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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.[1] 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

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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.[7] 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).[9] 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.[10] 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.[11]

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 non-core 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 Applied to Medicare and Medicaid Portions of the Baseline Capitated Rate			Quality Withhold		
	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.

health care personnel, all working within an interdisciplinary team.

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."[16] 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 quality-of-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

1. G. Jacobson, T. Neuman, and A. Damico, *Medicare's Role for Dual Eligible Beneficiaries*, 2012 (Washington, D.C.: Kaiser Family Foundation), http://www.kff.org/medicare/upload/8138-02.pdf.

2. Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies* (Washington, D.C.: CBO, 2013), http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308_DualEligibles.pdf.

3. J. Kasper, M. O'Malley Watts, and B. Lyons, *Chronic Disease and Co-Morbidity Among Dual Eligibles* (Washington, D.C.: Kaiser Family Foundation, 2010), http://www.kff.org/medicaid/upload/8081.pdf.

4. Today, full and partial duals make up 15 percent of Medicaid enrollees and 16 percent of Medicare enrollees, but account for 39 percent of Medicaid spending and 27 percent of Medicare spending, respectively. Under current law, total Medicare and Medicaid spending on dual eligibles is projected to reach $3.7 trillion over the next decade.

5. K. Thorpe, *Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles* (Atlanta: Emory University, 2011), http://www.healthandwelfare.idaho.gov/Portals/0/Medical/Managed%20Care/Estimated%20Saviings%20from%20Care%20Coordination.pdf.

6. E. Breslin Davidson and T. Dreyfus, *Risky Business: Capitated Financing in the Dual Eligible Demonstration Projects* (Boston: Community Catalyst, March 2013).

7. Center for Medicaid, CHIP, Survey and Certification and Medicare-Medicaid Coordination Office, "Re: Financing Models to Support State Efforts to Integrate Care for Dual Eligibles" (Washington, D.C.: CMS, July 8, 2011), http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

8. Centers for Medicare and Medicaid Services, "Revised D-SNP Contracting Issues and Discussion" (Washington, D.C.: CMS, 2011), http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/D_SNP_Contracting_Issues_Discussion_092611.pdf.

9. Quality withholds are withheld from the actual Demonstration rate (with savings percentage applied) not the baseline (before savings percentage applied).

10. Until now, there had not been a federal research program specifically focused on designing and evaluating quality measures for this population. National Quality Forum, *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population* (Washington, D.C.: NQF, 2012), http://www.qualityforum.org/Publications/2012/06/Measuring_Healthcare_Quality_for_the_Dual_Eligible_Beneficiary_Population.aspx.

11. A. Lind, *Quality Measurement in Integrated Care for Medicare–Medicaid Enrollees. Center for Health Care Strategies* (Washington, D.C.: Center for Health Care Strategies, 2013), http://www.chcs.org/usr_doc/Quality_Measurement_in_Integrated_Care.pdf.

12. R. Berenson, "Examining Medicare and Medicaid Coordination for Dual-Eligibles," Testimony, Senate Special Committee on Aging, U.S. House of Representatives, July 18, 2012, http://www.urban.org/UploadedPDF/901520-Examining-Medicare-and-Medicaid-Coordination-for-Dual-Eligibles.pdf.

13. Medicare Payment Advisory Commission, "Chapter 3: Care Coordination Programs for Dual-Eligible Beneficiaries," *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, D.C.: MedPAC, June 2012), pp. 95–111.

14. V. Wilbur and R. Bringewatt, *Improving Payment and Performance for High-Risk Beneficiaries* (Washington, D.C.: National Health Policy Group, Jan. 9, 2006), http://www.nhpg.org/media/3014/snpalliancedsnpperfromancemeasures.pdf.

15. It should be noted that the practices labeled as quality measures for the SNP and PACE programs should not be portrayed as the full range of practices these programs undertake to ensure quality of care. Many of the quality measures included in

state MOUs are standard practices for PACE plans, even if they are not reported as quality measures per se. For example, PACE plans are required to conduct comprehensive assessments twice a year, or more frequently, if a beneficiary's health condition changes. By comparison, comprehensive assessments are a core measure for providers and plans participating in the Financial Alignment Initiative.

