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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%20Savings%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-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/snpalliancesnppperformanceasures.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.
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 - 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-POSMTTool_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).

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	
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	
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	
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	
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	
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	
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	
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	
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). Percent who have used tobacco within past six months, frequency of use, whether health care professional discussed cessation strategies.	MA-PCPI						X				X	

QUALITY MEASURE	DESCRIPTION	DATA SOURCE	PACE	SNPs	CMS CORE MEASURE	STATE MEMORANDUMS OF UNDERSTANDING							
						MA	OH	WA*	IL	CA	VA	NY	SC
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	
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	
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	
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	
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	
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—Substance 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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