NEW YORK STATE | Department of Health | Medicaid Redesign Team

Value Based Payment Advisory Group – Services for the Intellectually/Developmentally Disabled

I/DD VBP Advisory Group Meeting 3

Meeting Date: May 17, 2016

May 2016

Tentative Meeting Schedule & Agenda

Depending on the number of issues address during each meeting, the meeting agenda for each CAG meeting will consist of the following:

Meeting 1

- VBP Advisory Group Overview
- Role of VBP in Achieving Quality, Cost Effective Care
- I/DD Services in Transition
- System Platforms - High value care in a I/DD context

Meeting 2

- Review themes from first meeting
- Introducing new themes
- Exercise: Reflections on Value
- Special considerations for measuring quality
- Previewing Quality Measures

Meeting 3

- VBP Overview
- Group Exercise – Recap and Reflections
- I/DD VBP---the larger picture
  - Aligning with research and best practices
- Quality Measures
  - Aligning with prior OPWDD quality measure efforts
  - Discussion framework
  - Measure categorization
- The IDD-FIDA framework

Content Overview

Part I:

- Meeting 2 Review
  - VBP Overview
  - VBP Implementation Example
  - Advisory Group Objectives

Part II:

- Meeting 2 Exercise Review
  - Review of Key Domains and Findings

Part III:

- Aligning Research and Best Practices in I/DD
  - Brief review of literature/experiences in VBP to date

Part IV:

- Where do we start?
  - Aligning With Prior OPWDD Quality Measure Efforts
  - Reviewing some frameworks - Food for thought

Part I

A. Meeting 2 Review

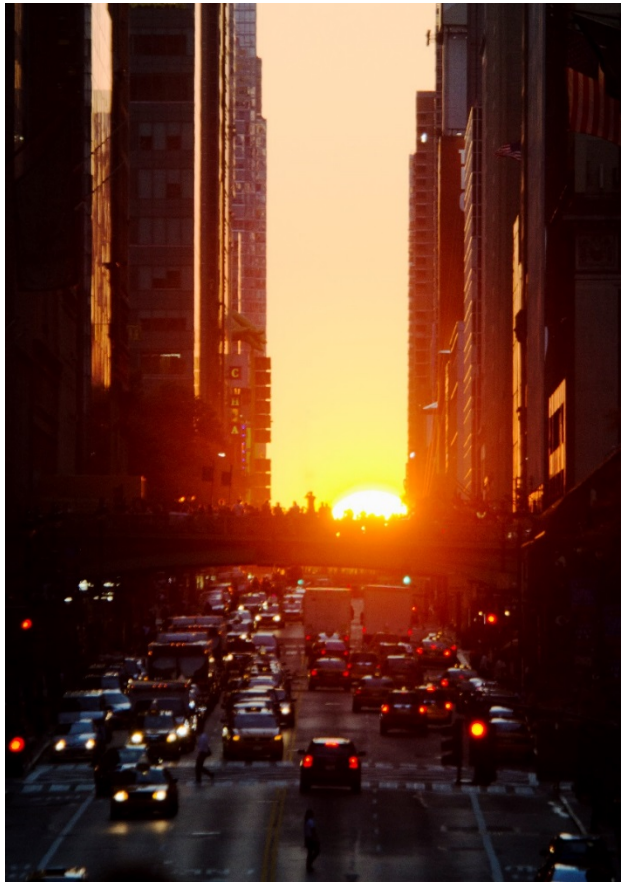
-VBP Overview

-VBP Implementation Example

-Advisory Group Objectives

Payment Reform: Moving Towards Value Based Payment

- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the Special Terms and Conditions of the waiver)
- The State and CMS have committed to the Roadmap
- Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap
- If Roadmap goals are not met, overall DSRIP dollars from CMS to NYS will be significantly reduced



How does VBP fit together?

Phase I – Drafting the Roadmap

July 2015 – CMS Approved Roadmap

Phase II – Stakeholder Engagement

August 2015-June 2016 – Sub-Committees and CAG Process

Phase III – Implementation and Beyond…

Recommendations feed back into:

- Roadmap updates
- Review by VBP Work Group
- Pilot activities

Sub-Committees

- Tech Design I
- Tech Design II
- Regulatory Impact
- Social Determinants of Health & Community Based Organizations
- Advocacy & Engagement

Clinical Advisory Groups

- Maternity
- Behavioral Health
- HIV/AIDS
- Chronic Conditions (Pulmonary, Heart and Diabetes)
- IPC
- MLTC
- I/DD

Updates can be found online:

