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Issue Brief

Assessing Care Integration for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative

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Abstract: Caring for the 9 million low-income elderly or disabled adults who are eligible for full benefits under both Medicare and Medicaid can be extremely costly. As part of the federal Financial Alignment Initiative, states have the opportunity to test care models for dual-eligibles that integrate acute care, behavioral health and mental health services, and long-term services and supports, with the goals of enhancing access to services, improving care quality, containing costs, and reducing administrative barriers. One of the challenges in designing these demonstrations is choosing and applying measures that accurately track changes in quality over time—essential for the rapid identification of effective innovations. This brief reviews the quality measures chosen by eight demonstration states as of December 2013. The authors find that while some quality domains are well represented, others are not. Quality-of-life measures are notably lacking, as are informative, standardized measures of long-term services and supports.

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OVERVIEW

An estimated 9 million low-income seniors and under-65 adults with disabilities are eligible for full benefits under both Medicare and Medicaid. Many within this "dual-eligible" population have complex physical and mental health conditions, and 44 percent require long-term care services and supports. ^{2,3}

Care for this population can be extremely costly, and not only because of the greater number of health and social services that these individuals need. The fragmented nature of care delivery in much of the United States drives costs up as well. Dual-eligible beneficiaries in particular receive care in multiple settings, and many individuals—particularly those lacking a regular primary care physician—have difficulty getting consistent, appropriate care. ^{4,5} With separate coverage from Medicare and Medicaid, dual-eligible beneficiaries, or duals, often

do not benefit from integrated approaches to care that ensure the best balance of primary, preventive, and community-based services.⁶

Many state policymakers, encouraged by the Affordable Care Act, are turning to managed care organizations to help ensure that duals have access to seamless, high-quality, and affordable health care. As part of the federal Financial Alignment Initiative, launched in 2011, states have the opportunity to test models of care that integrate acute care, behavioral health and mental health services, and long-term services and supports (LTSS) (such as personal care services) for duals. The demonstrations' goals are to enhance access to services, improve quality, contain costs, and reduce administrative barriers for beneficiaries and providers. States that successfully achieve these objectives have an opportunity to share in any savings realized. 8

Among the many challenges that states, insurers, and the Centers for Medicare and Medicaid Services (CMS) face in designing and implementing these demonstration projects is how to choose and apply measures that accurately track changes in quality and performance over time. This brief reviews the quality measures chosen for the eight states with federally approved memorandums of understanding (MOUs) for their demonstrations as of December 2013. The discussion is informed by insights obtained from interviews conducted in early 2013 with health service providers, beneficiary advocates, and state and federal officials to understand various perspectives on different aspects of the demonstrations.

HOW THE DUAL-ELIGIBLE DEMONSTRATIONS WORK

States participating in the Financial Alignment Initiative choose between a managed fee-for-service model and a capitated model. Under managed fee-for-service, states build and contract with qualified provider networks to deliver services to duals. If quality benchmarks are met and savings targets are realized, CMS and the states will provide participating providers with a retrospective performance payment. Alternatively, states may choose a capitated model, in

which they contract with CMS and managed care organizations (MCOs) to provide the full range of Medicare and Medicaid benefits. CMS and states reduce their payments to MCOs according to a negotiated schedule to generate savings in each year of the demonstration. Thus, savings are created automatically as CMS and the states reduce their respective baseline contributions to the plans by a set percentage each year.

Exhibit 1 shows the upfront savings required of the demonstrations (these percentages will be deducted from both Medicare and Medicaid payments to MCOs for each year) and the "quality withhold" percentages (the portion of the capitation rate that will be withheld upfront). MCOs can earn back the quality withholds if they meet specified federal quality benchmarks as well as state-specified quality measures.

MEASURING QUALITY OF CARE

A major component of the demonstrations in the Financial Alignment Initiative is the evaluation and expanded use of quality-of-care measures, which are essential in making ongoing adjustments to the delivery of services to enrolled dual eligibles. However, there are many challenges around quality and performance measures. One is that many measures are designed for only one system of care or for a specific subpopulation. Another is that some of the most important aspects of care, such as care coordination, do not have standardized measures. In

The accompanying table on page 8 catalogs the quality measures of the eight states that have completed MOUs prior to December 2013: Massachusetts, Ohio, Washington, Illinois, California, Virginia, New York, and South Carolina. These states agreed to collect data on both core quality measures selected by CMS, as well as additional measures specified by the states, all of which will be reported and analyzed by CMS.

The noncore measures or state-specified measures were chosen to reflect different health and support services needs among subpopulations of duals. For example, Ohio aims to achieve a shift, or rebalancing, of the state's current reliance on institutional LTSS for

older adults to less costly (on a per capita basis) home and community-based services (HCBS). In contrast, Massachusetts' demonstration focuses on younger individuals with disabilities, many of whom have significant behavioral health needs.

Thus, quality measures vary from state to state. While this may be necessary, given that the demonstrations are not identical across states, these are still demonstrations that are subject to further scrutiny. Researchers and, ultimately, policymakers will need a common and comparable set of metrics if they are to make useful cross-state comparisons of models of care.

Quality Measures in the MOUs

The accompanying table on page 8 presents federally required core measures and state-specified noncore measures selected for the Financial Alignment Initiative alongside measures required by other programs to improve coordination of care for duals. As a practical matter, only a modest number of MCOs have experience with coordinating Medicare and Medicaid services for duals. ¹² Past efforts include Medicare

Special Needs Plans (SNPs),¹³ which are now required to contract with state Medicaid agencies, though not necessarily to coordinate services, and the Program of All-Inclusive Care for the Elderly (PACE), which was created to address the health and LTSS needs of duals with chronic care needs. Other potentially promising models are either small in scale or are still in the beginning phases (e.g., medical or health homes, and accountable care organizations).

PACE plans and Dual Eligible SNPs (D-SNPs)—a type of Medicare Advantage plan that exclusively enrolls duals—are among the most well-known models of care that support integration of Medicare and Medicaid. PACE plans, which are effectively small staff-model MCOs that provide both health care and social services at an adult day care center, are at financial risk for providing all medically necessary health, LTSS, and related social supports to nursing home—eligible elders. The focus of care is on primary and secondary prevention, with primary care services available five days a week in the PACE center, which is staffed by physicians, nurses, therapists, and other

Exhibit 1. Savings Requirements and Quality Withholds in the Financial Alignment Initiative

State	Saving Percentages Portions of t	Applied to Medicate he Baseline Capit		(Quality Withhol	d
	YEAR 1	YEAR 2	YEAR 3	YEAR 1	YEAR 2	YEAR 3
Massachusetts*	none for first 6 months, 1% for remainder of year	2%	more than 4%**	1%	2%	3%
Ohio	1%	2%	4%	1%	2%	3%
Washington***	1%	2%	3%	1%	2%	3%
Illinois	1%	3%	5%	1%	2%	3%
California	1% min. and 1.5% max.	2% min. and 3.5% max.	4% min. and 5.5% max.	1%	2%	3%
Virginia	1%	2%	4%****	1%	2%	3%
New York	1%	1.5%	3%	1%	2%	3%
South Carolina	1%	2%	4%	1%	2%	3%

^{*} Based on three-way contract between CMS, the Commonwealth of Massachusetts, and Commonwealth Care Alliance, Inc./Fallon Community Health Plan Network Health, LLC. Issued: July 11, 2013. Available online at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf.

^{**} In year 3 in Massachusetts, the 4% savings will be increased based on the amount of savings that would have been achieved had a 1% savings been applied throughout year 1.

^{***} The information for Washington is for its capitated model, not its managed fee-for-service model.