[16] Robert Wood Johnson Foundation, "Quality/Equality Glossary" (Princeton, N.J.: RWJF), http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/04/quality-equality-glossary.html.

[17] National Committee for Quality Assurance, *HEDIS 2013 Narrative, Vol. 1* (Washington, D.C.: NCQA, 2012).

[18] National Committee for Quality Assurance and the Centers for Medicare and Medicaid Services, *Medicare Health Outcomes Survey* (Washington, D.C.: NCQA, 2013), http://www.hosonline.org/surveys/hos/download/HOS_2013_Survey.pdf.

[19] While some researchers have done preliminary work with HOS to identify factors that affect dual eligibles' quality of life, such as functional impairments, the tool does not include measures of cognitive and intellectual disability. See G. Khatutsky, E. G. Walsh, and D. W. Brown, "Urinary Incontinence, Functional Status, and Health-Related Quality of Life Among Medicare Beneficiaries Enrolled in the Program for All-Inclusive Care for the Elderly and Dual Eligible Demonstration Special Needs Plans," *Journal of Ambulatory Care Management,* Jan.–March 2013 36(1):35–49; T. R. Lied and S. C. Haffer, "Health Status of Dually Eligible Beneficiaries in Managed Care Plans." *Health Care Financing Review,* Summer 2004 25(4):59–74; and Assistant Secretary for Planning and Evaluation, *Disability Data in National Surveys: Medicare Health Outcomes Surveys* (Washington, D.C.: ASPE, 2011), http://aspe.hhs.gov/daltcp/reports/2011/DDNatlSur.pdf.

[20] However, some states, notably Illinois and Ohio, are requiring multiple state-specified measures in these categories.

[21] National Quality Forum, *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population* (Washington, D.C.: NQF, 2012).

[22] M. J. Press, D. P. Scanlon, A. M. Ryan et al., "Limits of Readmission Rates in Measuring Hospital Quality Suggest the Need for Additional Metrics," *Health Affairs,* June 2013 32(6):1083–91.

[23] Centers for Medicare and Medicaid Services and The State of Illinois (2013), "Memorandum of Understanding Between the Centers for Medicare & Medicaid Services and The State of Illinois," https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ILMOU.pdf.

[24] Centers for Medicare and Medicaid Services and The Commonwealth of Massachusetts (2013), "Contract Between United States Department of Health and Human Services, Centers for Medicare and Medicaid Services in Partnership with the Commonwealth of Massachusetts and Commonwealth Care Alliance, Inc., Fallon Community Health Plan and Network Health, LLC," http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf.

[25] A. Lind, *Quality Measurement in Integrated Care,* 2013.

[26] University of Michigan, "Participant Outcomes and Status Measures (POSM) Quality of Life Assessment," http://www.michigan.gov/documents/Handout_3-POSMTool_DraftC_1_19_06_156244_7.pdf.

[27] Authorizing legislation provides the Center for Medicare and Medicaid Innovation with enhanced authority to waive budget neutrality for testing new initiatives. See §3021 of the ACA, Pub.L. 111–148, 124 Stat. 119, codified as amended at scattered sections of the Internal Revenue Code and in 42 U.S.C. See also M. Gold, D. Helms, and S. Guterman, *Identifying, Monitoring, and Assessing Promising Innovations: Using Evaluation to Support Rapid-Cycle Change* (New York: The Commonwealth Fund, June 2011).