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm

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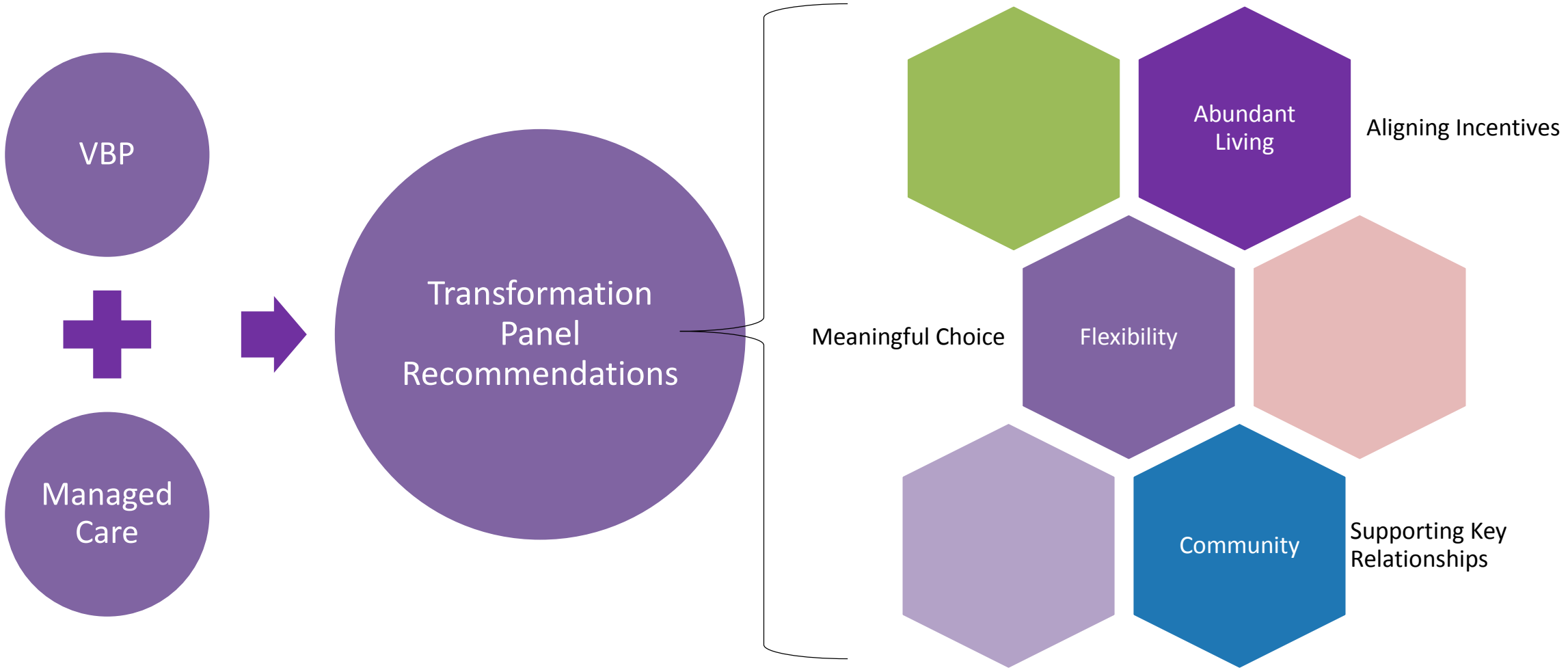
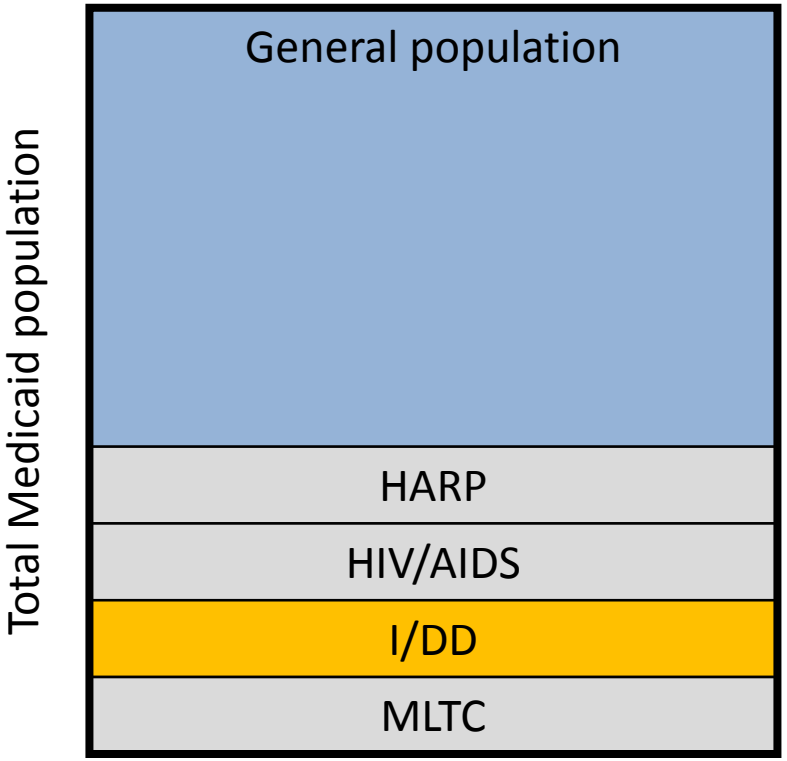
VBP & Transformation Agenda: Platforms for Change



Review: General Population and Subpopulations

- VBP arrangement for I/DD is a subpopulation total cost of care arrangement



- The total population is divided into the general population and four specific subpopulations
  1) HARP (Behavioral Health)
  2) HIV/AIDS
  3) I/DD
  4) MLTC

- Subpopulations are contracted for the total cost of care for their Medicaid members.

Review: MCOs and PPSs can choose different levels of Value Based Payments

In addition to choosing what integrated services to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

What does VBP look like in implementation?

- Example: HARP (also a subpopulation, total cost total population arrangement)

Pilot Year 1

1. Provider identifies
   - VBP Arrangement
   - Population
   - Level of VBP
   - Network
   - Payer

2. Provider submits data for attribution and target budget setting

3. Provider negotiates contracts with MCOs for VBP arrangement

4. Provider monitors progress on quality measures and budget

5. Provider is evaluated on quality and if applicable receive shared savings

Building Up the I/DD VBP Model

- But I/DD is not HARP, therefore the example is limited at this point
  - HARP is a managed care product

- We are not trying to put I/DD into the MRT model, rather build the I/DD VBP arrangement up
  - Only after we have envisioned what the system should look like, can we begin to delve into the logistics and implementation details

- Questions to frame our discussion:
  - How do we capture the value the system is already producing?
  - How do we build out quality measures to further improvement in the I/DD world?