^{****} Savings in year 3 in Virginia will be reduced to 3% if one-third of plans experience losses exceeding 3% of revenue in all regions in which those plans participate in year 1 (Feb. 2014-Dec. 2015). Note: This chart reflects the saving percentages and quality withholds in MOUs and three-way contracts as of Dec. 2013.

Though the demonstrations are still in the early stages of testing models of care for different subpopulations of duals, a majority of the participating states are using a managed care model. Moreover, CMS has now approved MOUs covering more than half of the intended population that the agency hopes will be enrolled in the program.

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health care personnel, all working within an interdisciplinary team.

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D-SNPs were initially not required to have contracts with state Medicaid programs and they were not at risk for LTSS services. Owing to changes in federal requirements, a growing number of D-SNPs contracting with states are now putting themselves at risk for delivering some LTSS services. There are long-standing concerns that standard measurement sets, like the Healthcare Effectiveness Data and Information Set (HEDIS), which are required of most MCOs, are not well suited for measuring the quality of care provided to duals and comparable populations. ^{14,15}

Observations Based on Stakeholder Interviews

Quality metrics have traditionally demonstrated "the ability of a doctor, hospital or health plan to provide services for individuals and populations that increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Interviewees agreed that the Financial Alignment Initiative's quality measures must be expanded to capture the performance of states in ensuring that duals receive the long-term services and supports that they so often require. As the accompanying table on page 8 illustrates, there is a paucity of quality measures appropriate for home and community-based LTSS settings.

A further challenge is to collect and report quality data at the individual practitioner or provider group level, not just at the plan level. Under current practice, states generally require contracting Medicaid MCOs to report their performance on HEDIS metrics, which yield plan-level data for comparing quality of care provided to Medicare and Medicaid beneficiaries and to commercial enrollees. 17 Interviewees agreed on the importance of having core quality measures for all participating plans and providers participating in the initiative so that states and CMS can compare them fairly. Having such a comprehensive measure set, they argue, would allow states, CMS, and others to calculate bonuses that reward high-quality care and quality improvement, while also focusing needed corrective action on providers whose performance lags. However, they also noted that achieving these aims would require substantial investments in new data collection and analysis systems.

During the initial phase, great emphasis has been placed on making sure that participating states and plans are developing demonstrations that are patient-centered. Yet there are no validated quality-of-life measures for a population with high needs for social and medical services. Plans will report results from the Medicare Health Outcomes Survey (HOS), which measures self-reported mental and physical health, pain, and activity limitations, as well as the extent to which poor physical or mental health impairs usual activities, such as self-care or employment. ^{18,19}

Stakeholders acknowledge that it takes time to adapt existing quality measurement tools such as the HOS, or to develop novel measures, which must also then be validated. Some states are launching efforts to do just that: California will track beneficiary satisfaction with LTSS workers and case managers, and Illinois is tracking stability in living situations, return to work (or school), and involvement with the criminal justice system among beneficiaries with severe mental illness.

DISCUSSION

Three broad observations arose in categorizing the quality measures currently being considered by states participating in the demonstrations.

1. Some categories include multiple core measures, while others have few or none. For example, there are nine core measures in the prevention and screening category, as well as numerous beneficiary- and family-centered care measures and prescription drug benefit measures in the core set. However, in the categories of nursing home and long-term care, only one measure—percentage of high-risk residents with pressure ulcers—is a core measure. This suggests that a great deal of work remains to be done to either develop new measures or adapt existing measures in these areas.²⁰

Similarly, there is only one major core hospital measure—all-cause hospital readmissions. As

noted by the National Quality Forum, this measure is meant to examine the "connectedness" of care for duals across settings, since the frequency of readmissions is thought to indicate whether care coordination, communication, and community supports are in place and working well.²¹ But all-cause readmission rates alone may not capture the effects of all aspects of care, and they are not well correlated with other common hospital quality measures. Other measures of care coordination during hospital transfers may be necessary.²²

2. There is an absence of quality-of-life measures in wide use. A few states, such as Illinois, which is using the Participant Outcomes and Status Measures Quality of Life Survey, 23 and Massachusetts, which will be developing a qualityof-life measure for demonstration years 2 and 3,²⁴ include quality-of life measures. South Carolina's demonstration includes a quality-of-life measure that tracks the percentage of enrollees receiving the palliative care benefit whose pain was brought under control within 48 hours. However, the measures are few in number, and, moreover, no such measures are required by CMS within the core set.²⁵ Quality of life might span multiple domains outside medical care, such as consumers' perception that they can choose their living arrangements and friends, that they are treated with respect, that they have good relationships with their caretakers, and that they participate in community activities.²⁶

If Congress or the federal government wants to know whether integrated care programs make a difference in the lives of beneficiaries, additional research and funding may be needed to conduct integrated consumer surveys in the places where people receive services.

3. There is a lack of informative, standardized LTSS measures. Though some states, such as Ohio and Virginia, have incorporated measures of long-term services and supports for use in home care or community-based care settings, the majority of the LTSS measures used in the demonstrations are based on nursing facility measures, such

as the percentage of residents who have been physically restrained. Adapting such measures for use in other settings would allow greater cross-setting comparison and maximize their utility.

At present, there are comparatively few quality measures used to assess home- and community-based services. Massachusetts will track the number of members with access to an independent-living LTSS coordinator, while California will collect consumer satisfaction data. But entirely absent are any kind of patient experience-of-care measures based on an individual's goals and preferences. In addition, there are few measures that can be used to assess whether demonstration states are making progress on rebalancing LTSS from institutional to HCBS services, and there is no consistency among states in the use of such measures.

CONCLUSION

The duals demonstrations place a great deal of attention on the design, validation, and incorporation of quality measures that allow for the rapid identification of effective innovations, with the goal of improving the program-wide performance of Medicare and Medicaid.²⁷ If this occurs, the experience of duals will also benefit people receiving services in accountable care organizations, among other care delivery models, and from traditional fee-for-service providers. Once quality measures for these populations become standardized, it is conceivable to imagine a tool that enables researchers, policymakers, stakeholders, and consumers to readily understand what the most commonly used quality measures are across similar models of care for comparable populations. Furthermore, one could imagine working to develop quality comparison tools that draw from standardized core quality metrics, allowing consumers to actually compare the performance of individual plans in their area.

