that have an IL-LTSS Coordinator on their interdisciplinary care team.	MassHealth	X		

[2] These state-defined quality measures were taken from: 1) "Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the Commonwealth of Massachusetts." Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf; 2) "Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the State of Ohio." https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OHMOU.pdf; and 3) "Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the State of Washington." http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf.

Measure	Description	Measure Steward/Data Source	MA	OH	WA
3-Item Care Transition Measure (CTM-3)	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions.	University of Colorado	X		
Chronic Obstructive Pulmonary Disease (PQI 5)	Assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	AHRQ	X		
Congestive Heart Failure Admission Rate (PQI 8)	Percent of county population with an admission for congestive heart failure.	AHRQ	X		
Percent of residents whose need for help with daily activities has increased	This measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents in a nursing facility whose need for help with late-loss Activities of Daily Living (ADLs), as reported in the target quarter's assessment, increased when compared with a previous assessment. The four late-loss ADLs are: bed mobility, transferring, eating, and toileting. This measure is calculated by comparing the change in each item between the target MDS assessment (OBRA, PPS or discharge) and a previous assessment (OBRA, PPS or discharge).	NQF/CMS		X	
Percent of residents who have/had a catheter inserted and left in their bladder	This measure updates CMS' MDS 2.0 quality measure on catheter insertions. It is based on data from Minimum Data Set (MDS) 3.0 assessments of long-stay nursing home residents (with cumulative days in the facility greater than 100 days). This measure captures the percentage of low risk long-stay residents who have had an indwelling catheter in the last seven days noted on the most recent MDS 3.0 assessment, OBRA, PPS or discharge during the selected quarter (3-month period). Long stay residents are those residents who have been in nursing care for over 100 days. The measure is restricted to this population, which has long-term care needs, rather than the short-stay population, who are discharged within 100 days of admission.	NQF/CMS		X	
Percent of residents who were physically restrained	Measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents who were physically restrained. The measure reports the percentage of all long-stay residents in nursing facilities with an annual, quarterly, significant change, or significant correction MDS 3.0 assessment during the selected quarter (3-month period) who were physically restrained daily during the 7 days prior to the MDS assessment (which may be annual, quarterly, significant change, or significant correction MDS 3.0 assessment).	NQF/CMS		X	
Percent of residents experiencing one or more falls with a major injury	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge	NQF/CMS		X	

Measure	Description	Measure Steward/Data Source	MA	OH	WA
	assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.				
Percent of residents with urinary tract infection	This measure updates CMS' MDS 2.0 QM on Urinary Tract Infections in the nursing facility population. It is based on MDS 3.0 data and measures the percentage of long-stay residents who have a urinary tract infection on the target MDS assessment (OBRA, PPS or discharge). In order to address seasonal variation, the proposed measure uses a 6-month average for the facility. Long-stay nursing facility residents are those with cumulative days in the facility over 100 days.	CMS		X	
Long Term Care Overall Balance Measure*	Reporting of the number of Enrollees who did not reside in a NF as a proportion of the total number of Enrollees in an ICDS Plan. Numerator: of those Enrollees in the denominator, those who did not reside for more than 100 continuous days in a NF during the current measurement year. Denominator: Enrollees in ICDS Plan eleven out of twelve months during the current measurement year. Exclusions: Any member with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.			X	
Ambulatory Care-Sensitive Condition Hospital Admission (PQI Composite #90)					X
Emergency Department Visits for Ambulatory Care-Sensitive Conditions (Rosenthal)					X
Health Action Plans	Percentage of beneficiaries with Health Action Plans with 60 days of beneficiary being assigned to a Care Coordination Organization.				X
Training	State delivery of training for Health Home Networks on disability and cultural competence and health action planning.				X
Agreement to Receive Part D data	Percentage of health homes with an agreement to receive data from health home beneficiaries' Medicare Part D plans				X

AHRQ = Agency for Healthcare Research and Quality; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; HEDIS = Healthcare Effectiveness and Data Information Set; ICO = Integrated Care Organization; ICDS = Integrated Care Delivery System; LTSS = Long-term Services and Supports; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum

About the Center for Health Care Strategies

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

This technical assistance brief is part of CHCS' *Technical Assistance for Dual Eligible Integrated Care Demonstrations* program, made possible through The SCAN Foundation and The Commonwealth Fund. Through this program, CHCS is helping demonstration states develop and implement integrated-care models for individuals eligible for both Medicare and Medicaid services. For more information, visit www.chcs.org.