DUAL DEMONSTRATION QUALITY MEASURES OF PARTICIPATING STATES

QUALITY MEASURE	DESCRIPTION	DATA SOURCE	PACE	SNPs	CMS CORE MEASURE	STATE MEMORANDUMS OF UNDERSTANDING							
						MA	OH	WA*	IL	CA	VA	NY	SC
ASSESSMENTS AND CARE PLAN MEASURES													
Documentation of Care Goals	Percent of enrollees with documented discussions of care goals.	CMS/State-defined process measure			X	X	X	X	X		X	X	
	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						X					
	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 care goals with enrollee and/or caregiver and multidisciplinary team.	State-specified measure											X
Assessments	Percent of enrollees with initial assessments completed within required time frames.	CMS/State-defined process measure											X
	Percent of members with initial assessments completed within 30 days of enrollment.	CMS/State-defined process measure			X	X					X	X	
	Percent of members with initial assessments completed within 90 days of enrollment.	CMS/State-defined process measure					X			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			X			X	X				
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				X							
Individualized Care Plans	Percent of members with care plans by specified time frame.	CMS/State-defined process measure			X	X	X	X	X	X	X		X
	Percent of participants with care plans within 30 days of initial assessment	CMS/State-defined process measure										X	
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									X		
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									X		
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									X		
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									X		
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									X		
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									X		

QUALITY MEASURE	DESCRIPTION	DATA SOURCE	PACE	SNPs	CMS CORE MEASURE	STATE MEMORANDUMS OF UNDERSTANDING							
						MA	OH	WA*	IL	CA	VA	NY	SC
PREVENTION AND SCREENING													
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			X	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X	X
Rate of Falls Resulting in Injury	Total number of falls for PACE participants resulting in an Injury Severity Rating* level of III–V (moderate to death) in all locations.	NQF 21 measures for nursing homes	X										
Number of Falls	Number of falls resulting in an Injury Severity Rating* level of I–V (none to death).	NQF 21 measures for nursing homes	X										
Fall Intervention	Percent of enrollees with: documented fall risk assessment; a history of falls with documented fall intervention; and who receive appropriate fall prevention interventions based upon the results of their fall risk assessment.	NQF/CMS state-specific measure											X
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	X				
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											X
Care for Older Adults—Functional Status Assessment	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 dressing, eating, and bathing).	NCQA/HEDIS		X	X	X	X	X	X	X	X	X	X
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		X	X	X	X	X	X	X	X	X	X
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											X
Breast Cancer Screening	Percent of female plan members ages 40–69 who had a mammogram during the past two years.	NCQA/ HEDIS			X	X	X	X	X	X	X	X	X
Colorectal Cancer Screening	Percent of plan members ages 50–75 who had appropriate screening for colon cancer.	NCQA/HEDIS		X	X	X	X	X	X	X	X	X	X
Cervical Cancer Screening	Percent of women ages 21–64 who received one or more Pap tests to screen for cervical cancer.	NCQA/HEDIS				X		X	X				
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			X	X	X	X	X	X	X	X	X
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	X	X	X		X	X	X	X
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS; survey data			X	X	X	X	X	X	X	X	X
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	X										
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.		X										
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 Immunization	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						X					X
Aspirin Use and Discussion (ASP)	Aspirin Use: A rolling average represents the percent of members who are currently taking aspirin. 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.	State; MCO/Survey							X				X
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					X				
Screening for Dementia	Percent of members with intellectual disability who are screened for dementia using a standardized instrument.	MassHealth				X							
Tobacco Use Assessment and Tobacco Cessation Intervention	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).	MA-PCPI				X							
	Percent who have used tobacco within past six months, frequency of use, whether health care professional discussed cessation strategies.												X

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Medical Assitance with Smoking and Tobacco Use Cessation	Rolling average represents the percent of members age 18 and older who are 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.	AHRQ/CAHPS						X					
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											X
EFFECTIVE TREATMENT 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		X	X	X	X	X	X	X	X	X	X
Rheumatoid Arthritis Management	Percent of plan members with rheumatoid arthritis who got one or more prescriptions for an antirheumatic drug.	NCQA/HEDIS			X	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X	X
Diabetes Care—Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	NCQA/HEDIS			X	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X	X
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. 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.	State; MCO/Survey							X				X
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) Exacerbation	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 —dispensed a bronchodilator within 30 days of the event	NCQA/HEDIS		X					X				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	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					X				
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 alternative medication during the year.	NCQA/HEDIS				X							
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	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					X				
Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	Percent of members age 18 and older with a diagnosis of heart failure with a current or prior LVEF < 40, who were prescribed ACE inihibitor or ARB therapy either within a 12-month period when seen in the outpatient setting or at hospital discharge.	AMA-PCPI				X							
Ischemic Vascular Disease (IVD): Blood Pressure	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			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									