NOTES

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DUAL DEMONSTRATION QUALITY MEASURES OF PARTICIPATING STATES

QUALITY MEASURE	DESCRIPTION	DATA Source	PACE	SNPs	CMS CO MEASU		STA			randl Tandii		OF
						M	Α 0	H WA	* IL	CA V	A N	ΥS
ASSESSMENTS AND (CARE PLAN MEASURES											
Documentation of Care Goals	Percent of enrollees with documented discussions of care goals.	CMS/State-defined process measure		_	X	Х	: х	X	Х	Х	()	(
	Percent of enrollees in Tier 3 enrolled at least 90 days with documented discussion of care goals in the health action plan.	State-defined process measure						Х				
	Proportion of enrollees at each risk level with individual care plan (ICP) developed within specified time frames compared with total enrollees at each risk level requiring ICPs. Percent of enrollee ICPs that contain documented discussion of	State-specified measure										X
Assessments	care goals with enrollee and/or caregiver and multidisciplinary team. Percent of enrollees with initial assessments completed within required time frames.	CMS/State-defined process measure	•						<u>-</u>)
	Percent of members with initial assessments completed within 30 days of enrollment.	CMS/State-defined process measure	-		X	Х				Х	· ·	(
	Percent of members with initial assessments completed within 90 days of enrollment.	CMS/State-defined process measure	-				Х			X		
Risk Assessments	Percent of enrollees stratified to medium or high risk with a completed comprehensive assessment within 90 days of enrollment.	CMS/State-defined process measure	-		Х			Х	Х			
Pain Assessment Conducted	Percent of home health episodes where the member had any pain at start of episode and was assessed using a standardized pain assessment tool.	University of Colorado		•	-	Х						
Individualized Care Plans	Percent of members with care plans by specified time frame.	CMS/State-defined process measure	-		X	Х	Х	X	Х	х х		Х
	Percent of participants with care plans within 30 days of initial assessment	CMS/State-defined process measure	•						•••••)	(
Level of Care Evaluation	Number and percent of all new enrollees who have a level of care indicating a need for institutional/waiver services.	State/1915(c) EDCD waiver requirement	•							Х		
Level of Care Reevaluation	Number and percent of waiver participants who received an annual level of care (LOC) evaluation of eligibility within 365 days of their initial LOC evaluation or within 365 days of their last annual LOC evaluation using the state's approved form(s).	State/1915(c) EDCD waiver requirement								Х		
Level of Care Reviews	Number and percent of completed LOC forms entered into LOCERI system for standardized LOC review. Number and percent of LOC reviews that LOCERI indicate do not meet LOC criteria sent for higher-level review (HLR). Number and percent of waiver individuals who did not meet LOC criteria after HLR who were terminated from the waiver after completion of appeal process (if any).	State/1915(c) EDCD waiver requirement								х		
Service Plans	Number and percent of waiver individuals who have a service plan in the record. Number and percent of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals, as indicated in the assessment. Number and percent of service plans developed in accordance with the state's regulations and policies. Number and percent of waiver individuals whose service plan was updated/revised at least annually. Number and percent of waiver individuals whose service plan was revised as needed, to address changing needs.	State/1915(c) EDCD waiver requirement								х		
Services	Number and percent of waiver individuals who received services of the type specified in the service plan. Number and percent of waiver individuals who received services in the frequency specified in the service plan. Number and percent of waiver individuals who received services for the duration specified in the service plan. Number and percent of waiver individuals who received services in the scope specified in the service plan. Number and percent of waiver individuals who received services in the amount specified in the service plan.	State/1915(c) EDCD waiver requirement								х		
Choice	Number and percent of waiver individuals whose records contain an appropriately completed and signed form that specifies choice was offered between institutional care and waiver services. Number and percent of waiver individuals whose records contain an appropriately completed and signed form that specifies choice was offered among waiver services. Number and percent of waiver individuals whose records documented that choice of waiver providers was provided to the individual.	State/1915(c) EDCD waiver requirement								Х		

	DESCRIPTION	SOURCE	PACE	SNPs	MEASUR	Ε	ļ	JNDI	RS	ΓΑΝΙ)IN(3)F
						MA	ОН	WA*	IL	CA	VA	NY	S
PREVENTION AND SCI	REENING												
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			Х	Х	Х	Х	Х	Х	Х	Х)
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/HEDIS; HOS			X	Х	Χ	X	Х	X	Χ	Х)
Rate of Falls Resulting	Total number of falls for PACE participants resulting in an Injury Severity Rating*	NQF 21 measures	X							-	•••••		
n Injury Number of Falls	level of III-V (moderate to death) in all locations. Number of falls resulting in an Injury Severity Rating* level of I-V (none to death).	for nursing homes NQF 21 measures	X				-		-				
all Intervention	Percent of enrollees with: documented fall risk assessment; a history of falls with documented fall intervention; and who receive appropraite fall prevention interventions based upon the results of their fall risk assessment.	for nursing homes NQF/CMS state- specific measure								-)
Adult BMI Assessment	Percent of members ages 18–74 who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.	NCQA/HEDIS						X	Х				
Adult Weight Screening and Follow-Up	Percent of patients age 18 and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented.	NCQA/HEDIS				X							
Care for Older Adults Composite	Percent of adults age 65 and older who had each of the following during the measurement year: advance care planning, medication review, functional status assessment, and pain screening.	NCQA/State- specified measure											Х
Care for Older Adults— Functional Status	Percent of plan members whose doctor has done: 1) a functional status assessment to see how well they are doing 2) activities of daily living (such as drassing acting and betting)	NCQA/HEDIS		X	Х	X	Х	X	Х	X	Х	Х	Х
Assessment Care for Older Adults— Pain Screening	activities of daily living (such as dressing, eating, and bathing). Percent of plan members who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS		X	X	X	Х	Х	Х	X	Х	Х	Х
Pain Management	Percent of enrollees with documented assessment of pain using standardized tool during each review period (comprehensive assessment and reassessment). Percent of enrollees with documented intervention for acute or chronic pain.	AMDA											Х
Breast Cancer Screening	Percent of female plan members ages 40-69 who had a mammogram during the past two years.	NCQA/ HEDIS			X	X	Х	Х	Х	Х	X	Х	Х
Colorectal Cancer Screening	Percent of plan members ages $50-75$ who had appropriate screening for colon cancer.	NCQA/HEDIS		X	X	Х	Х	Х	Х	Х	Х	Х	Х
Cervical Cancer Screening	Percent of women ages 21–64 who received one or more Pap tests to screen for cervical cancer.	NCQA/HEDIS				Х	_	Х	Х				-
Cardiovascular Care— Cholesterol Screening	Percent of plan members with heart disease who have had a test for bad cholesterol (LDL) within the past year.	NCQA/HEDIS			Х	Х	X	X	X	Х	X	X	Х
Diabetes Care— Cholesterol Screening	Percent of plan members with diabetes who have had a test for bad cholesterol (LDL) within the past year.	NCQA/HEDIS			X	Х	Х	X		Χ	Χ	Х	Х
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS; survey data			X	Х	Х	Х	Х	Х	Х	Х	Х
Percent of Eligible Participants Who Received Flu Immunization	Number of eligible participants who received flu immunization/number of participants who were eligible to receive flu immunization during the current flu season.	Originated from HPMS	Х										
Percent of Eligible Participants Who Declined Flu Immunization	Number of eligible participants who were offered flu immunization but were documented as refusing to be immunized or have signed a declination form.		Х				•		•	•		•	
Percent of Participants Who Had Contraindications	Number of participants who have documented medical contraindications as defined by the CDC guidelines.		X						••••••	•			
Percent of Eligible Participants Who Received Pneumococcal mmunization	Number of eligible participants who received a pneumococcal immunization in the past 10 years/number of participants who were eligible to receive pneumococcal immunization.	Originated from HPMS	X										
Pneumonia Vaccination Status for Older Adults	Percent of members age 65 and older who have ever received a pneumonia vaccine.	AHRQ/CAHPS					•	Х				-	Х
Aspirin Use and Discussion (ASP)	Aspirin Use: A rolling average represents the percent of members who are currently taking aspirin.	State; MCO/Survey							Х				Х
	Discussing Aspirin Risks and Benefits: A rolling average represents the percent of members who discussed the risks and benefits of using aspirin with a doctor or other health provider.												
Glaucoma Screening in Older Adults	Percent of members ages 40–59, 60–64, 65 and older and total who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions.	NCQA/HEDIS		X					Х				
Screening for Dementia	Percent of members with intellectual disability who are screened for dementia using a standardized instrument.	MassHealth				X				•			
obacco Use Assessment and Tobacco Cessation ntervention	Percent of patients who were queried about tobacco use one or more times during the two-year measurement period (received cessation intervention during measurement period). Percent who have used tobacco within past six months, frequency of use, whether	MA-PCPI				Х							х