- Which brings us back to our Advisory Group objectives…

I/DD VBP Advisory Group: Objectives

- Understand the State's vision for the Roadmap to Value Based Payment
- Review VBP arrangement for people with I/DD receiving services
- Make recommendations on:
  - Quality measures
  - Data and other support required for providers to be successful
  - Other implementation details related to VBP

- Definitions are standard, but financial arrangements between plans and providers around the bundles are not set by the State

Part II

A. Meeting 2 Exercise Review

-Review of Key Domains and Findings

Group Exercise Review

- Exercise
  - Advisory Group divided into four groups
  - Brainstormed and discussed:
    - "What is the value proposition?"
    - "How do we want to be measured?"
  - Wrote ideas on sticky notes → Ideas were grouped into thematic domains → Discussed preliminary findings
- Key Discussion Points:
  - Expanded the category of choice to include flexibility and self-determination
  - Reinforced importance of focusing on outcomes for the individual (rather than system-level)
- Results indicative of a holistic focus on personal goal attainment, community participation, meaningful activities, rewarding relationships, quality of life, and socially desirable endeavors such as employment
- **<u>See the "Word Cloud" for a thematic, schematic interpretation of results!</u>**

A Thematic, Schematic Interpretation of Results

The word cloud below is a visual presentation of qualitative data—words with greater prominence are words that appeared more frequently in the written submissions of the group exercise.

A More Traditional Summary of Key Quality Domains

After reviewing the Advisory Group ideas around capturing value, they were compiled into domains to ground the quality measure discussion. Quality measures will be selected specific to each domain.

Employment/Personal Goals/Meaningful day Activities

Life in Community

Social Roles

Life Goal Attainment/Satisfaction

Choice & Self-Determination/Flexibility

Safety & Health

Service Matching Need/Flexibility

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Part III

A. Aligning Research and Best Practices in I/DD

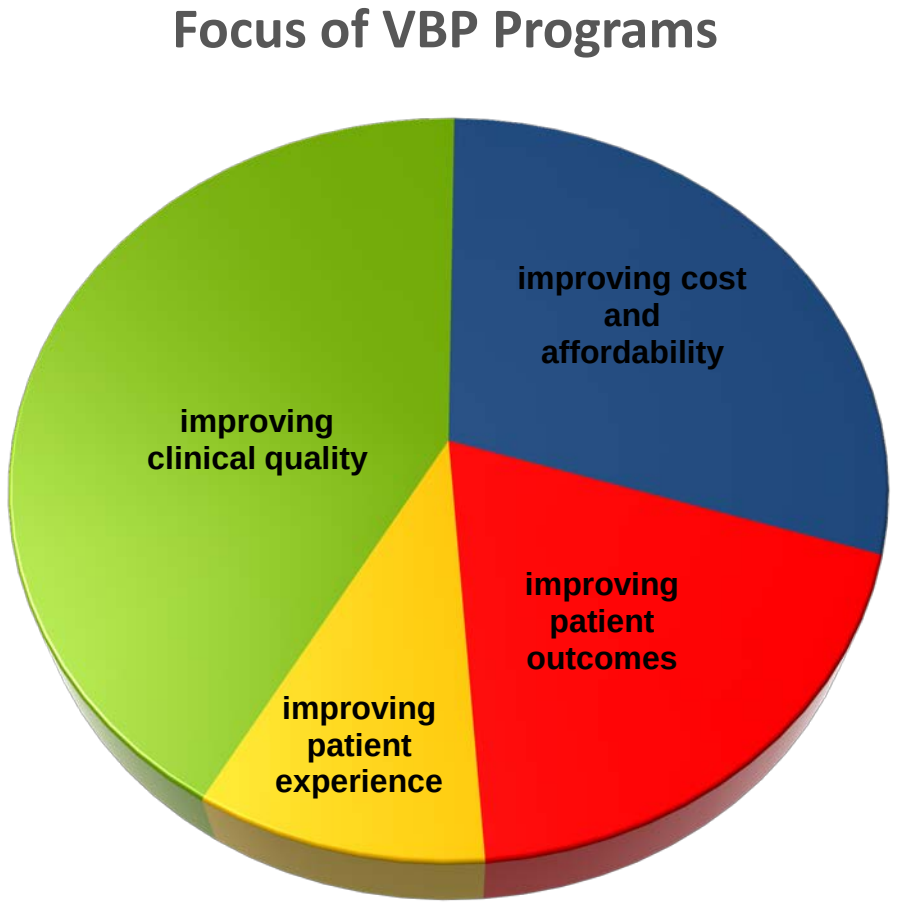
Brief review of literature/experiences in VBP to date

Important considerations for VBP measures

- Breadth of measures
  - Research shows 20 percent of care currently captured in VBP arrangements
- Maturity of measurement systems
- Capturing the value beyond acute care/reductions in inpatient care
- Claims and risk adjustment
- Threshold versus Counterfactuals
  - Pros & Cons
- Nimbleness, adjustment, and real-time actionable information
- Process versus Outcome
  - Process measures: Process measures assess steps that should be followed to provide good care.
  - Outcome measures: Outcome measures assess the results of healthcare that are experienced by patients. They include endpoints like well-being, ability to perform daily activities, etc.
- System needs versus person-centered services
- Room for improvement – lagging versus leading

