California Dual Demonstration Project
Stakeholder Comments on Quality Measures
July 2, 2012

Lisa Shugarman The SCAN Foundation

Thank you for the opportunity to provide input on quality and evaluation metrics for the Dual Eligibles Integration Demonstration. First, we want to alert you to work that the National Committee for Quality Assurance (NCQA) has underway to develop structure and process measures for integrated care expressly for the dually eligible population. NCQA has a set of proposed measures still under review that will then need to undergo testing but they could be available in time for the second and/or third year of the Demonstration. Several of these measures are foundational to supporting access to long-term services and supports (LTSS). Second, we want to alert you to a comprehensive scan of home- and community-based services (HCBS) measures performed for the Agency for Healthcare Research and Quality (AHRQ) and released in 2010. Among the appendices of this report are measures that have been tested and reflect beneficiary experience and performance measures. This report can be found at: http://www.ahrq.gov/research/ltc/hcbsreport/. There are numerous measures that have been tested from which to select that would be relevant for those who are receiving LTSS. Especially relevant are the measures that reflect consumer opportunity to make choices about providers and services.

One set of evaluation metrics that might be considered would include the identification of those who were deemed "at risk" for LTSS (as defined by the State) and then to evaluate the proportion of those at risk who received a comprehensive assessment that included physical and cognitive function assessment (and those who refuse the assessment should be appropriately documented). While there are existing SNP measures around complex case management that address assessment, they define "complex" in clinical terms and do not expressly consider functional status and LTSS risk. Those who have previously been deemed "at risk" for needing LTSS should continue to be re-assessed at some regular interval and the evaluation should monitor that this is occurring. Furthermore, among those who have been deemed "at risk" and have participated in a comprehensive assessment, the health record should document a care plan or document that services have been offered (whether they are put in place or not).

Given there are few validated measures of structure and process for LTSS and care transitions that are needed for the Demonstration, it is important to ensure that the quality monitoring include periodic surveys of consumers to understand their experience in the Demonstration. Questions should include whether they understand their rights and benefits under the Demonstration, do they know who to contact if they have questions/concerns, and if they need to appeal a care decision. The existing SNP measures require health plans to demonstrate they have developed materials to inform consumers of their rights and benefits, but do not reflect how effective the materials are in communicating these issues and the consumer's experience in comprehending the information.

The Experience of Care and Health Outcomes (ECHO) measure set focuses on behavioral health but many of the measures in this set would also apply to populations using LTSS. Examples of measures that would be relevant include whether the individual is involved as much as he/she wanted in treatment/service plan decisions. We recommend close examination of this measure set to determine whether there are measures that can appropriately be adapted to the LTSS population.

Eric Schwimmer SEIU-UHW

I'm looking for any respected resources with recommendation on the topic of inclusion of social model values and priorities with respect to outcomes in evaluations (e.g. consumer control, social participation, caregiver support).

I am looking at the document, "California Coordinated Care Initiative Evaluation Strategy" distributed to the Quality and Evaluation Workgroup. I see how measures of utilization of HCBS and beneficiary satisfaction can be indicators of quality of life, one of the CCCI's core aims, and an aim that's important to the HCBS advocacy community. But it seems like there's an opportunity with the CCCI to pilot new measures and methods that speak more directly to the social model.

I think I understand the difficulties inherent. Social model principles may be difficult to translate into measures that are valid and reliable. The national evaluation probably won't include them due to issues with comparability with other states, and that makes sense. But if we don't make them more of a priority in the evaluation I am concerned that plans and providers won't make them a priority.

David Pilon, MHALA

My general impression of the quality measures is that they are extremely "thin" on behavioral health in general. What behavioral measures there are tend to focus on decreasing adverse impacts, such as reducing (psychiatric) hospitalizations and emergency room usage. There is also some reference to standardized measures of depression and anxiety, which are certainly appropriate for people with mild to moderate depression and/or anxiety.

However, for people with severe and persistent mental illnesses, whom I assume many of the dual eligibles will be, these measures will be inadequate. What is needed for this population is a positive measure of their mental health recovery status. As I wrote in a prior email, SAMHSA has defined recovery as consisting of 4 dimensions: Health, Home, Purpose (meaningful activity) and Community (relationships and social networks). The fact that there is significant evidence that social support has a positive effect on mortality and morbidity is an additional reason for including a measure of recovery. MHA's Milestones of Recovery Scale is a valid and reliable measure of recovery. But even if you don't choose that specific measure, please include some measure of recovery for people with severe and persistent mental illnesses.

Marilyn Ditty, AGE WELL SENIOR SERVICES, INC.

Thanks for sending all of the information to me. I had an interesting call from a Pharma Research Group who is lobbying pretty hard to delay the approval by CMS of the Dual Demonstration Program., I asked them why they are lobbying against it and they said that they didn't feel the seniors would be treated fairly and would lose their doctors and the services they have come to expect. I really questioned that logic. I wanted you to know what is going on. They are calling the entire list of people who attended the hearings. They feel that the State of California can't handle four sites and especially oppose eight sites.