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MENTAL AND BEHAVIORAL HEALTH AND SUBSTANCE ABUSE													
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			X	X	X	X	X	X	X	X	X
Follow-Up After Hospitalization for Mental Illness	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	X	X	X	X	X	X	X	X
Antidepressant Medication Management	Percent of members age 18 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		X	X	X	X	X	X	X	X	X	X
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	X	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	X										
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	X	X	X	X	X	X	X	X
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							X				
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		X		
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							X				
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. 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.	State-defined measure								X			
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								X			
Multiple Psychotropic Medications	Percent of members with intellectual disability who are taking multiple antipsychotic medications.	MassHealth				X							
Unhealthy Alcohol Use: Screening and Brief Counseling	Screening and brief counseling for substance use.	AMA-PCI				X							
Retention Rate—Mental Illness	Percent of clients assigned to the MMIP with a history of mental illness retained for six months.	State-defined measure						X					
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					

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EFFECTIVE COMMUNICTION AND CARE COORDINATION													
Advance Care Planning	Percent of participants with documentation of advance directives (includes a properly executed advance health care directive including power of attorney for health care decisions, a living will, a written or oral statement of treatment preferences).		X	X									
Advance Care Planning	Percent of enrollees age 65 and older who have an advance care plan or 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.	AGS/NCQA											X
Care Transition Record Transmitted to Health Care Professional	Percent of patients, regardless of age, 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 other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI			X	X	X	X	X	X	X	X	X
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Percent of adults ages 18–64 with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	NCQA/HEDIS				X							
Use of High-Risk Medication in the Elderly	Percent of Medicare members age 65 and older who received at least two different high-risk medications.	NCQA/HEDIS		X									
Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients age 65 and older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing ongoing care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS		X	X	X	X	X	X	X	X	X	X
Medication Reconciliation	Percent of enrollees discharged from an inpatient facility to home or any other site 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.	PCPI											X
Reconciled Medication List	Percent of relevant participant transfers to the PACE organization's ambulatory setting who received medication reconciliation.	CMS meaningful use key elements	X										
Comprehensive Medication Review	Percent of beneficiaries who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA)			X	X	X	X	X	X	X	X	X
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 nonprescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/HEDIS		X	X	X	X	X	X	X	X	X	X
Ambulatory Care Follow-Up with a Provider Within 14 Days of Emergency Department (ED) Visit	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 Inpatient Discharge	Ambulatory care follow-up visit within 14 days of having an inpatient hospital stay.	State							X				
3-Item Care Transition Measure (CTM-3)	Unidimensional self-reported survey that measures the quality of preparation for care transitions.	University of Colorado				X							
Transition Record with Specified Elements	Percent of patients, regardless of age, discharged from an inpatient facility to 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 elements.	AMA-PCPI				X				X			
Timely Transmission of Transition Record	Percent of patients, regardless of age, 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				X							
Tracking of Demographic Information	Percent of all demonstration participants for whom specific demographic data are 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				X		
Real-Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified time frame.	CMS/State-defined process measure			X	X	X	X	X	X	X	X	X
Discharge Follow-Up	Percent of members with specified time frame between discharge to first follow-up visit.	CMS/State-defined process measure			X	X	X	X	X	X	X	X	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							

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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		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		X	X	X	X	X	X	X	X	X	X
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		X	X	X	X	X	X	X	X	X	X
Case Manager Contact with Member	Ability to identify case manager or contact case manager	State-defined measure								X			
Care Coordination	Percent of medium- and high-risk enrollees able to identify care coordaintor and/or HCBS case manager.	State specific measure											X
Care Coordination (person-centered)	Percent of documented discussions of care goals with enrollee and/or caregiver involvement.	State specific measure											X
BENEFICIARY AND FAMILY-CENTERED CARE													
Consumer Assessment of Health Providers & Systems (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	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			X	X	X	X	X	X	X	X	X
CAHPS Hospital Survey (HCAHPS)	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							
Participant Outcomes and Status Measures (POSM) Quality of Life Survey	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.	State; MCO/Survey							X				
Quality of Life	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.	NCF measure											X
Consumer Satisfaction	Percent of enrollees receiving HCBS who are satisfied/very satisfied with these services.	State-specified measure											X
Improving Member Satisfaction (SNP 2)	Element A: Assessment of member satisfaction Element B: Opportunities for improvement Element C: Improving satisfaction	NCQA/HEDIS		X									
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.	Independent Review Entity (IRE)			X	X	X	X	X	X	X	X	X
Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.	Independent Review Entity (IRE)			X	X	X	X	X	X	X		X