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Endnotes

[1] For a general overview of quality measurement including the standardized measurement sets described in this brief, please see S. Scholle. "Introduction to Quality Measurement." Presented at the National Council on Aging's Friday Morning Collaborative "Introduction to Quality Measures in Managed Long-Term Services and Supports." November 30, 2012. Available at: http://www.ncoa.org/public-policy-action/long-term-services--supports/webinars-on-medicaid-hcbs.html.
[2] Medicare/Medicaid Plans, Quality Improvement Program. See 42 C.F.R. § 422.152(g)(2)(iii) (2011). Available at: http://cfr.regstoday.com/42CFR422.aspx#42_CFR_422p152.
[3] Medicare Payment and Advisory Commission. "Report to Congress: Medicare Payment Policy." Chapter 12. March 2012.
[4] Centers for Medicare & Medicaid Services. "2012 HEDIS, HOS, and CAHPS Measures for Reporting by Medicare Advantage and Other Organization Types." Memorandum August 8, 2011.
[5] A. Simon. Minnesota Department of Health. "The Measurement Universe: Overview of Current Measures and Reporting Requirements for Medicare, Medicaid and Clinics in Minnesota" Presentation on November 29, 2012.
[6] Ibid.
[7] Among MSHO plans reporting HEDIS results are UCare, South Country Health Alliance, Prime West, Metropolitan Health Plan, Medica, Itasca Medical Care, Health Partners/Group Health, and Blue Plus. "HEDIS 2011. Reporting Year: January 1, 2011 to December 31, 2011." Minnesota Department of Health. Available at http://www.health.state.mn.us/divs/hpsc/mcs/hedis12.htm.
[8] "HEDIS and Quality Measurement. HEDIS Measures. HEDIS 2012: Technical Specifications for Health Plans, Volume 2." Available at www.ncqa.org.
[9] 2012 Plan Rating Fact Sheet and Technical Notes. Found at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.
[10] "Medicare Plan Finder." Medicare.gov. Available at https://www.medicare.gov/find-a-plan/questions/home.aspx
[10] Hilltop Institute -- MedPac, June 2008; based on data from the 2005 MCBS Cost and Use file
Data from 2003 MCBS http://www.cms.hhs.gov/MCBS/Downloads/CNP_2003_dhsec8.pdf.
[11] Ibid.
[12] See http://www.mass.gov/eohhs/provider/insurance/masshealth/senior-care-options/senior-care-options-overview.html.
[13] MassHealth SCO Program Evaluation Nursing Facility Entry Rate in CY 2004-2005 Enrollment Cohorts." Available at http://www.mass.gov
[14] Senior Care Options Evaluation Phase 2: Member Experience Report of Individual Interviews, found at mass.gov website above. September 2007.
[15] Analysis of Care Coordination Outcomes /A Comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries, July 2012, found at http://www.avalerehealth.net/research/index.php.
[16] Ibid.
[17] Texas Health and Human Services Commission. HHSC Uniform Managed Care Manual. "Performance Indicator Dashboard for Quality Measures." February 1, 2012. Available at: http://www.hhsc.state.tx.us/medicaid/umcm/Chp10/10_1_7.pdf.
[18] Medicare-Medicaid Demonstrations - Frequently Asked Questions. Found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidDemoFAQ.pdf.
[19] S.C. Reinhard, E. Kassner, A. Houser, R. Mollica. "Raising Expectations: A Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers. AARP. September 2011.
[20] Link to BRFSS is at http://www.cdc.gov/brfss/questionnaires/english.htm
[21] Federal Register**.** United States Government Printing Office. Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-07-24/pdf/2012-17924.pdf
[22] CDC source for Healthy Days measure found at http://www.cdc.gov/hrqol/hrqol14_measure.htm).
[23] R. Kane. "Quality of Life Scales for Nursing Home Residents." December 2003.
[24] "National Core Indicators." HSRI.org. Available at http://www.hsri.org/project/national-core-indicators/overview
[25] "Development of Methods and Training for Assessing Personal Experience Outcomes for Adults with Developmental or Physical Disabilities and Frail Elders in Wisconsin's Medicaid-Funded HCBS And Managed Long-Term Care Programs." Wisc.edu. Available at http://www.chsra.wisc.edu/peonies/index.htm
[26] National Quality Forum Measure Application Partnership. "Measuring Healthcare Quality for the Dual Eligible Beneficiary Population, Final Report to HHS." June 2012. Available at: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71218.
[27] [27]"Nursing Home Compare" Medicare.gov. Available at http://www.medicare.gov/NursingHomeCompare/search.aspx?bhcp=1
[28] "Health Home Compare." Medicare.gov. Available at http://www.medicare.gov/homehealthcompare
[29] Saucier et al., The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update. Prepared for the Centers for Medicare & Medicaid Services (CMS), Disabled and Elderly Health Programs Group, July 2012.
[30] D. Lipson, J. Libersky, R. Machta, L. Flowers, and W. Fox-Grage. "Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports. AARP Public Policy Institute. July 2012. Available at: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf.
[31] "Memorandum of Understanding (MOU) Between the Centers for Medicare & Medicaid Services (CMS) and the Commonwealth of Massachusetts." Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf.
[32] National Quality Forum Measure Applications Partnership, op. cit. Also see the National Quality Forum's "Quality Positioning System" that allows users to search for quality measures using a variety of search filters such as condition, care setting, measure steward, and data source. Available at: http://www.qualityforum.org/QPS/.
[33] Raising Expectations, found at http://www.longtermscorecard.org/
[34] Ibid.
[35] Approved MOUs can be found here: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