I feel that the best metric for year 1 is the access question, whether any of the seniors have lost any services they had received before. And if so, why and for how long. The primary care physician is going to have to have some clear guidance on how services will be ordered and delivered by who. All of this the first year.

Metrics for years 2 and 3 will be tracking and customer satisfaction tools. The biggest concern is how all the medical history data will be compiled for each person and how will it be transmitted. Many seniors complain that their primary physician doesn't refer them to specialist quickly enough and they have problems getting that referral. I would measure the timeliness of referrals, appointments, and what treatment is now being recommended. The biggest concern is how long does it really take to get a referral to a specialist and how long for the specialist to see the patient and start treatment.

I hope this helps. Keep me in the loop about the Pharma Research Group. Let me know if you have any more hearings.

California Mental Health Directors Association (CMHDA) Comments on Performance Measures for Behavioral Health Molly Brassil, MSW, Associate Director, Public Policy

Thank you for this opportunity to provide input on the development of performance measures for behavioral health integration. The demonstration proposal indicates that CMS may require a performance-based withhold of 1%, 2%, and 3% respectively for years one, two and three of the demonstration. According to the proposal, health plans will be able to earn back the capitation revenue if they meet to-be-established quality objectives. Since, as the proposal underscores, a key aim of this demonstration is to reduce cost shifting across delivery systems, CMHDA strongly urges DHCS/CMS to identify a behavioral health objective to include as part of the plans' "quality withhold." If the plans succeed in meeting the behavioral health quality objective, the earnings received should then be shared with the MHP to further support, incentivize and reward the coordination efforts that resulted in the achievement of the objective. If the state is to pursue a shared accountability and savings arrangement between county MHPs and demonstration MCOs, the quality withhold may be an important opportunity to identify the necessary incentive payments in the first years before shared savings would be achieved as a result of the coordination infrastructure established through the process changes.

CMHDA believes it is important to note that the vast majority of savings related to better coordination and integration of mental health and substance use disorder services with primary care are realized on the healthcare side of the aisle – in terms of reduced costs and improved health outcomes. In order for this demonstration to be successful, it is imperative that this dynamic be recognized through shared savings arrangements between the MCOs and county MHPs. CMHDA believes this might be an important opportunity to leverage the significant available research in this area in order to best incentivize and reward effective care coordination between MCOs and MHPs.

CMHDA is particularly interested in further exploring opportunities for the state to create a shared savings pool from which dollars are allocated based on performance on measures that the physical health MCO and county behavioral health organization can jointly influence. CMHDA particularly supports a tiered approach that allows for a phased-in implementation. ***CMHDA believes that a phased approach to achieving a greater level of shared accountability and savings between MCOs and county mental health makes the most sense for California in this demonstration.*** For example, in the first year, measures could strictly be process-oriented, representing tangible, measurable activities that indicate collaboration and form the foundation necessary for integrating care. Such measures could include such activities as the establishment of care plans and hospitalization notification. The measures would then evolve to outcome measures in subsequent years. Such outcomes might include reduced emergency and inpatient utilization. Pharmacy is another important opportunity to identify better coordination processes to ultimately reduce costs and improve health outcomes.

Health plans operating Medicare Advantage plans currently already monitor and report on a variety of health measures. CMHDA believes that is may be most prudent to build on this existing infrastructure by identifying opportunities to tailor current measures and outcomes to apply to this subset of the population with serious and persistent mental illness. For example, current protocols to measure medication adherence for beneficiaries with depression could be tailored to be more relevant to a population subset of individuals with bipolar disorder. Similarly, measures and outcomes related to weight gain and obesity could be applied to individuals taking atypical medications for psychotic disorders.

CMHDA appreciates the opportunity to continue to work with DCHS over the next few months to further develop and refine a strategic framework for coordination and alignment, including shared accountability and savings, between managed care organizations and county mental health authorities in the demonstration.

Rusty Selix, California Council of Community Mental Health Agencies (CCCMHA)

CCCMHA is the state association of providers of community mental health and related services to people with severe and disabling mental illnesses under contracts with county mental health departments. The services are generally not covered by Medicare and usually go beyond what MediCal will pay for in its mental health

managed care program and often include alcohol and drug services and some services not reimbursable by Medicare or MediCal. In recent years these providers have begun to create partnerships to address the physical health needs of the people they serve.

CCCMHA has had a major interest in performance measurement for more than 20 years and our findings of what works and what does not is now in statute in the Mental Health Adults and Older Adults System of Care set forth in Welfare and Institutions Code Sections 5800-5815. Funding for that model of care is the heart of Proposition 63 the Mental health Services Act and counties collect outcome data for those programs already so there is no need to reinvent the wheel.