VBP Quality Measures In Practice…

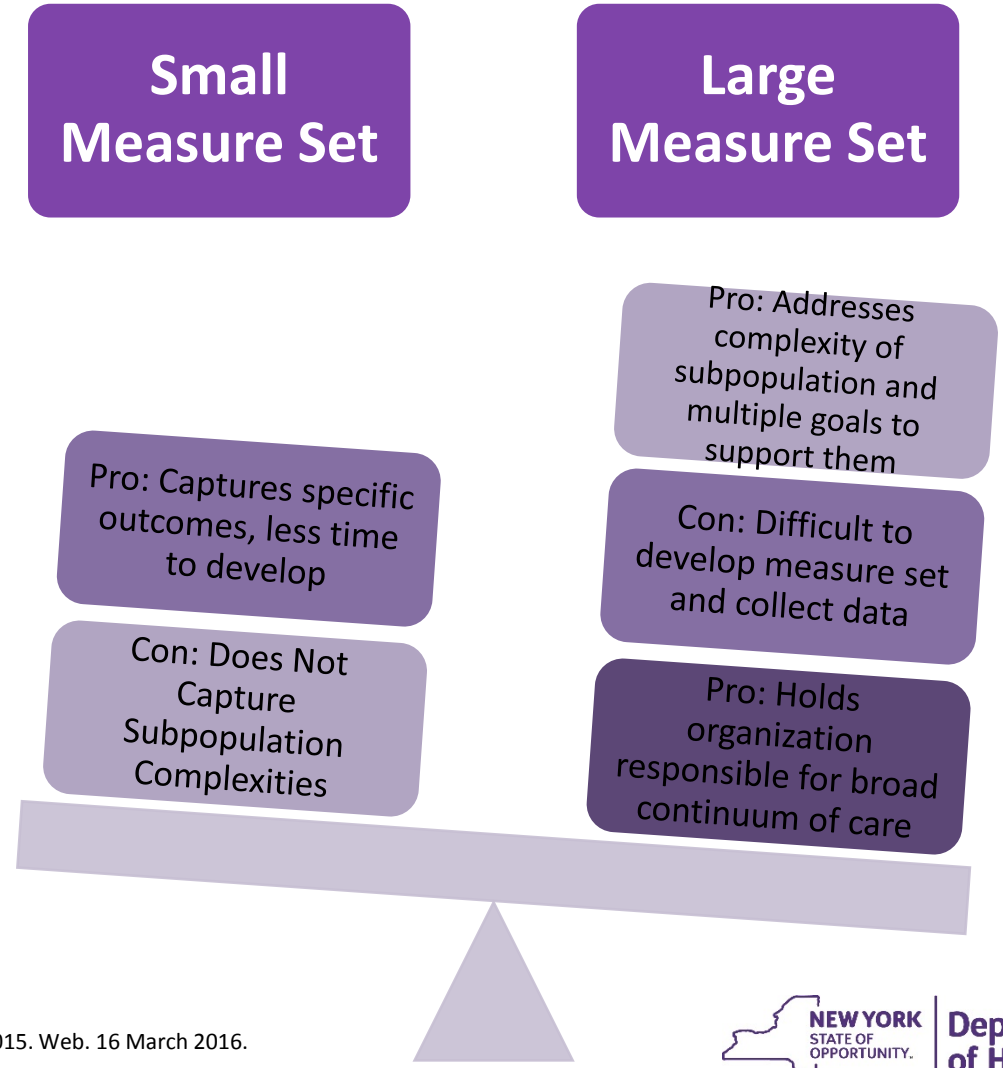
- Often they have narrow set of quality measures which may help specific outcomes… but can also lead to:
  - "Teaching to the test"
  - Limited data collection – >20% of all care delivered by providers is addressed by measures in VBP programs
    - An exception is "total cost of care" contracts
  - Topping out measures
  - Race to the top
- Important focuses:
  - Patient experience/Patient Focused
  - Care Coordination
  - Subpopulation specific definitions of health status and functional metrics



Sources:
- Damberg, Cheryl, Melony E. Sorbero, Susan L. Lovejoy, Grant Martsolf, Laura Raaen, and Daniel Mandel. *Measuring Success in Health Care Value-Based Purchasing Programs – Findings from an Environmental Scan, Literature Review and Expert Panel Discussion.* RAND. 2014. Web. 15 March 2016.
- Houston, Rob and Tricia McGinnis. *Accountable Care Organizations: Looking Back and Moving Forward.* Center for Healthcare Strategies, Inc., Jan. 2016. Web. 16 March 2016.
- Kodner, Dennis. *Value-Based Purchasing Health Care: Strategic Implications for Vulnerable Populations.* The ArthurWebbGroup, Jun. 2015. Web. 16 March 2016.