QUALITY MEASURE	DESCRIPTION	DATA Source	PACE SNPs	CMS CORE MEASURE			ORAND STAND		
Medical Assitance with	Rolling average represents the percent of members age 18 and older who are	AHRQ/CAHPS			MA OH	WA* I	L CA	VA I	NY SC
Smoking and Tobacco Use Cessation	current smokers or tobacco users and who received advice to quit during the measurement year, who discussed or were recommended medications to quit, or who discussed or were provided cessation methods or strategies during the measurement year.								
Frequency of Ongoing Prenatal Care	Proportion of pregnant women with expected number of prenatal visits.	NCQA/HEDIS			X				
Prenatal and Postpartum Care	Percent of deliveries of live births between November 6 of the year prior to the measurement period and November 5 of the measurement year. For these women, the measure assesses facets of prenatal and postpartum care.	NCQA/HEDIS	-		X	***************************************			
Vision	Percent of enrollees who received glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions.	NCQA							Х
EFFECTIVE TREATMEN	T OF CHRONIC CONDITIONS								
Controlling Blood Pressure	Percent of plan members ages 18–85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	Х	Х	х х	X	(X	X	х х
Rheumatoid Arthritis Management	Percent of plan members with rheumatoid arthritis who got one or more prescriptions for an antirheumatic drug.	NCQA/HEDIS		X	х х	X :	(X	Х	х х
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		X	х х	X	(X	Х	х х
Diabetes Care—Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	NCQA/HEDIS		Х	х х	X :	(X	X	х х
Diabetes Care—Blood Sugar Controlled	Percent of plan members with diabetes who had an HbA1c lab test during the year that showed their average blood sugar is under control.	NCQA/HEDIS		X	х х	X :	(X	Х	х х
Comprehensive Diabetes Care	Percent of plan members ages 18-75 with diabetes (type 1 and type 2) who had each of the following: HbA1c poor control (>9.0%); HbA1c control (<8.0%); HbA1c control (<7.0%); eye exam (retinal) performed; LDL-C screening; LDL-C control (<100 mg/dL); medical attention for nephropathy; blood pressure control (<140/90); smoking status and cessation advice or treatment.	NCQA/HEDIS			X				
Management of Urinary Incontinence in Older Adults	Discussing: Members who reported having a problem with urine leakage in the past six months and who discussed their urine leakage problem with their current practitioner.	State; MCO/Surve	y				(Х
	Receiving Treatment: Members who reported having a urine leakage problem in the past six months and who received treatment for their current urine leakage problem.								
Osteoporosis Management in Older Women Who Had a Fracture	Percent of women age 67 and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.	NCQA/HEDIS	X					_	
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD)	Percent of COPD exacerbations for members age 40 and older who had an acute inpatient discharge or emergency department encounter and who were dispensed appropriate medications. —dispensed a systemic corticosteroid within 14 days of the event	NCQA/HEDIS	Х			į	(
Exacerbation Use of Spirometry Testing in the Assessment and	 dispensed a bronchodilator within 30 days of the event Percent of members age 40 and older with a new diagnosis or newly active COPD, and who received appropriate spirometry testing to confirm the diagnosis. 	NCQA/HEDIS	X			,	(_
Diagnosis of COPD Use of Appropriate Medications for People with Asthma	Percent of members who were identified as having persistent asthma during the measurement year and the year prior to the measurement year and who were dispensed a prescription for either an inhaled corticosteroid or acceptable	NCQA/HEDIS			X				
Persistence of Beta- Blocker Treatment After a	alternative medication during the year. Percent of members who were hospitalized with acute myocardial infarction and who received persistent beta-blocker treatment for six months after discharge.	NCQA/HEDIS	X	-			(_	
Heart Attack (PBH) Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic	Percent of members age 18 and older with a diagnosis of heart failure with a current or prior LVEF < 40, who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting or at hospital	AMA-PCPI			X			•	
Dysfunction Ischemic Vascular Disease (IVD): Blood Pressure	discharge. Percent of patients age 18 and older who were discharged alive with acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) during the measurement year or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had blood pressure reported as under control (<140/90).	NCQA/HEDIS			X				
Evaluation of Left Ventricular Systolic Function	Percent of heart failure patients with documentation in the hospital record that left ventricular systolic function was evaluated before arrival, during hospitalization or is planned for after discharge.	CMS			X				
Annual Monitoring for Patients on Persistent Medications (MPM)	Percent of members who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the agent during the measurement year. Report on each of the following rates: ACE/ARB, digoxin, diuretics, anticonvulsants, and total.	NCQA/HEDIS	X		X		(
Potentially Harmful Drug- Disease Interactions in the Elderly	Percent of Medicare members age 65 and older who have a diagnosis of dementia and a prescription for tricyclic antidepressants or anticholinergic agents.	NCQA/HEDIS	X			***************************************			
Clinical Quality Improvements (SNP 3)	Element A: Clinical Improvements	NCQA/HEDIS	X						

QUALITY MEASURE	DESCRIPTION	DATA Source	PACE	SNPs	CMS CORE MEASURE	S	TATE L	ME INDI					0F
						MA	ОН	WA*	IL	CA	VA	N۱	/ SC
Improving or Maintaining	ORAL HEALTH AND SUBSTANCE ABUSE Percent of all plan members whose mental health was the same or better than	CMS; HOS			X	Х	X	Х	Х	Х	Х	Х	X
Mental Health Follow-Up After Hospitalization for Mental Illness	expected after two years. Percent of discharges for members age 6 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		X	X	Х	X	X	X	X	X	Х	Х
Antidepressant Medication Management		NCQA/HEDIS		X	X	Х	X	X	Х	Х	Х	Х	Х
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percent of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: —Initiation of AOD treatment: Percent 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: Percent 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			X	X	X	X	X	X	X	Х	X
Depression Screening Performed During Enrollment Year	Percent of participants screened during initial enrollment for depression using a nationally recognized assessment tool (i.e., PHQ-9, GDS-15, GDS-30, MDS, Cornell Scale).	HEDIS measure revised for PACE	X							•			
Depression Screening Performed Annually	Percent of participants screened annually for depression using a nationally recognized assessment tool (i.e., PHQ-9, GDS-15, GDS-30, MDS, Cornell Scale).	HEDIS measure revised for PACE	Х								***************************************		
Screening for Clinical Depression and Follow- Up Care	Percent of patients age 18 and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS			X	Х	Х	Х	Х	Х	Х	х	Х
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Percent of members with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening during the measurement year.	NCQA/HEDIS	•						X				
Adherence to Appropriate Medications for Individuals Diagnosed with Psychoses and Bipolar Disorders (PBD)	Percent of members diagnosed with psychoses and bipolar disorders who maintained medication adherence at six months and 12 months.	State							Х				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Percent of members ages 19–64 with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	NCQA/HEDIS							X		Х	_	
Diabetes Monitoring for People with Diabetes and Schizophrenia	Percent of members with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NCQA/HEDIS							Х				
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	Percent of members with schizophrenia and cardiovascular disease, who had a LDL-C test during the measurement year.	NCQA/HEDIS							X				
Severe Mental Illness (SMI)	Recovery-oriented measures for persons with SMI receiving mental health services (stability in family and living conditions; return to or stay in school; criminal/juvenile justice involvement; employment status).	State	•			•	•		X	•	X	•	
Behavioral Health Shared Accountability Process Measure	Phase A: Policies and procedures attached to an MOU with county behavioral health department(s) around assessments, referrals, coordinated care planning, and information-sharing.	State-defined measure								X			
	Phase B: Percent of demonstration enrollees receiving Medi-Cal specialty mental health and/or drug Medi-Cal services receiving coordinated care plan as indicated by having an individual care plan that includes the evidence of collaboration with the primary behavioral health provider.												
Behavioral Health Shared Accountability Outcome Measure	Reduction in emergency department use for seriously mentally ill and substance use disorder enrollees (greater reduction in Demonstration Year 3)	State-defined measure								Х			
Multiple Psychotropic Medications	Percent of members with intellectual disability who are taking multiple antipsychotic medications.	MassHealth				Χ			***************************************	•	•		
Unhealthy Alcohol Use: Screening and Brief Counseling	Screening and brief counseling for substance use.	AMA-PCI				Х	•		•	•		•	
Retention Rate—Mental Illness	Percent of clients assigned to the MMIP with a history of mental illness retained for six months.	State-defined measure						Х					
Retention Rate— Susbtance Abuse	Percent of clients assigned to the MMIP with a history of substance abuse diagnosis retained for six months.	State-defined measure						X					