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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			X	X	X	X	X	X	X	X	X
Complaints About the Health Plan	How many complaints Medicare received about the health plan.	CMS; CTM data			X	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X	X
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in 2013.	CMS			X	X	X	X	X	X	X	X	X
Access to Care	Percent of respondents who always or usually were able to access care quickly when they needed it.	AHRQ/CAHPS			X	X				X			
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed.	AHRQ/CAHPS		X	X	X	X	X	X	X	X	X	X
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.	AHRQ/CAHPS			X	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X		X
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		X	X	X	X	X	X	X	X	X	X
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care.	AHRQ/CAHPS		X	X	X	X	X	X	X	X	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	X	X	X	X	X	X	X	X
Overall Rating of Plan	Percent of best possible score the plan earned from plan members who rated the overall plan.	AHRQ/CAHPS			X	X	X	X	X	X	X	X	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							
Access to Specialists	Percent of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS			X	X	X	X	X	X	X	X	X
Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS			X	X	X	X	X	X	X	X	X
Access to PCMH Providers	Number and percent of members served by PCMHs.												X
Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS			X	X	X	X	X	X	X	X	X
Being Examined on the Examination Table	Percent of respondents who report always being examined on the examination table.	AHRQ/CAHPS			X	X	X	X	X	X	X	X	X
Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS			X	X	X	X	X	X	X	X	X
Health Status/Functional Status	Percent of members who report their health as excellent.	AHRQ/CAHPS			X	X	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			X	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X	X
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	X		X	X	X	X	
Part D Complaints About the Drug Plan	How many complaints Medicare received about the drug plan.	CMS, CTM data			X	X	X	X	X	X	X	X	X
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			X	X	X	X	X	X	X	X	X

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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			X	X	X	X	X	X	X	X	X
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	X	X	X	X	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	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X
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	X	X	X	X	X	X	X	X
READMISSION AND UTILIZATION 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	X	X	X	X	X	X	X	X	X
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	X										
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							X				
Chronic Obstructive Pulmonary Disease (COPD) (PQI 5)	Assess the number of admissions for 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							
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				X			X				X
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						X					
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							X				
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							X				
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								X			
Physician Access	Utilization measure.	State-defined measure								X			
Psychiatric Bed Days	Utilization measure.	State-defined measure								X			
Emergency Department Utilization Rates	Utilization measure, potentially revised to reflect avoidable emergency deparment visits.	State-defined measure								X			
IHSS Utilization	Utilization measure.	State-defined measure								X			
Retention Rate—All	Percent of clients assigned to the MMIP who are retained for six months.	State-defined measure						X					