Special considerations, special populations

- Small Measure Set vs. Large Measure Set?
- I/DD TCTP is complex → likely need more measures to capture total care goals and comprehensive support system
- However, large measure sets are difficult due to:
  - Long lead time
  - Intensive resources and technical difficulties to develop, test and validate new measures
  - High burden and cost related to data collection

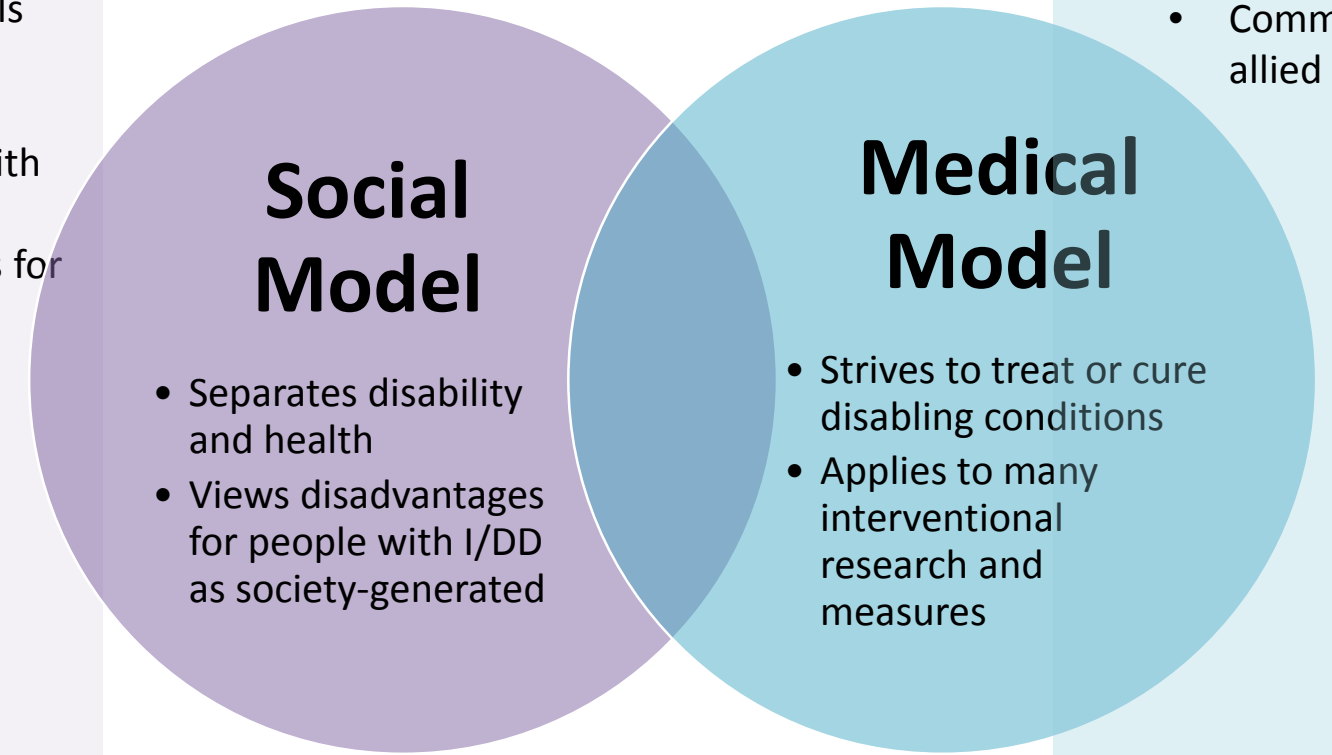


Source: Kodner, Dennis. *Value-Based Purchasing Health Care: Strategic Implications for Vulnerable Populations.* The ArthurWebbGroup, Jun. 2015. Web. 16 March 2016.

Toggling lenses, incorporating various perspectives

Social Perspective

- Commonly used by professionals who:
  1. study I/DD
  2. provide care to people with I/DD
  3. focus on support services for people with I/DD
- Acknowledges medical and rehabilitative efforts
- But emphasizes supporting and empowering people with I/DD to be full participants in community and their lives



Rehabilitation Perspective

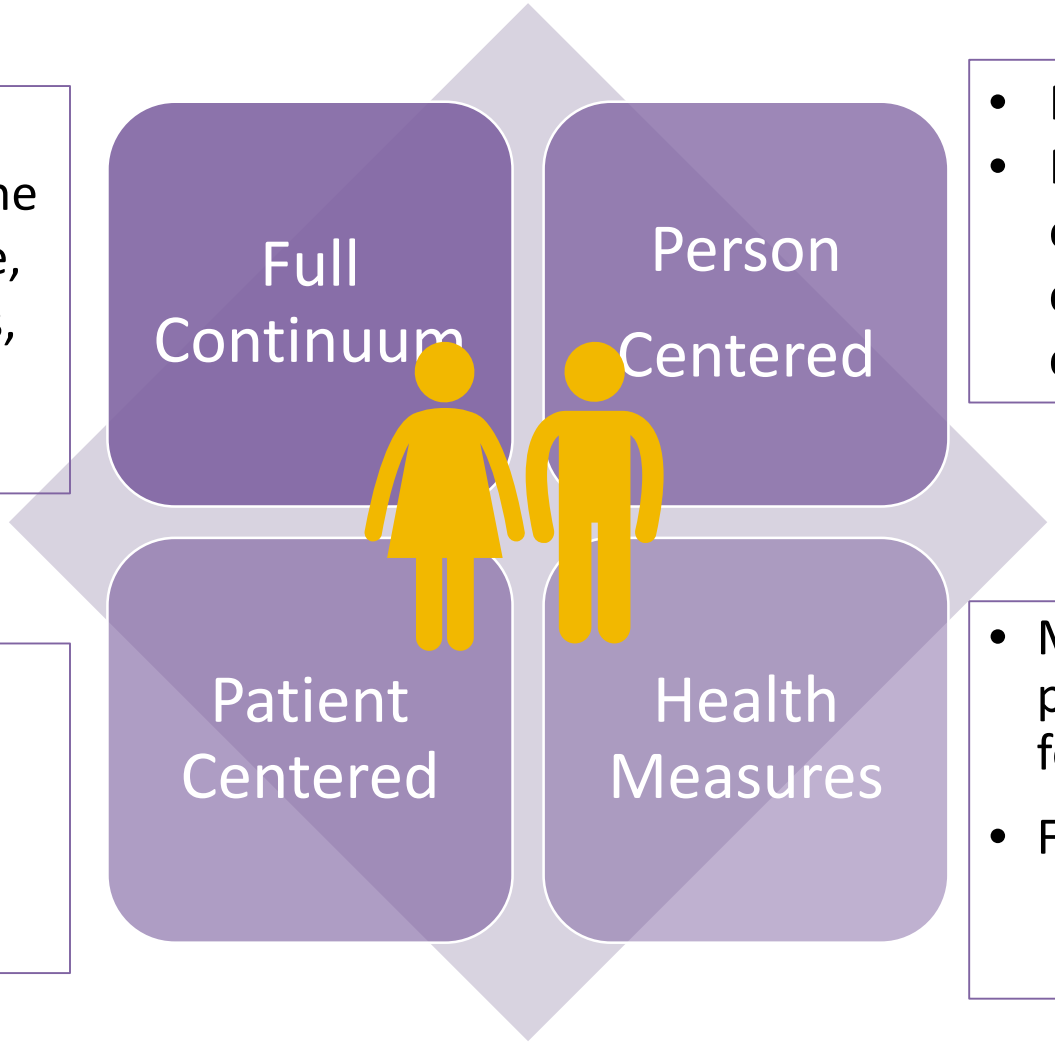
- Commonly used by medical and allied professional fields
  - Strives to maximize function and optimize potential opportunities for an individual to live life as desired