DATA CMS CORE STATE MEMORANDUMS OF QUALITY MEASURE DESCRIPTION SOURCE PACE SNPs MEASURE UNDERSTANDING MA OH WA* IL CA VA NY SC **EFFECTIVE COMMUNICTION AND CARE COORDINATION** Advance Care Planning Percent of participants with documentation of advance directives (includes a X X properly executed advance health care directive including power of attorney for health care decisions, a living will, a written or oral statement of treatment Percent of enrollees age 65 and older who have an advance care plan or Advance Care Planning AGS/NCOA surrogate decision-maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision-maker or provide an advance care plan. **Care Transition Record** Percent of patients, regardless of age, discharged from an inpatient facility to AMA-PCPI X X X X XTransmitted to Health Care home or any other site of care for whom a transition record was transmitted to Professional the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. Avoidance of Antibiotic Percent of adults ages 18-64 with a diagnosis of acute bronchitis who were not NCQA/HEDIS Treatment in Adults with dispensed an antibiotic prescription. **Acute Bronchitis** Use of High-Risk Percent of Medicare members age 65 and older who received at least two NCQA/HEDIS Medication in the Elderly different high-risk medications. Medication Reconciliation Percent of patients age 65 and older discharged from any inpatient facility and X Х **X X X X X X** NCQA/HEDIS After Discharge from seen within 60 days following discharge by the physician providing ongoing care Inpatient Facility who had a reconciliation of the discharge medications with the current medication list in the medical record documented. Medication Reconciliation Percent of enrollees discharged from an inpatient facility to home or any other site PCPI of care, who either themselves or their caregiver received a reconciled medication list at the time of discharge including, at a minimum, medication in the specified categories. Reconciled Medication Percent of relevant participant transfers to the PACE organization's ambulatory CMS meaningful X List setting who received medication reconciliation. use key elements Comprehensive Percent of beneficiaries who received a comprehensive medication review (CMR) **Pharmacy Quality** $X \quad X \quad X \quad X$ **Medication Review** out of those who were offered a CMR. Alliance (PQA) Care for Older Adults-Percent of plan members whose doctor or clinical pharmacist has reviewed a list NCQA/HEDIS Χ X $X \quad X \quad X$ X X х х Medication Review of everything they take (prescription and nonprescription drugs, vitamins, herbal remedies, other supplements) at least once a year. Follow-up with any provider within 14 days following emergency department visit. State X **Ambulatory Care Follow-**Up with a Provider Within 14 Days of Emergency Department (ED) Visit Ambulatory Care Follow-X Ambulatory care follow-up visit within 14 days of having an inpatient hospital State Up with a Provider Within 14 Days of Inpatient Discharge 3-Item Care Transition Unidimensional self-reported survey that measures the quality of preparation for University of Х Measure (CTM-3) Colorado care transitions Х Transition Record with AMA-PCPI X Percent of patients, regardless of age, discharged from an inpatient facility to **Specified Elements** home or any other sites of care, or their caregiver(s), who received a transition record at the time of discharge including, at a minimum, all of the specified **Timely Transmission of** Percent of patients, regardless of age, discharged from an inpatient facility to AMA-PCPI Χ Transition Record 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. Tracking of Demographic Percent of all demonstration participants for whom specific demographic data are CMS/State-defined Х collected and maintained in the ICO centralized enrollee record, including race, Information process measure ethnicity, disability type, primary language, and homelessness, in compliance with contract requirements. Real-Time Hospital Percent of hospital admission notifications occurring within specified time frame. CMS/State-defined X X X X X**Admission Notifications** process measure x x x x x Discharge Follow-Up Percent of members with specified time frame between discharge to first follow-CMS/State-defined process measure Documented Discussion Percent of members with documented discussion of their rights and choices for MassHealth X of Member Rights and providers. Member Choices for **Providers**

QUALITY MEASURE	DESCRIPTION	DATA Source	PACE SNPs	CMS CORE MEASURE	S		ME Jnde				MS O
					MA	ОН	WA*	IL	CA	VA	NY
Complex Case Management (SNP 1)	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 care management Element C: Care management systems Element D: Frequency of member IDs 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 care management Element J: Analyzing effectiveness/Identifying opportunities Element K: Implementing interventions and follow-up evaluation	NCQA/HEDIS	X	X	X	X	X	X	X	X	
Care Transitions (SNP 4)	The organization manages the process of care transitions, identifies problems that could cause transitions and, where possible, prevent unplanned transitions. Element A: Managing transitions Element B: Supporting members through transitions Element C: Analyzing performance Element D: Indentifying unplanned transitions Element E: Analysing transitions Element F: Reducing transitions	NCQA/HEDIS	Х	x	Х	X	X	X	X	X	Х
Coordination of Medicare and Medicaid Benefits (SNP 6)	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	х	X	X	X	X	X	X	X	х
Case Manager Contact with Member	Ability to identify case manager or contact case manager	State-defined measure							Х		
Care Coordination	Percent of medium- and high-risk enrollees able to identify care coordaintor and/ or HCBS case manager.	State specific measure				-					
Care Coordination	Percent of documented discussions of care goals with enrollee and/or caregiver	State specific			***************************************			*	•	•	
(person-centered) RENFFICIARY AND FA	involvement. MILY-CENTERED CARE	measure									
Consumer Assessment of Health Providers & Systems (CAHPS), Various Settings, Including: —Health Plan Plus	A comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important.	AHRQ/CAHPS		Х	Х	х	X	X	Х	Х	Х
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		AUDO GAUDO									
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 CAHPS Hospital Survey	27-item survey instrument with seven domain-level composites including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information.	AHRQ/CAHPS			X						
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 CAHPS Hospital Survey (HCAHPS) Participant Outcomes and Status Measures (POSM)	communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and	AHRQ/CAHPS State; MCO/Surve	y		X			X			
and Health Outcomes for Behavioral Health (ECHO) —Home Health —Nursing Home —People with Mobility Impairments —Cultural Competence —Patient-Centered	communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information. Program participant perception of quality of life. Purposes: 1) help determine quality of life measures that should be considered in developing service plans; 2) determine if quality of life improvements are reported by participants over		y		X			x			
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 CAHPS Hospital Survey (HCAHPS) Participant Outcomes and Status Measures (POSM) Quality of Life Survey	communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information. Program participant perception of quality of life. Purposes: 1) help determine quality of life measures that should be considered in developing service plans; 2) determine if quality of life improvements are reported by participants over time; and, 3) assist in identifying areas in need of quality improvement. Percent of enrollees receiving the palliative care benefit who indicate they are uncomfortable because of pain whose pain was brought to a comfortable level within 48 hours of start of service. Percent of enrollees receiving HCBS who are satisfied/very satisfied with these	State; MCO/Surve	y		X			x			
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 CAHPS Hospital Survey (HCAHPS) Participant Outcomes and Status Measures (POSM) Quality of Life Survey	communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information. Program participant perception of quality of life. Purposes: 1) help determine quality of life measures that should be considered in developing service plans; 2) determine if quality of life improvements are reported by participants over time; and, 3) assist in identifying areas in need of quality improvement. Percent of enrollees receiving the palliative care benefit who indicate they are uncomfortable because of pain whose pain was brought to a comfortable level within 48 hours of start of service.	State; MCO/Surve	y X		x			X			
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 CAHPS Hospital Survey (HCAHPS) Participant Outcomes and Status Measures (POSM) Quality of Life Survey Quality of Life Consumer Satisfaction Improving Member	communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information. Program participant perception of quality of life. Purposes: 1) help determine quality of life measures that should be considered in developing service plans; 2) determine if quality of life improvements are reported by participants over time; and, 3) assist in identifying areas in need of quality improvement. Percent of enrollees receiving the palliative care benefit who indicate they are uncomfortable because of pain whose pain was brought to a comfortable level within 48 hours of start of service. Percent of enrollees receiving HCBS who are satisfied/very satisfied with these services. Element A: Assessment of member satisfaction Element B: Opportunities for improvement	State; MCO/Surve	X	X	X	X	X		X	X	X