We have learned that for people with severe and disabling mental illnesses (including all duals who become duals due to a psychiatric disability) only functional outcomes are useful in measuring the success of mental health care. Other measures used elsewhere in healthcare are relevant for their physical health but not their mental health.

For this population, when it is getting services under the Mental Health Services Act, the relevant outcomes are set forth in Welfare and Institutions Code Section 5814. They focus on recovery as measured by increased independence in housing, increased income/employment and avoiding institutions (jails, nursing homes and hospitals). It is also important to measure whether they are engaged in meaningful activity and have adequate social support. Their level of social support is particularly important because there is significant evidence that increased levels of social support are related to decreases in mortality and morbidity.

Measuring progress over time on these domains are the only useful performance measures for this population (besides their physical health which other measures will address). In order to improve outcomes overall it is essential to report these outcomes for each program as the goal should be to identify the best performers based on results and costs and to study what they are doing differently from those whose results are not as good. In large counties there will often be significant variation among providers so reporting county wide will not be as useful as reporting for each provider.

In addition to measuring cost of services while someone is in a program an equally important measure of cost is how long someone needs this level of care and the average duration and numbers for which there is graduation to a lower level of care.

For those not getting served but who have severe mental illnesses, a single measure of the number of psychiatric hospitalizations determines who probably needs the county level services but is not getting them.

For people without severe and disabling mental illnesses, the first goal is to get them outpatient mental health care in a timely manner so that their mental and physical health is not allowed to deteriorate to a level that may require hospitalization. Therefore, a measure of penetration rate progress – numbers of people receiving outpatient mental health care (including those who are only receiving psychotropic medications but do not require continued therapy) and comparing each health plan based on its improvement and overall penetration rate is an important measure of progress and success.

In addition, many of these less disabled individuals will suffer from mild to moderate depression and/or mild to moderate anxiety. Therefore, specific measures for both depression and anxiety that can show improvement over time (e.g., PHQ – 9) should be considered.

While not as useful other more traditional measures have some value. These include information on numbers of people successfully completing a treatment program. Not useful are measures relating to inpatient care and 30 day follow up unless that focuses solely on getting people into a System of Care program upon hospital discharge and verifying that they are still in that program 30 days later. Rehospitalizations usually don't occur for several months after discharge so a 30 day rehospitalization report is of little value. Similarly simply having an outpatient appointment shortly after discharge says little either as nearly always it is a much more comprehensive program that is required.

Mental Health America of California (Also submitted by Rusty Selix, some overlap with above)

MHAC is most concerned about performance related to people with severe and disabling mental illnesses. These are people who become duals due to a psychiatric disability. Accordingly most important to us is to separately track outcomes for this segment of dual eligibles and to compare both physical health and mental health care results for that population both among the participating counties and against the status quo trend for other counties..

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Jorge Weingarten, MD, Chief Medical Officer, Care First

Year 1

We agree that the focus on year 1 measures should be one of process rather than outcomes as it will take some time for both member integration into Managed Care an effective integration of County Mental Health and Plan activities. Therefore we propose that Year 1 measures should be focused on the effectiveness of this later integration. Some possible measures are:

- Percentage of behavioral health/substance use members with integrated (medical/behavioral) care plan
- Percentage of behavioral health/substance use members under Care Management
- Percentage of behavioral health/substance use members completing a HRA

Year 2 and 3

Focus should shift more towards outcome related measures:

- Reducing psychiatric bed days
- Reducing ER utilization rates
- Reducing 30 day readmission rates
- Increasing medication adherence
- Reducing total cost of care
- Improved Behavioral health focused HEDIS measures

I hope you find this helpful

John Black, Chair, California Mental Health Planning Council

Thank you for this opportunity to provide input on the identification and evaluation of quality metrics to be included in the Dual Eligible Demonstration Project. The California Mental Health Planning Council (Council) has been a long-standing advocate for a system of accountability and continuous quality improvement based on program evaluation, and we are happy for this opportunity to weigh in on this essential issue. The Council is a majority consumer and family member advisory body mandated in federal and state statute to provide oversight of the public mental health system, advocate for individuals and families across the life span living with serious mental illnesses or serious emotional disturbance. In addition to advocating for program evaluation, we also strongly promote a culturally competent mental health system that is wellness and recovery based and inclusive of stakeholders.

A large percentage of the dual eligible population has behavioral health issues, and many live with serious mental illness. The "Faces of Medicaid III" (October 2009) reports that, when pharmacy data is included in their research, the investigators found that "*psychiatric illness is represented in three of the top five most prevalent pairs of diseases, or dyads, among the highest-cost 5% of Medicaid-only beneficiaries with disabilities*" and that 49% of Medicaid beneficiaries with disabilities have a psychiatric condition (52% of dual eligibles).