Source: Quality Improvement Measurement of Outcomes for People with Disabilities – Closing the Quality Gap: Revisiting the State of Science. The Agency for Healthcare Research and Quality (AHRQ), October 2012. Web. 16 March 2016.

Person Centered, Full Continuum of Care

- Inclusive of all supportive care relationships across the spectrum of primary, acute, long-term support services, and OPWDD specialty services

- Disease-oriented care
- Clinically focused decision making
- Medical model



- Non-disease oriented
- Focus on the whole-person to ensure comprehensive, continuous and coordinated care

- Measures that capture population-specific outcomes for physical health
- For example:
  - Preventive screenings
  - BMI

Source: Kodner, Dennis. *Value-Based Purchasing Health Care: Strategic Implications for Vulnerable Populations.* The ArthurWebbGroup, Jun. 2015. Web. 16 March 2016.

Examples from HARP and MLTC Subpopulations

- For other subpopulations discussions have broadened from medical and behavioral health measures to more holistic measurement of quality of life and the social determinants of health
- The pilot phase will be used to further refine and validate quality measures, especially for new measures

HARP Quality Measures

- Employment & economic stability
- Education
- Housing stability
- Interaction with the criminal justice system
- Social connectedness
- Satisfaction

MLTC Quality Measures

- Personal decisions about care prioritized
- Continuity & stability of care relationships
- Improvement in ability to self-support in community
- Participation in community & social supports
- Satisfaction

Part IV

A. Where do we start?

- Aligning With Prior OPWDD Quality Measure Efforts
- Reviewing some frameworks - Food for thought

VBP: Criteria for Selecting Quality Measures

I/DD RELEVANCE

- **Focused on key outcomes of integrated care process**
  - *Outcome measures are preferred over process measures*
  - *Outcomes of the total care process are preferred over outcomes of a single component of the care process*
    - *i.e. the quality of one type of professional's care*
- **For process measures: crucial evidence-based steps in integrated care process that may not be reflected in the person-centered outcome measures**
- **Existing variability in performance and/or possibility for improvement**

RELIABILITY AND VALIDITY

- **Measure is well established by reputable organizations and/or used on a large program scale**
  - *By focusing on established measures in existing programs (e.g., CMS ACO, FIDA-IDD, etc.) the validity and reliability of measures can be assumed to be acceptable.*
- **Outcome measures are adequately risk-adjusted**
  - *Measures without adequate risk adjustment make it impossible to compare outcomes between providers.*

VBP: Criteria for Selecting Quality Measures

FEASIBILITY

- **Claims-based measures are preferred over non-claims based measures (e.g., provider-reported, survey data)**
- **When provider reporting or surveys are required, existing sources must be available**
- **Preferably, data sources be person-level data**
  - *This allows drill-down to person level and/or adequate risk-adjustment.*
  - *When such a measure is deemed crucial, and the infrastructure exists to gather the data, these measures could be accepted.*
- **Data sources must be available without significant delay**
  - *Data sources should not have a lag longer than the claims-based measures (which have a lag of six months).*

KEY VALUES

- **I/DD transformation focus**
  - *Advisory Group Brainstormed Domains:*
    - *Physical Health & Safety*
    - *Behavioral Health*
    - *Personal Goals*
    - *Meaningful Day*
    - *Employment Activities*
    - *Life in the Community*
    - *Social Roles*
    - *Life Goal Attainment*
    - *Satisfaction*
    - *Choice and Self Determination*
    - *Service Matching Need*
    - *Flexibility*

Categorizing and Prioritizing Measures by Category (or 'Buckets')

CATEGORY 1
Approved quality measures that are felt to be both I/DD relevant, reliable and valid, and feasible.