QUALITY MEASURE	DESCRIPTION	DATA Source	PACE SNPs	CMS CORE MEASURE	S		ME JND					; OF	:
. *					MA	• • •	WA*	• • •	• • •	• • •	• • •	IY S	sc.
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		Х	х	Х	X	Х	Х	Х		(Х
Complaints About the Health Plan	How many complaints Medicare received about the health plan.	CMS; CTM data		X	Х	Х	Х	X	Х	Х		X	Χ
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		X	Х	X	X		Х				Х
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in 2013.	CMS		X	Х	Х	Х	Х	Х	Х		(Х
Access to Care	Percent of respondents who always or usually were able to access care quickly when they needed it.	AHRQ/CAHPS		X	Х				Х		_		
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed.	AHRQ/CAHPS	Х	X	Х	Х	Х	Х	Х	Х		(Х
Getting Information from Drug Plan	Percent of 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.			X	Х	Х	Х	X	Х	Х		X	Х
Rating of Drug Plan	Percent of best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs.	AHRQ/CAHPS		X	Х	Х	Х	X	Х	Х		X	Х
Getting Needed Prescription Drugs	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.	AHRQ/CAHPS	X	X	Х	Х	Х	Х	Х	Х			Х
Getting Needed Prescription and Nonprescription Drugs	Percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs and nonprescription drugs they need using the plan.						•	•	-			X	
Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.	AHRQ/CAHPS	Х	Х	Х	Х	Х	Х	Х	Х		(Х
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care.	AHRQ/CAHPS	Х	Х	Х	X	Х	Х	Х	Х		X	X
Overall Rating of Health Care Quality	Percent of best possible score the plan earned from plan members who rated the overall health care received.	AHRQ/CAHPS		X	Х	X	Х	X	Х	Х		X	Х
Overall Rating of Plan	Percent of best possible score the plan earned from plan members who rated the overall plan.	AHRQ/CAHPS		X	Х	Х	Х	Х	Х	Х		(Х
Screening for Preferred Language	Percent of members who are screened for their preferred language.	MassHealth			Х								
Wait Time for Interpreter	Percent of members who need an interpreter and always wait fewer than 15 minutes for the interpreter.	MassHealth			Х	-	-	-	-		-		
Access to Specialists	Percent of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS		X	Х	Х	Х	Х	Х	Х		(Х
Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS		X	Х	Х	Х	Х	Х	Х		(Х
Access to PCMH Providers	Number and percent of members served by PCMHs.					-		-					X
Getting Care Quickly Being Examined on the	Composite of access to urgent care. Percent of respondents who report always being examined on the examination	AHRQ/CAHPS AHRQ/CAHPS		X X		X X	X X	X		X			X X
Examination Table Help with Transportation	table. Composite of getting needed help with transportation.	AHRQ/CAHPS		X	Х	Х	Х	Х	Х	Х		X	Χ
Health Status/Functional Status	Percent of members who report their health as excellent.	AHRQ/CAHPS		X	X	X	X	X	X				X
PART D MEASURES													
Part D Call Center— Pharmacy Hold Time	How long pharmacists wait on hold when they call the drug plan's pharmacy help desk.	CMS; call center data		Х	Х	Х	Х	Х	Х	Х		X	Χ
Part D Call Center—Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan's customer service phone number.	CMS; call center data	•	X	Х	Х	Х	Х	Х	Х		Х	Х
Part D Appeals Auto- Forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions.	Independent Review Entity (IRE)		X	Х	Х	Х	X	Х	Х		(Х
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.	Independent Review Entity (IRE)		X	Х	Х	Х	Х	Х	Х		X	Х
Part D Enrollment Timeliness	The percent of enrollment requests that the plan transmits to the Medicare program within seven days.	Medicare Advantage Prescription Drug System (MARx)		X	X	Х		X	Х	Х		(
Part D Complaints About the Drug Plan	How many complaints Medicare received about the drug plan.	CMS, CTM data	*	X	Х	Х	Х	Х	Х	Х		X	Х
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	a	X	X	Х	Х	X	Х	Х		(Х

QUALITY MEASURE	DESCRIPTION	DATA Source	PACE	SNPs	CMS CORE MEASURE	S	TATE U	ME INDE)F
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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			х				х				
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			x	X	X	X	Х	Х	X	Х	X
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			X	Х	X	Х	Х	Х	Х	Х	Х
Part D Diabetes Treatment	Percent 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			X	Х	Х	X	Х	Х	X	Х	Х
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			X	Х	Х	X	Х	Х	Х	Х	Х
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			X	X	Х	X	X	X	X	Х	Х
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 supposed to be taking the medication.	CMS; PDE data			X	Х	X	Х	Х	Х	Х	Х	Х
READMISSION AND U	TILIZATION MEASURES												
Plan All-Cause Readmissions	Percent of members 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		X	Х	Х	X	X	Х	Х	Х	Х	Х
30-Day All-Cause Acute Hospital Readmission	The number of acute inpatient admissions for participants that were followed by an acute admission for any diagnosis within 30 days.	HEDIS measure revised for PACE	Х		-				•	-	•		-
Inpatient Hospital 30-Day Readmission Rate	Inpatient hospital readmission for the same discharge diagnosis within 30 days after having an initial inpatient hospital stay.	State							Х	-	-		
Chronic Obstructive Pulmonary Disease (COPD) (PQI 5)	Assess the number of admissions for COPD per 100,000 population.	AHRQ				Х							
Congestive Heart Failure Admission Rate (PQI 8)	Percent of county population with an admission for congestive heart failure.	AHRQ				Х							
Rate of Emergency Visits	Number of visits experienced by PACE participants to acute care hospital emergency departments, urgent care clinics, or equivalent outpatient health care facilities (not including the PACE Center clinic) requiring emergent evaluation by the facility's clinical specialists that does not result in an inpatient hospital day.	Originated from HPMS	X										
Mental Health Utilization	Number and percent of members receiving mental health services during the measurement year.	NCQA/HEDIS				Х			Х				Х
Behavioral Health Utilization	Percent of Medicare–Medicaid enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.	NQF, CMS, NCQA						Х					
Behavioral Health Utilization	Percent of Medicaid–Medicare enrollees age 12 and older screened for clinical depression using an age-appropriate standadardized tool and if positive, a follow-up plan is documented on the date of the positive screen.	NQF, CMS						X				_	
Ambulatory Care	Emergency department visits per 1,000 enrollees.	NCQA/HEDIS			-				X				
Inpatient Utilization— General Hospital/Acute Care	Utilization of acute inpatient care and services, per 1,000 enrollees, in the following categories: total inpatient, surgery, medicine, and maternity.	NCQA/HEDIS							Х				
Annual Dental visit	Percent of members ages 19-20 and age 21 and older who had at least one dental visit during the measurement year.	State							Х	_			
Dental Eemergency Department Visit	Number of dental emergency department visits during the measurement year per 1,000 members.	State							X				
Complaints and Appeals	Utilization measure.	State-defined measure								Х			
Physician Access	Utilization measure.	State-defined measure							•	Х	•		•
Psychiatric Bed Days	Utilization measure.	State-defined measure				-				Х	•		***************************************
Emergency Department Utilization Rates	Utilization measure, potentially revised to reflect avoidable emergency department visits.	State-defined measure							-	X			
IHSS Utilization	Utilization measure.	State-defined measure								Х			
Retention Rate—All	Percent of clients assigned to the MMIP who are retained for six months.	State-defined			•			Х	•	•	•		