The Council is concerned that the metrics in current consideration do not include enough indicators on mental health and substance use services. Moreover, they do not reflect the attitude or perspective of an individual consumer's satisfaction based on choice, accessibility, or follow-up to treatment. For example, the prescription drug metric queries on drug education, courteous treatment, and cost information, but does not ask about whether the prescription needed was covered under the formulary, or whether refills for chronic

mental health issues were easy to obtain or required a separate office visit, evaluation, and prescription. We are also concerned at the lack of any shared accountability metrics for county behavioral health plan carve outs.

The majority of the indicators emphasize physical health indicators, and/or appear to be based on complaints rather than successes. We support measuring improvement of health status for those with mental health and substance use issues – a very important potential outcome of these demonstration projects. We also support and appreciate the suggestions of the four pilot counties to use existing data collection sources to monitor benchmarks such as reduction in psychiatric bed days, ER visits, and re-admits.

At a minimum, the Council would respectfully suggest that for the first year, the metrics should query on:

- Whether the plans demonstrated a continuum of substance abuse and mental health rehabilitative services which are sufficient to serve the percentage of serious mentally ill clients enrolled in the demonstration projects.

The Planning Council recently participated in a workgroup to develop reporting requirements for the Mental Health Services Act and the projected Integrated Plan.
It developed a crosswalk of indicators and measurements across the life span using existing data sources collected by the DMH and DHCS that counties already used. The outcomes are sourced from Data Collection & Reporting (DCR), the Client Services and Information System (CSI), the Youth Satisfaction Survey (YSS) and the YSS-Family (YSS-F), and lastly, the Mental Health Statistics Improvement Program (MHSIP). We would recommend consulting this crosswalk to obtain indicators that are very important to the mental health community.

The Planning Council agrees with our colleagues at the California Mental Health Directors Association on the need for shared accountability mentioned earlier, and supports their suggestion for some type of performance and incentive metric that would promote coordinated care for emergency and pharmacy services. Additionally, we observe that the "Faces of Medicaid III" study gained a much more thorough understanding of the prevalence and needs of the Medicaid population by studying the pharmacy records. There may be some application for that in the Dual Eligibles demonstration project as well. We also support the comments of the California Council of Community Mental Health Agencies (CCCMHA), particularly in regard to the usefulness of the criteria that are measured (i.e., hospital days & readmission rates, social supports, continuity of care with periodic follow-ups beyond 30 days, etc.).

We regret that time does not permit as thorough a response as we feel this important topic deserves. However, we appreciate this opportunity to comment on what we've seen, and to reinforce the importance of pertinent metrics. Consumer choice and person directed care are high priorities in any system reform. Given more time we could search for a metric that would be appropriate to assess progress in these important areas. We are optimistic that your experts might be able to suggest something that could accomplish this goal.

We look forward to seeing what metrics are finally decided upon, and appreciate and welcome the opportunity to provide additional input. If you have any questions, please contact our Executive Officer, Jane Adcock at jane.adcock@dmh.ca.gov or by phone at (916) 651-3803.

National Senior Citizen Law Center

Thank you for the opportunity to comment on the draft list of potential performance measures. This letter addresses those performance measures that could potentially be added to the list.

Performance Measures to Be Added
The current suggested performance measures are taken in general from the required measures for SNPs, Part C Plans, and Part D Plans. As a result, they do little to address the long-term services and supports funded

generally by the Medicaid program. Based on the recent report from the National Quality Forum[1], we suggest addition of the following measures specific to LTSS:

- Degree to which consumers experience an increased level of functioning;
- Unmet need in ADLs/IADLs;
- Participants reporting unmet need for community involvement;
- Degree to which people with identified physical health problems obtain appropriate services and degree to which health status is maintained and improved;
- Degree to which consumers report that staff are sensitive to their cultural, ethnic, or linguistic backgrounds and degree to which consumers felt they were respected by staff;
- Degree of active consumer participation in decisions concerning their treatment;
- Case manager helpfulness;
- Service satisfaction scales for home workers, personal care, and home-delivered meals;
- Ability to identify case manager;
- Ability to contact case manager;
- Percent of adults with disabilities in the community usually or always getting needed support;
- Percent of caregivers usually or always getting needed support;
- Proportion of people with disabilities reporting recent preventive health care visits; and
- Proportion of people reporting that service coordinators help them get what they need.

Also, we suggest that the state require a medical loss ratio of a certain percentage to assure that Medicare and Medicaid funding is well utilized towards the care of dual eligible persons. This would be consistent with the MLR requirements established by the Affordable Care Act for health insurers.[2]

Another useful measure of systemic performance would be the proportion of HCBS spending to LTSS institutional spending. Such a measure is put forward in the recent NQF report, which adapts this measure from the National Balancing Indicators.[3]

Of the "Other Measures to Consider," we have no opinion on the three measures related to behavioral health, but support the two LTSS measures, Care Transition Record Transmitted to Health Care Professional, and Percent of High Risk Residents with Pressure Ulcers (Long Stay).
We note that the pressure ulcers measure relates solely to nursing facility residents, and suggest that the State also use many of the other measures that already are used by CMS in the evaluation of nursing facilities. As you know, nursing facility residents are regularly assessed with the Minimum Data Set document, which results in a great amount of useful data. We have listed below some of the CMS quality measures that would seem to be useful in measuring the quality of nursing facility care, and do not seem to be duplicated by the other measures already proposed for enrollees generally.