QUALITY MEASURE	DESCRIPTION	DATA SOURCE	PACE	SNPs	CMS CORE MEASURE	STATE MEMORANDUMS OF UNDERSTANDING							
						MA	OH	WA*	IL	CA	VA	NY	SC
NURSING FACILITY MEASURES													
Long-Term Care—Urinary Tract Infection Admission Rate	Long-term care hospital utilization because of urinary tract infections.	State							X				
Long-Term Care—Bacterial Pneumonia Admission Rate	Long-termcare hospital utilization because of bacterial pneumonia.	HSAG/State							X				
Transition of Members Between Community, Waiver and Long-Term Care Services	Report number of members moving from: institutional care to waiver services, community to waiver services, community to institutional care, and waiver services to institutional care (exclude institutional stays ≤ 90 days).	State						X	X		X		X
Percent of High-Risk Residents with Pressure Ulcers (Long-Stay)	Percent of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (three-month period) who were identified as high risk and who have one or more Stage 2 to 4 pressure ulcer(s).	NQF endorsed			X	X	X	X	X	X	X	X	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 percent 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's MDS 2.0 QM 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 >100 days). This measure captures 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 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 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).	NQF/CMS					X						
Percent of Residents Experiencing One or More Falls with a Major Injury	This measure is based on data from all nonadmission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant 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.	NQF/CMS					X					X	
Percent of Residents with Urinary Tract Infection	This measure updates CMS's MDS 2.0 QM on urinary tract infections in the nursing facility population. It is based on MDS 3.0 data and measures the percent 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.	State-specified measure					X						
Nursing Facility Diversion Measure	Report of the number of enrollees who lived outside the nursing facility during the current measurement year as a proportion of the enrollees who lived outside the nursing facility during the previous year.	State-specified measure					X					X	
Nursing Facility Utilization Measure	Utilization measure.	State-defined measure								X			
Participants Referred to Preadmission Screening Teams or Money Follows the Person (MFP) Program	Percent of participants in the FIDA demonstration who reside in a nursing facility, wish to return to the community, and were referred to preadmission screening teams or the MFP program.	State-specified measure										X	

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

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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. Percent of enrollees receiving HCBS who experienced a decrease in the authorization of attendant care or companion service hours.	State-specified measure											X
HCBS Authorization—Respite Care	Percent of enrollees receiving HCBS who experienced an increase in the authorization of respite hours. Percent of enrollees receiving HCBS who experienced an increase in the authorization of respite hours.	State-specified measure											X
HCBS Authorization—Non-consumer–directed services	Percent of enrollees receiving HCBS who experienced a decrease in the authorization of HCBS services. Percent of enrollees receiving HCBS who experienced an increase in the authorization of non-consumer–directed HCBS.	State-specified measure											X
Integration of Care	Number/percent of care coordinator actions/care decisions in response to critical incident reports by the in-home providers and/or changes in conditions identified by LTC specialist/waiver case managers.	State-specified measure											X
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 coordinators who are trained on how to make appropriate waiver referrals and use Phoenix and Care Call.	State-specified measure											X
Integration of Care	Percent of enrollees who have a waiver case manager participating in multidisciplinary team.	State-specified measure											X
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											X
Adjudicated Claims, Including HCBS Case Management	Percent of adjudicated claims submitted to CICOs that were paid within the timely filing requirements.	State-specified measure											X
ADMINISTRATIVE MEASURES													
Consumer Governance Board	Establishment of beneficiary/consumer advisory board or inclusion of beneficiaries/consumers on governance board consistent with contract requirements.	CMS/State-defined process measure			X	X	X	X	X	X	X	X	X
Self-Direction	Percent of care coordinators that have undergone state-based training for supporting self-direction under the demonstration.	CMS/State-defined process measure			X	X	X	X	X	X	X		X
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-defined process measure			X	X		X	X		X		
Risk Stratification Based on LTSS or Other Factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS/State-defined process measure			X	X	X	X	X	X	X	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				X							
Encounter Data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State-defined measure			X					X			
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									X		
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									X		
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									X		
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									X		
Nonlicensed/Noncertified Consumer-Directed Employees	Number and percent of new nonlicensed/noncertified consumer-directed employees who meet requirements.	State/1915(c) EDCD waiver requirement									X		
Criminal Background Checks—Consumer-Directed Employees	Number and percent of new consumer-directed employees who have a criminal background check at initial enrollment. Number and percent of consumer-directed employees with a failed criminal background check that are barred from employment.	State/1915(c) EDCD waiver requirement									X		
Staff Training	Number and percent of waiver provider staff meeting provider staff training requirements.	State/1915(c) EDCD waiver requirement									X		

QUALITY MEASURE	DESCRIPTION	DATA SOURCE	PACE	SNPs	CMS CORE MEASURE	STATE MEMORANDUMS OF UNDERSTANDING							
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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									X		
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 administrative hearing unit										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										X	

* 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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