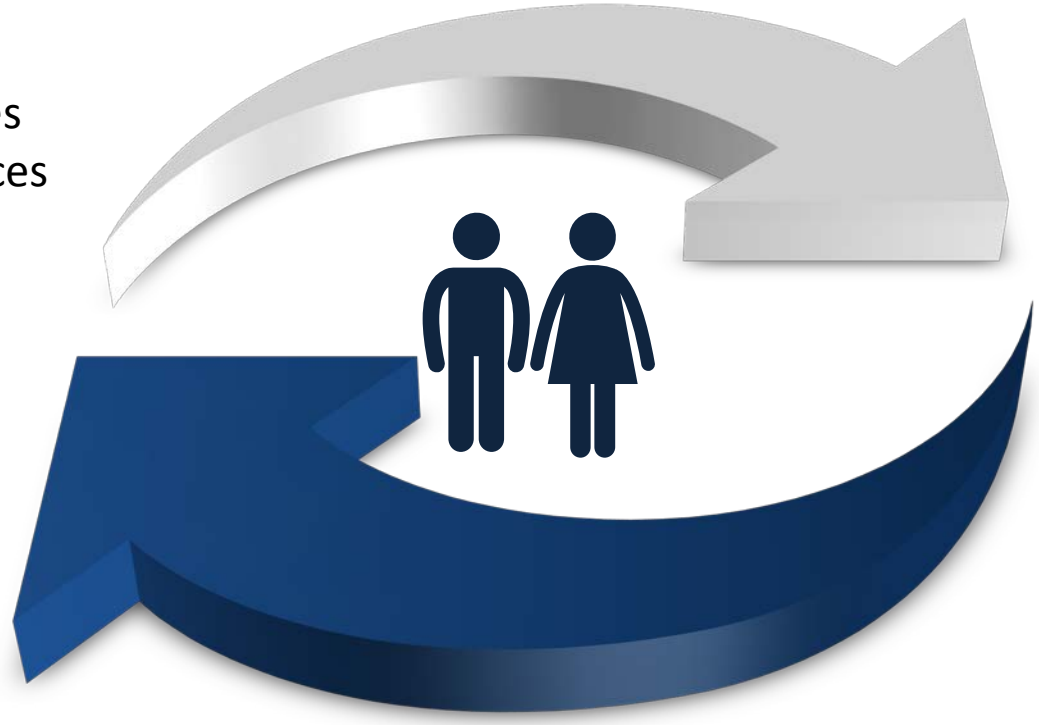
CATEGORY 2
Measures that are I/DD relevant, valid and probably reliable, but where the feasibility could be problematic. These measures should be investigated during the pilot phase.

CATEGORY 3
Measures that are insufficiently relevant, valid, reliable and/or feasible.

The I/DD FIDA Measurement Model – A Helpful Theoretical Framework

I/DD Measures

- OPWDD specialty services
- Long-term support services
- Care coordination
- Personal outcomes
- Community inclusion
- Quality of life



Medicare Measures

- Acute care – inpatient etc.
- Medication management
- Medicare ACO +

NYS Embarking on an Ambitious Medicaid-Medicare Alignment Project for I/DD Services in 2016 – FIDA-IDD

	NYS FIDA-IDD Demonstration
Objective	• To test new model to provide Medicare-Medicaid I/DD Enrollees in the NYS downstate region • NYC, Long Island, Rockland and Westchester
Stakeholders	• Partnership between NYS DOH, NYS OPWDD and CMS • CMS and NYS are contracting with Partners Health Plan
Enrollment	• Anticipated eligibility of 20,000 members; enrollment up to 5,000 • Voluntary • Start date for opt-in enrollment is no sooner than April 1, 2016
Care Coordination	• Person-centered, comprehensive array of services
Quality Measures	• CMS and NYS have established quality measures related to beneficiary's overall experience, care coordination and fostering and supporting community living

Demonstration Overview

- The FIDA-I/DD Demonstration seeks to improve care comprehension, coordination and access for ‘full benefit’ Medicare-Medicaid Enrollees who are 21+ and have intellectual/developmental disabilities.

- The demonstration emphasizes a holistic approach towards patient treatment, seeking to address physical, mental and social determinates of health by ensuring each participant has an adequate network of medical and supportive service (e.g. behavioral health, community-based LTSS, etc.).