- Percent of long-stay residents who were assessed and given pneumococcal vaccination;
- Percent of long-stay residents whose need for help with daily activities has increased;
- Percent of residents (short-stay and long-stay) who have moderate to severe pain;
- Percent of long-stay residents who were physically restrained;
- Percent of long-stay residents who are more depressed or anxious;
- Percent of low-risk long-stay residents who lose control of their bowels or bladder;
- Percent of long-stay residents who have/had a catheter inserted and left in their bladder;
- Percent of long-stay residents who spent most of their time in bed or in a chair;
- Percent of long-stay residents whose ability to move about in and around their room got worse;
- Percent of long-stay residents who had a urinary tract infection;
- Percent of long-stay residents who lose too much weight; and

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[1] National Quality Forum, Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS (June 2012). The Report's potential LTSS measures are listed in the Report's Appendix H (Selected Potential Measures for Medicaid Home and Community-Based Services).

[2] *See* 42 U.S.C. § 300gg-18; 42 C.F.R. Part 158.

[3] National Quality Forum, Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS at Appendix H, p. 85.

- Percent of short-stay residents who have delirium.

In general, consistent with a comment that I made during the original meeting of this work group in Sacramento, we urge that there be significant work on connecting these measures to quality improvement and consumer protection. Measurement is necessary but not sufficient.

In conclusion, we appreciate the opportunity to comment on the draft list of performance measures. Please feel free to call with any questions or suggestions.

Potential Quality Measures for Health Plan Reporting
Current SNP and Medicare Advantage/Part D Required Measures
With Health Net Comments

Measurement period and outcome availability: In the following assessment, it is assumed that the evaluation period should not start prior to June 1, 2013 when both the MediCare and MediCaid parts of the program are both in place. This has implications to the availability of standardized metrics including HEDIS, CAHPS based metrics, and CMS Part C and D metrics.

- **HEDIS Metrics**: The earliest measurement period that can be evaluated is determined based on the eligibility criteria for the metric.

- **CAHPS Metrics**: CAHPS are fielded in the first quarter of each year. The look back period is the 6 months prior to the survey date. Based on this, the earliest that a CAHPS survey can be fielded for Duals is the first quarter of 2014. Results for this survey would be expected in June 2014 to reflect 2013 experience.

- **CMS Medicare Part C and D Metrics**: Many of these metrics are MediCare star metrics based on CMS data and calculated by CMS. It is not known at this time if CMS will be doing the same for Duals. For these metrics measurement timelines are estimated based CMS document 'Medicare Health & Drug Plan Quality and Performance Ratings 2012 Part C & D Technical Notes'. Reporting time lines are unknown.

General Comments
- In general, HEDIS and CAHPS are standard measures already in place, for which Health Net and our providers already have processes and mechanisms to track the needed elements and, for those reasons we recommend.
- The set of members needs to be defined in terms of who is included in the measurements, etc... (members in the plan 12 months, etc...) This argues for delay in using metric results to fund Health Plan to out years.
- Solid definitions are required. (better define the numerator vs. denominator)
- Are Plans measured against performance of others? Or against set standards.
- What levels of credibility will be put in place?
- We have concerns about obtaining/capturing required data for measurements from our capitated providers
- Given the late stage in obtaining critical information regarding this program, we have concerns about how quickly the provider network is up and running on the measurements.
- Frequency of Metrics: many of the metrics they captured on an annual basis (HEDIS, CAHPS) and on a specific calendar cycle. Be realistic in the expectations for reporting

- Some of the proposed measures (Antidepressant medication management, Follow-up After Hospitalization for Mental Illness) require time frames for measuring the follow-through activities/visits. There is a challenge to capture across spectrum of different providers (capitated vs. carved out, unrelated, etc...).
- How will timely accurate documentation and communication to Health Plan be ensured?
- Program should at most begin with standard metrics and measurements already reported for CMS, HEDIS, and CAHPS programs. The reporting requirements should be mandated in the provider contracts and because the Duals Pilot has so many unknowns (rates, product design, etc...) we should insist to stick with current standard reporting. There are enough program implementation components to deal with in the condensed time frame. Provider contracts should specify requirements to provide metrics or information needed to measure quality, both specified by the program and to be specified at a future date.