DATA CMS CORE STATE MEMORANDUMS OF SOURCE **QUALITY MEASURE** DESCRIPTION PACE SNPs MEASURE UNDERSTANDING MA OH WA* IL CA VA NY SC NURSING FACILITY MEASURES Long-Term Care-Urinary Long-term care hospital utilization because of urinary tract infections. X State Tract Infection Admission Rate Long-Term Care—Bacterial Long-termcare hospital utilization because of bacterial pneumonia. HSAG/State Х Pneumonia Admission Rate Transition of Members Report number of members moving from: institutional care to waiver services, Χ X State Х Х Between Community. community to waiver services, community to institutional care, and waiver services Waiver and Long-Term to institutional care (exclude institutional stays \leq 90 days). **Care Services** Percent of High-Risk Percent of all long-stay residents in a nursing facility with an annual, quarterly, NOF endorsed Χ Х Х Residents with Pressure significant change or significant correction MDS assessment during the selected Ulcers (Long-Stay) quarter (three-month period) who were identified as high risk and who have one or more Stage 2 to 4 pressure ulcer(s). This measure is based on data from the MDS 3.0 assessment of long-stay Percent of Residents NOF/CMS X Whose Need for Help nursing facility residents and reports the percent of all long-stay residents in a with Daily Activities Has nursing facility whose need for help with late-loss activities of daily living (ADLs), Increased 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). This measure updates CMS's MDS 2.0 QM on catheter insertions. It is based on Percent of Residents Who Х NOF/CMS Have/Had a Catheter data from Minimum Data Set (MDS) 3.0 assessments of long-stay nursing home Inserted and Left in Their residents (with cumulative days in the facility >100 days). This measure captures Bladder the percent of low-risk long-stay residents who have had an indwelling catheter in the past seven days noted on the most recent MDS 3.0 assessment, OBRA, PPS, or discharge during the selected quarter (three-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 Percent of Residents Who Measure is based on data from the MDS 3.0 assessment of long-stay nursing NOF/CMS X Were Physically Restrained facility residents and reports the percent of all long-stay residents who were physically restrained. The measure reports the percent 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 (three-month period) who were physically restrained daily during the seven days prior to the MDS assessment (which may be annual, quarterly, significant change, or significant correction MDS 3.0 assessment). Percent of Residents This measure is based on data from all nonadmission MDS 3.0 assessments of NOF/CMS X X **Experiencing One or More** long-stay nursing facility residents which may be annual, quarterly, significant Falls with a Major Injury change, significant correction, or discharge 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 past 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. This measure updates CMS's MDS 2.0 OM on urinary tract infections in the Percent of Residents with State-specified X nursing facility population. It is based on MDS 3.0 data and measures the percent measure **Urinary Tract Infection** 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 six-month average for the facility. Long-stay nursing facility residents are those with cumulative days in the facility >100 days. **Nursing Facility Diversion** Report of the number of enrollees who lived outside the nursing facility during State-specified Х Measure the current measurement year as a proportion of the enrollees who lived outside measure the nursing facility during the previous year. **Nursing Facility Utilization** Utilization measure. State-defined X Measure measure Participants Referred to Percent of participants in the FIDA demonstration who reside in a nursing facility, State-specified Х **Preadmission Screening** wish to return to the community, and were referred to preadmission screening measure **Teams or Money Follows** teams or the MFP program. the Person (MFP) Program

CMS CORE STATE MEMORANDUMS OF DATA QUALITY MEASURE DESCRIPTION SOURCE PACE SNPs MEASURE UNDERSTANDING MA OH WA* IL CA VA NY SC LONG-TERM CARE MEASURES Long-Term Services and Modified CAHPS X Satisfaction with case manager, home workers, personal care, Supports (LTSS) Consumer **Satisfaction Measures** Long-Term Care Overall Х X Reporting of the number of enrollees who did not reside in a nursing facility as a State-specified **Balance Measure** proportion of the total number of enrollees in a plan. measure Long-Term Care Reporting of the number of enrollees who were discharged to a community setting State-specified X from a nursing facility and who did not return to the nursing facility during the **Rebalancing Measure** measure current measurement year as a proportion of the number of enrollees who resided in a nursing facility during the previous year. Long-Term Care Transition Reporting of the number of enrollees who were in a nursing facility during the X State-specified Measure current measurement year, the previous year, or a combination of both years measure who were discharged to a community setting for at least nine months during the current measurement year as a proportion of the number of enrollees who resided in a nursing facility during the current measurement year, the previous year, or a combination of both years. Pressure Ulcer Prevalence The proportion of participants with (Stage III, Stage IV, or Unstageable) pressure CMS Level Two Х (Community and ulcer(s) on the last day of the reporting period. Reporting (includes Institutional) stages III, IV, Unstageable). Definitions for pressure ulcer staging are from the National Pressure Ulcer Advisory Panel (NPUAP). **Enrollees with LTSS Needs** Percent of members with LTSS needs that have an IL-LTSS coordinator on their MassHealth Х Who Have an IL-LTSS interdisciplinary care team. Coordinator Access to IL-LTSS Percent of enrollees with LTSS needs who have an IL-LTSS coordinator. CMS/State-defined Coordinator process measure **Unmet Need in LTSS** Unmet need in ADLs/IADLs, and IHSS functional level. State-defined Х measure Utilization of ITSS Report of the personal care hours noted in the CARE eligibility tool and what was X State authorized, by enrollee. Utilization of ITSS Report of the LTSS clients that had DME and SMES requests documented in the X State CARE eligibility tool and those that were authorized/provided, by enrollee and request. Utilization of LTSS HCBS service plans are delivered in accordance with the individualized care plan, X including in the type, scope, amount, duration, and frequency specified in the Retention Rate-LTSS Percent of clients assigned to the MMIP who received long-term care services and State-defined Х support in month 1 and were retained for six months. process measure Consumer-Directed Percent of waiver individuals who used consumer-directed services. State Services Personal Care Percent of waiver individuals who experienced an increase or decrease in the X State authorization of personal care hours. Respite Care Percent of waiver individuals who experienced an increase or decrease in the State Х authorization of respite hours. Improvement/Stability in Participants in the FIDA Demonstration who remained stable or improved in ADL χ State-specified Activities of Daily Living functioning between previous assessment and most recent assessment. measure (ADL) Functioning Institutional SNP Х Element A: Monitoring members' health status NCQA/HEDIS Relationship with Facility Element B: Monitoring changes in members' health status (SNP 5) Element C: Maintaining members' health status Number and percent of all enrollees referred to LTSS; number and percent of all X **Integrated Care** State-specified enrollees referred to HCBS; number and percent of all enrollees referred to a longmeasure term care facility (nursing facility). Percent of enrollees newly approved (or newly determined eligible) for HCBS with Χ Integrated Care CMS/State-defined a plan of care developed, reviewed, and approved jointly by waiver case manager, process measure reviewer, and CICO designee, that is included in the overall ICP within 30 days of waiver enrollment. Percent of enrollees already receiving HCBS that have a plan of care included in **HCBS Plan on Care** CMS/State-defined X Integration into ICP the ICP within 30 days of enrollment into CICO. nrocess measure **Transitions Between Care** Percent of enrollees who transitioned to and from hospitals, nursing facilities and CMS/State-defined X Settings the community. process measure **HCBS Authorization** Percent of enrollees who require HCBS, as indicated by the comprehensive care State-specified assessment and the ICP, receive those services within 90 days of enrollment. measure HCBS Authorization-Percent of enrollees receiving HCBS who used consumer-directed services. State-specified X Consumer-Directed measure Services Percent of enrollees receiving HCBS who experienced a decrease in the authorization of attendant care or companion service hours.