[36] J. Kasper, M. O'Malley-Watts, B. Lyons. "Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending." Kaiser Commission on Medicaid and the Uninsured, July 2010. Available at http://www.kff.org/medicaid/8081.cfm.
[37] National Quality Forum Measure Application Partnership. "Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS. June 2012. Available at: http://www.qualityforum.org/Setting_Priorities/Partnership/Duals_Workgroup/Dual_Eligible_Beneficiaries_Workgroup.aspx.
[38] Medication possession ratio is a measure of continuity or adherence and is a ratio of the number of days between the most recent refill and the next expected refill to the number of days between the most recent refill and the next actual refill.
[39] Memorandum of Understanding between CMS and Massachusetts, op. cit.
[40] Health plans participating in the duals demonstration will be responsible for ensuring enrollees have seamless access to all necessary medical, LTSS and behavioral health services. The blended capitation rates paid to the health plans participating in the duals demonstration will cover all Medicare and Medi-Cal benefits EXCEPT for Medi-Cal specialty mental health and Drug Medi-Cal services. Because counties have financial and administrative control over funding and delivery of these services, they will remain carved out of the demonstration service package. However, CMS and DHCS have proposed a "framework for shared accountability" that will promote close coordination between the participating health plans and county behavioral health agencies. This includes requiring them to update their MOUs and develop specific care coordination policies and procedure. For more information see: http://www.calduals.org/wp-content/uploads/2012/09/FAQBH090512.pdf.
[41]California Dual Demonstration DRAFT Quality Metrics found at http://www.calduals.org/workgroup/quality/
[42] J.Y. Kim, et al. SMI Innovations Project in Pennsylvania: Final Evaluation Report, Center for Health Care Strategies, October 2012.
[43] National Committee for Quality Assurance. "Special Needs Plans Structure & Process Measures. 2012. Available at: http://www.ncqa.org/LinkClick.aspx?fileticket=22sptw2WMV8%3d&tabid=1434&mid=5960&forcedownload=true.
[44] United States Government Accountability Office. "CMS Should Improve Information Available about Dual-Eligible Plans' Performance." United States Government Accountability Office. Available at http://www.gao.gov/products/GAO-12-864.
[45] Massachusetts Executive Office of Health and Human Services. "Massachusetts-specific Readiness Review Plan." November 28, 2012. Available at: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/readiness-review-tool.pdf.
[46] Available at: www.calduals.org.
[47] Ibid.
[48] "The SCAN Foundation's 2012 California Long-Term Services and Supports Summit Report." The SCAN Foundation. Available at http://www.thescanfoundation.org/scan-foundations-2012-california-long-term-services-and-supports-summit-report.
[49] Agency for Healthcare Research and Quality (AHRQ) 2010. Appendix includes tested measures that reflect beneficiary experience and performance measures. Found at: http://www.ahrq.gov/research/ltc/hcbsreport/.
[50] "Promoting Integrated Care for Dual Eligibles, Phase 1." The Commonwealth Fund. Available at: http://www.commonwealthfund.org/Grants/2012/Apr/Promoting-Integrated-Care-for-Dual-Eligibles-Phase-1.aspx
[51] Supporting Statement for Evaluation and Development of Outcome Measures for Quality Assessment in Medicare Advantage and Special Needs Plans, Contract Number: HHSM-500-2005-00028I, Task Order Number: HHSM-500-T0004.
[52] "CMS Should Improve Information Available about Dual-Eligible Plans' Performance." United States Government Accountability Office. Available at http://www.gao.gov/products/GAO-12-864.