Current SNP Required Measures (Health Net comments)		
Antidepressant medication management	Percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	HEDIS AMM. Based on the intake period for this metric, the first year this metric can be calculated for is measurement year 2014 (MY2014) with the outcome reported in June 2015. Recommend include. First available outcome will be in June 2015.
Follow-up After Hospitalization for Mental Illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	HEDIS FUH. Intake requires measurement year only. Recommend include. First available outcome will be in June 2014 for partial MY2013. The minimum age needs to be changed to adjust for the Demonstration.
SNP1: Complex Case Management	The organization coordinates services for members with complex conditions and helps them access needed resources. Element A: Identifying Members for Case Management Element B: Access to Case Management Element C: Case Management Systems Element D: Frequency of Member Identification Element E: Providing Members with Information Element F: Case Management Assessment Process Element G: Individualized Care Plan Element H: Informing and Educating Practitioners Element I: Satisfaction with Case Management Element J: Analyzing Effectiveness/Identifying Opportunities Element K: Implementing Interventions and Follow-up Evaluation	These are not standardized metrics. Instead we should include standardized metrics addressing SNP1 that can be uniformly measured across states. Recommend do not include. These are elements of the program, rather than metrics/measures. How are these to be used to "measure" quality or are these just requirements of the program that must be documented (a yes or no that the elements are included?)
SNP 4: Care Transitions	The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions. Element A: Managing Transitions Element B: Supporting Members through Transitions Element C: Analyzing Performance Element D: Identifying Unplanned Transitions Element E; Analyzing Transitions Element F: Reducing Transitions	These are not standardized metrics. Instead we should include standardized metrics that can be uniformly measured across states. Recommend do not include. Seems like elements of the program, rather than metrics/measures. How are these to be used to "measure" quality or are these just requirements of the program that must be documented (a yes or no that the elements are included?)
SNP 6: Coordination of Medicare and Medicaid Benefits	The organization coordinates Medicare and Medicaid benefits and services for members. Element A: Coordination of Benefits for Dual Eligible Members	These are not standardized metrics. Instead we should include standardized metrics addressing SNP1 that can be uniformly

	Element B: Administrative Coordination of D-SNPs Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages Element D: Service Coordination Element E: Network Adequacy Assessment	measured across states. Recommend do not include. Seem like elements of the program, rather than metrics/measures. How are these to be used to "measure" quality or are these just requirements of the program that must be documented (a yes or no that the elements are included?)
Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented	Medication Reconciliation - Requires coordination between hospital physician and patients' primary physician. As stated, similar but not identical to HEDIS MRP. Inclusion of non-HEDIS metrics will entail substantial work for plans. Recommend include but change to HEDIS MRP metric. First available outcome will be in June 2014 for partial MY2013.
CAHPS Survey (Health Plan version plus supplemental items/questions)	For scoring and reporting purposes, survey questions are combined into the following six composite measures: ▪ Getting Needed Care ▪ Getting Care Quickly ▪ Doctors Who Communicate Well ▪ Health Plan Customer Service ▪ Getting Needed Prescription Drugs ▪ Getting Information from the Plan About Prescription Drug Coverage and Cost	CAHPS. Recommend include. Outcome first available 2nd half of 2014 for 2013 experience.

Care for Older Adults – Medication Review	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	HEDIS COA. Recommend include but also add COA Advance Care Planning. First available outcome will be in June 2015 for MY2014.
Care for Older Adults – Functional Status Assessment	Percent of plan members whose doctor has done a functional status assessment to see how well they are doing —activities of daily living (such as dressing, eating, and bathing).	HEDIS COA. Recommend include. First available outcome will be in June 2015 for MY2014.
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.	HEDIS COA. Recommend include. First available outcome will be in June 2015 for MY2014.
Part D Required Measures ▪ Indicated metrics where data is collected by CMS. Availability of the metrics depends on CMS, though similar outcomes for some of these metrics could be calculated by the plans. ▪ From a pharmacy perspective, these are reasonable and something we already track. We appreciate the consistency of tracking and intervening on the same issues versus adding any new ones.		
Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the drug plan's pharmacy help desk.	CMS Measure D01* First expected measurement period 01/31/2014 – 5/27/2014. Call

		center data collected by CMS.
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 Measure D02* First expected measurement period 01/31/2014 – 5/20/2014. Call center data collected by CMS.
Appeals Auto–Forward	How often the drug plan did not meet Medicare's deadlines for timely appeals decisions.	CMS Measure D03* First expected measurement period 01/1/2014 – 12/31/2014. Data source IRE (Independent Review Entity) contracted by CMS. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.
Appeals Upheld	How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member's appeal.	CMS Measure D04* First expected measurement period 01/1/2014 – 6/30/2014. Data source IRE (Independent Review Entity) contracted by CMS.

Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 days.	CMS Measure D05* First expected measurement period: 11/13/2013 – 4/27/2014. Data source Medicare Advantage Prescription Drug System (MARx).
Complaints about the Drug Plan	How many complaints Medicare received about the drug plan.	CMS Measure D06* First expected measurement period: 1/1/2014 – 6/30/2014. Data source CTM (CMS Complaint Tracking Module).
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 Measure D07* First expected measurement period: 1/1/2014 – 2/28/2015. Data source CMS Administrative Data. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.
Members Choosing to Leave the Plan	The percent of drug plan members who chose to leave the plan in 2013.	CMS Measure D08* First expected measurement period: 1/1/2014 – 12/31/2014.. Data source Medicare Beneficiary Database Suite of Systems. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.
MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data	CMS Measure D12 – Accuracy sub metric.* First expected measurement period: 1/1/2014 – 12/31/2014. Data source PDE Prescription Drug Event) data files submitted by plan, MPF pricing files, HPMS approved formulary extracts. The timeframe

		on this measure could be moved forward 1 year if a partial year of data were to be reported.

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 Measure D13 First expected measurement period: 1/1/2014 – 12/31/2014. Data source PDE data files submitted by plan. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.
Diabetes Treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS Measure D14 First expected measurement period: 1/1/2014 – 12/31/2014. Data source PDE data files submitted by plan. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.
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 Measure D15 First expected measurement period: 1/1/2014 – 12/31/2014. Data source PDE data files submitted by plan. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.
Part D Medication Adherence for Hypertension	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 Measure D16 First expected measurement period: 1/1/2014 – 12/31/2014. Data source PDE data files submitted by plan. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.
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 Measure D17 First expected measurement period: 1/1/2014 – 12/31/2014. Data source PDE data files submitted by plan. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.

Getting Information From Drug Plan	The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost. -In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs? -In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when	CAHPS. We recommend include but with the percent reported to be scoring of 90% or better. Outcome first available 2nd half of 2014 for 2013 experience.

	you tried to get information or help about prescription drugs? -In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? -In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?	
Rating of Drug Plan	The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs. -Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?	CAHPS. We recommend include but with the percent reported to be scoring of 90% or better. Outcome first available 2nd half of 2014 for 2013 experience.
Getting Needed Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan. -In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? -In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?	CAHPS. We recommend include but with the percent reported to be scoring of 90% or better. Outcome first available 2nd half of 2014 for 2013 experience.

Medicare Part C HEDIS Measures and Other CMS Monitoring Measures * Indicated metrics where data is collected by CMS. Availability of the metrics depends on CMS, though similar outcomes for some of these metrics could be calculated by the plans.		
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.	CMS Measure C34* First expected measurement period: 1/1/2014 – 12/31/2014. Data source IRE (Independent Review Entity) contracted by CMS. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.
Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.	CMS Measure C35* First expected measurement period: 1/1/2014 – 12/31/2014. Data source IRE (Independent Review Entity) contracted by CMS. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.
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 Measure C36* First expected measurement period 01/31/2014 – 5/20/2014. Call center data collected by CMS.
Diabetes Care – Eye Exam	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.	HEDIS CDC metric. First MY2014 with results reported in June 2015. Recommend include.

Diabetes Care – Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	HEDIS CDC metric. First MY2014 with results reported in June 2015. Recommend include.
Diabetes Care – Blood Sugar Controlled	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	HEDIS CDC metric. First MY2014 with results reported in June 2015. Recommend include.
Rheumatoid Arthritis Management	Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	HEDIS ART. First MY2014 with results reported in June 2015. Recommend include.
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.	HEDIS FRM. Recommend include. Based on Medicare Health Outcome Survey. First measurement Q1 2014 with results reported in reported summer 2015.
Plan All-Cause Readmissions	Percent of those 65 years and older 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.	HEDIS PCR. Recommend include. First available outcome will be in June 2015 for MY2014, though there may be insufficient comorbidity data.
Complaints about the Health Plan	How many complaints Medicare received about the health plan.	CMS Measure C31* First expected measurement period: 1/1/2014 – 6/30/2014. Data source CTM (CMS Complaint Tracking Module).
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 Measure C32* First expected measurement period: 1/1/2014 – 2/28/2015. Data source CMS Administrative Data. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in 2013.	CMS Measure C33* First expected measurement period: 1/1/2014 – 12/31/2014. Data source Medicare Beneficiary Database Suite of Systems. The timeframe on this measure could be moved forward 1 year if a partial year of data were to be reported.
Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years.	HEDIS BCS. Recommend include. Since there is a 2 year look back, first measurement year 2015 with data reported June 2016.
Colorectal Cancer Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.	HEDIS COL. Recommend against using. Correct evaluation of metric requires substantial look-back period that is not available.
Cardiovascular Care – Cholesterol Screening	Percent of plan members with heart disease who have had a test for ―bad‖ (LDL) cholesterol within the past year.	HEDIS CMC. Recommend include. Requires continuous enrollment measurement year and year prior. First measurement year 2015 with data reported June 2016.