QUALITY MEASURE	DESCRIPTION	DATA Source	PACE SNPs	CMS CORE MEASURE			RANDI TANDII	JMS OF NG
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HCBS Authorization— Personal Care Hours	Percent of enrollees receiving HCBS who experienced an increase in the authorization of personal care hours.	State-specified measure						Х
	Percent of enrollees receiving HCBS who experienced a decrease in the authorization of attendant care or companion service hours.							
HCBS Authorization— Respite Care	Percent of enrollees receiving HCBS who experienced an increase in the authorization of respite hours.	State-specified measure						Х
	Percent of enrollees receiving HCBS who experienced an increase in the authorization of respite hours.							
HCBS Authorization— Non-consumer-directed services	Percent of enrollees receiving HCBS who experienced a decrease in the authorization of HCBS services.	State-specified measure						х
Integration of Care	Percent of enrollees receiving HCBS who experienced an increase in the authorization of non-consumer-directed HCBS. Number/percent of care coordinator actions/care decisions in response to critical	State-specified						X
integration of care	incident reports by the in-home providers and/or changes in conditions identified by LTC specialist/waiver case managers.	measure						^
Utilization of Alternate Housing Options	Number of members who utilize assisted living, other congregate housing, and independent living options.	State-specified measure						X
Integration of Care	Number and percent of CICO care coordinatiors who are trained on how to make appropriate waiver referrals and use Phoenix and Care Call.	State-specified measure						Х
Integration of Care	Percent of enrollees who have a waiver case manager participating in multidisciplinary team.	State-specified measure						Х
Hospital, Nursing Facility, and Community Transition	CICO has an established work plan and systems in place for ensuring smooth transition to and from hospitals, nursing facilities, and the community.	State-specified measure						Х
Adjudicated Claims, Including HCBS Case Management	Percent of adjudicated claims submitted to CICOs that were paid within the timely filing requirements.	State-specified measure						Х
ADMINISTRATIVE MEA	SURES							
Consumer Governance Board	Establishment of beneficiary/consumer advisory board or inclusion of beneficiaries/consumers on governance board consistent with contract requirements.	CMS/State-define process measure	d	Х	х х	х х	X)	(X X
Self-Direction	Percent of care coordinators that have undergone state-based training for supporting self-direction under the demonstration.	CMS/State-define process measure	d	X	хх	х х	X)	(х
Ensuring Physical Access to Buildings, Services, and Equipment	Demonstration plan has established a work plan and identified individual in its organization who is responsible for ADA compliance related to this demonstration.	CMS/State-define process measure	d	Х	Х	х х)	(
Risk Stratification Based on LTSS or Other Factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS/State-define process measure	d	X	х х	х х	χ)	(x x
Board Certification	Board certification shows the percent of the plan's physicians whose board certification is active.	-	X			•		
Ability to Use Health Information Technology to Perform Care Management at Point of Care	Documents the extent to which a provider uses an electronic medical record.	CMS			Х	-		
Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State-define measure	d	X			Х	
Licensure/Certification	Number and percent of licensed/certified waiver agency provider enrollments, for which appropriate licensure/certification were obtained in accordance with law and waiver requirements prior to service provision.	State/1915(c) EDCD waiver requirement)	(
Continuing Licensure/ Certification	Number and percent of licensed/certified waiver provider agencies continuing to meet applicable licensure/certification following initial enrollment.	State/1915(c) EDCD waiver requirement)	(
Criminal Background Checks	Number and percent of licensed/certified waiver provider agency direct support staff who have criminal background checks as specified in policy/regulation with satisfactory results following initial enrollment.	State/1915(c) EDCD waiver requirement				***************************************)	(
Nonlicensed/ Noncertified Provider Enrollment	Number and percent of new nonlicensed/noncertified waiver individual provider enrollments, who initially met waiver provider qualifications.	State/1915(c) EDCD waiver requirement	•			-)	(
Nonlicensed/ Noncertified Consumer- Directed Employees	Number and percent of new nonlicensed/noncertified consumer-directed employees who meet requirements.	State/1915(c) EDCD waiver requirement	***************************************		***************************************	-)	(
Criminal Background Checks—Consumer- Directed Employees	Number and percent of new consumer-directed employees who have a criminal background check at initial enrollment.	State/1915(c) EDCD waiver requirement	***************************************		***************************************	-)	(
	Number and percent of consumer-directed employees with a failed criminal background check that are barred from employment.							
Staff Training	Number and percent of waiver provider staff meeting provider staff training	State/1915(c)				•)	(

QUALITY MEASURE	DESCRIPTION	DATA Source	PACE	SNPs	CMS CORE MEASURE		MORAN ERSTAN	DUMS OF DING
						MA OH WA*	IL CA	VA NY S
Consumer-Directed Employers Trained	Number and percent of consumer-directed employers trained, as required, regarding employee management and training.	State/1915(c) EDCD waiver requirement						X
Abuse, Neglect, or Exploitation	Number and percent of waiver individual's records with indications of abuse, neglect, or exploitation documenting appropriate actions taken.	State/1915(c) EDCD waiver requirement						X
Safety	Number and percent of waiver individual's records with indications of safety concerns documenting appropriate actions taken.	State/1915(c) EDCD waiver requirement						X
Risks in Physical Environment	Number and percent of waiver individual's records with indications of risk in the physical environment documenting appropriate actions taken.	State/1915(c) EDCD waiver requirement						Х
IAA/MOU/Contract Evaluations	Number and percent of satisfactory IAA/MOU/contract evaluations.	State/1915(c) EDCD waiver requirement						X
Adjudicated Waiver Claims	Number and percent of adjudicated waiver claims submitted to participating plans that were paid within the timely filing requirements.	State/1915(c) EDCD waiver requirement						X
Non-Part D Appeals Upheld	How often an integrated administrative hearing officer agrees with the plan's non-Part D decision to deny or say no to a participant's non-Part D appeal.	FIDA administrativ hearing unit	е					X
Self-Direction Participant- Level Measure	Percent of participants directing their own services through the consumer-directed personal assistance option at the plan each demonstration year.	State-specified measure						Х

^{*} Washington is utilizing both a capitated model and a managed fee-for-service model. The quality measures in this table reflect those being measured in the capitated duals demonstration. The quality measures specified in the MOU for the managed fee-for-service model are: all-cause hospital readmission, ambulatory care-sensitive condition hospital admission, ED visits for ambulatory care-sensitive conditions, follow-up after hospitalization for mental illness, depression screening and follow-up care, care transition record transmitted to health care professional, screening for fall risk, and initiatition and engagement of alcohol and other drug dependent treatment. In general, managed FFS models have many fewer measures. The capitated plans are responsible for all the same measures as Medicare Advantage and Part D plans—all HEDIS, the Health Outcomes Survey, and CAHPS—whereas the managed FFS model only has a few core measures. CMS is not mandating them through the MOU.

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