Diabetes Care – Cholesterol Screening	Percent of plan members with diabetes who have had a test for —bad‖ (LDL) cholesterol within the past year.	HEDIS CDC metric. First MY2014 with results reported in June 2015. Recommend include.
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	Based on CAHPS. First available June 2014 for measurement year 2013.
Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	Based on Medicare Health Outcome Survey – baseline and follow-up 2 years later. Earliest possible baseline survey that could be fielded would be Q1 2014, with 2 year follow-up survey in 2016. Substantial reporting time lag suggests data not timely enough to use. Recommend do NOT nclude.
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 PAO based on Medicare Health Outcome Survey. Recommend include. Earliest reporting 6/2015 for survey fielded Q1 2014. Since covers 12 months of experience, does not have full look-back period for evaluation.
Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS AAP. Recommend include. 1st available outcome 6/2015 for MY 2014.

Other Measures to Consider			
Behavioral Health	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	HEDIS IET. A/D treatment programs will have to be coordinated with the County. Given budget cuts, year three is a maybe to scope and collect data.
BH	Screening for Clinical Depression and Follow-up	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	Problematic / difficult to implement.
LTSS	Care Transition Record Transmitted to Health Care Professional	Percentage 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	Plans could start in year one but the time post discharge needs to be changed to a more realistic 48 hours

		care within 24 hours of discharge.	
LTSS	Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	This is not an appropriate measure for health plans. It is facility specific and already collected by the State.
LTSS	Perceived improvement in daily activity function (four items)	Not a standardized measure. Echo: employment, work sit, school, quality of life.	This really needs to be a long term goal and is more appropriate for SPD Medi-Cal only members. School should be removed

Performance Measures for Behavioral Health Integration Suggested by Health Plans/BH Partners
Health Net QI Comments

General Comment: Some of the measures don't seem to specifically relate to behavioral health (ER visit reductions, readmissions). Specific diagnoses (or other coding) that relates such visits/admits to behavioral health would be needed to develop such measurement.

Our plan does not endorse the items listed specifically for San Mateo county to be rolled into the other counties

Suggested measure *(tweak suggested by other county)*	**Comments**
Psychiatric bed days (utilization rate)	Yes. Report as per thousand covered members per year or as inpatient psychiatric admit rate. These are all measurable and appropriate for Year 1
Readmission rate	Yes. Report as 30 day readmit rate. These are all measurable and appropriate for Year 1
ER visit rate (*for members with SPMI)*	Yes. Report as Psychiatric ER visit rate (per thousand members per year) These are all measurable and appropriate for Year 1
Inpatient detox admit rate (per thousand members per year)	Add metric to capture inpatient detox utilization.
Residential Treatment Center days (per thousand members per year)	Add metric to capture residential treatment center utilization.
Partial Hospitalization Program days (per thousand members per year)	Add. Important to document lower levels of care.
Intensive Outpatient Program days (per thousand members per year)	Add. Important to document lower levels of care.
Selected HEDIS measures *(e.g. STAR rating measures)*	These are all measurable and appropriate for Year 1
F/u after hospitalization	Yes. HEDIS FUH.

Anti-depressant medication management	Yes. HEDIS AMM.
Use of high risk medication in the elderly	Yes. CMS D13.
Care of Older Adults – Functional Assessment	Add. HEDIS COA
Selected CAHPS measures *(member experience)*	These are all measurable and appropriate for Year 1
Medication adherence	Somewhat vague. Need to specify the measurement
Access to care standards	Specify the measurement
Screening, assessment and initial referral process in place	
Risk stratification using SPMI/SUD indicators	This specific section seems to refer to approaches, guidelines and/or tools (rather than measures).
Comprehensive provider network	
Comprehensive transitional care	
Days from discharge to first MH/PCP OP visit	
Cardiometabolic testing for members on antipsychotics	
Shared care planning *(interagency care coordination teams)*	This specific section seems to refer to approaches, guidelines and/or tools (rather than measures). Consider potentially for year 3
Alcohol/substance use/depression and anxiety screenings	This specific section seems to refer to approaches, guidelines and/or tools (rather than measures).
Screening for physical health conditions in BH care	
Rate of appropriate referrals	'Appropriate' is difficult to evaluate.
Rate of appropriate health home visits	'Appropriate' is difficult to evaluate.
Rate of hospital admission (medical and psychiatric) for members with SPMI	
Financial measurement	
Update MOUs between counties/plans to include referral, care coordination and admin processes	This specific section seems to refer to approaches, guidelines and/or tools (rather than measures).
BH Initiation (2nd visit) within 14 days of 1st contact	
BH Engagement (3rd and 4th visits) with 30 days of 2nd contact	
Percent of BH clients meeting goals	Will these be evaluated in a standardized way?

END OF COMMENTS FROM HEALTH NET