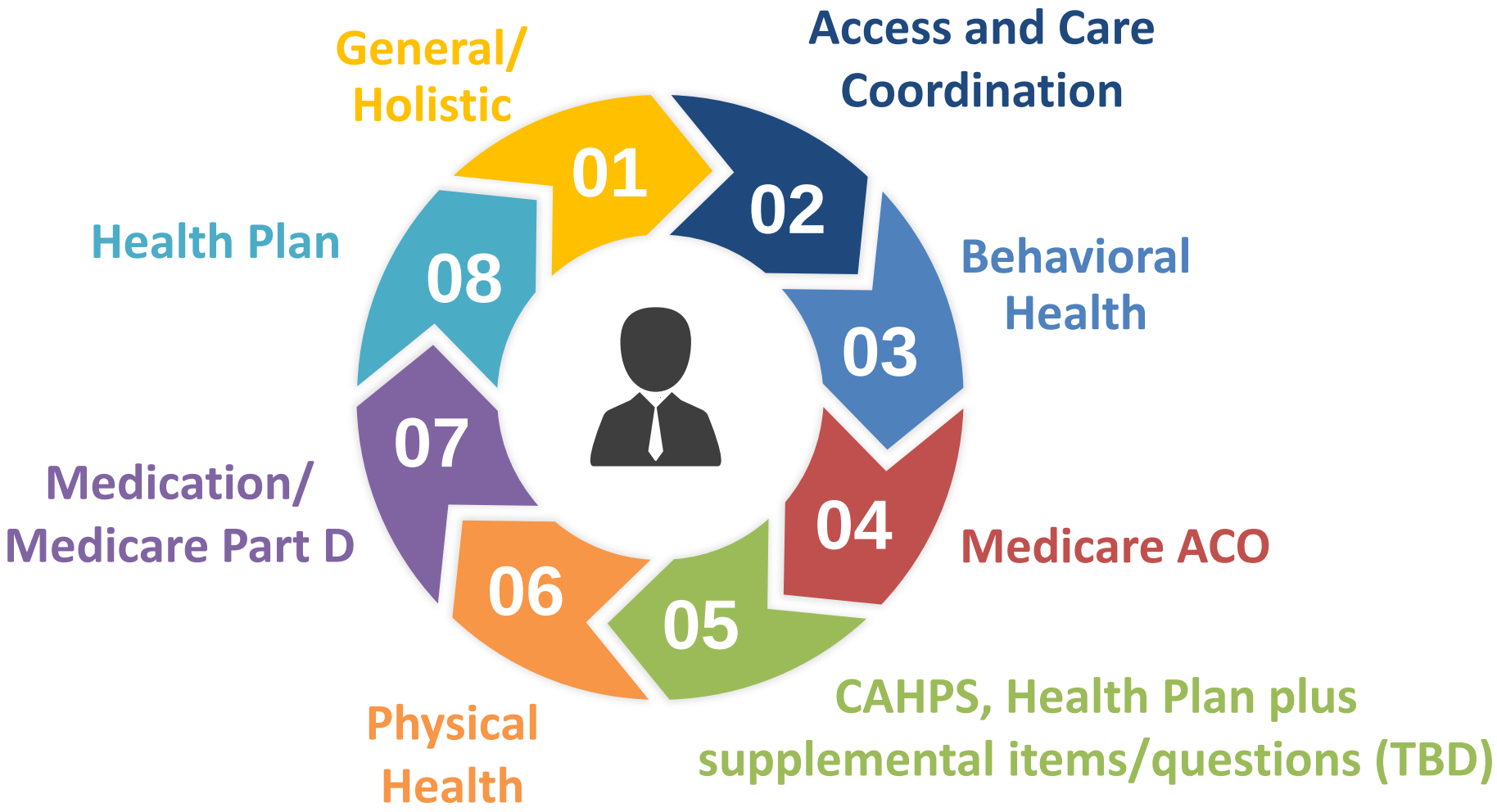
- Demonstration objectives are two-fold:
  - On the provision of services – increase service quality and reduce costs
  - On participant sovereignty – enabling participant to direct their own services, be involved in care planning and live independently in the community

Demonstration Overview (continued)

- The demonstration outlines commitment to significant payment reform to achieve financial align between Medicaid and Medicare.
  - Utilizes a blended (Medicaid-Medicare) capitated payment scheme
  - Will be paid prospectively to the contracted FIDA-I/DD Plan each month

- Participants are allotted extensive opportunities to determine the scope/direction of their care. Key initiatives include:
  - **Interdisciplinary Team (IDT)** – a team of professionals, selected by the participant to provide comprehensive, person-centered Care Management
  - **Care Manager** – participant-selected point of contact, responsible for the participant's care coordination and Care Management services
  - **Life Plan (LP)** – an individualized person-centered care and service plan that is collaboratively developed with the participant, their family and IDT to address the full continuum of care

FIDA I/DD Demonstration measures



FIDA I/DD Demonstration measures

- **General/Holistic**
  - Person-Centered Life Plans
  - Documentation of Care Goals
  - Monitoring Physical Activity
  - Self-Direction Participant-level Measure
  - Improvement / Stability in Activities of Daily Living (ADL) Functioning
  - Care for Older Adults – Functional Status Assessment
  - Care for Older Adults – Pain Screening

- **Access and Care Coordination**
  - Care Transition Record Transmitted to Health Care Professional
  - Real Time Hospital Admission Notifications
  - Risk stratification based on LTSS or other factors
  - Discharge follow –up
  - Long Term Care Overall Balance Measure
  - Nursing Facility Diversion Measure
  - Long Term Care Rebalancing Measure
  - Participants Referred to OPWDD Regional Office or Money Follows the Person (MFP) Program

- **Behavioral Health**
  - Antidepressant Medication Management
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - Follow-up After Hospitalization for Mental Illness
  - Improving or Maintaining Mental Health

- **Medicare ACO**
  - Getting Appointments and Care Quickly (ACO #1)
  - Access to Specialists (ACO #4)
  - Health Status/Function Status (ACO #7)
  - Plan All-Cause Readmissions (ACO #8)
  - Comprehensive Medication Review (ACO #12)
  - Reducing the Risk of Falling (ACO #13)
  - Influenza Immunization (ACO #14)
  - Screening for Clinical Depression and Follow-up Care (ACO #18)
  - Colorectal Cancer Screening (ACO # 19)
  - Breast Cancer Screening (ACO #20)
  - Controlling Blood Pressure (ACO #24)
  - Diabetes Care –Blood Sugar Controlled (ACO #27)
  - Part D Medication Adherence for Cholesterol (Statins) (ACO #32)

Underline = first time to review measure

FIDA I/DD Demonstration measures (cont.)

- **CAHPS, Health Plan plus supplemental items/questions (TBD):**
  - Getting Information about Prescription Drug Coverage and Cost
  - Getting Needed Prescription and Non-Prescription Drugs
  - Getting Needed Care
  - Overall Rating of Health Care Quality
  - Overall Rating of Plan
  - Customer Service
  - Getting Care Quickly
  - Being Examined on the Examination table
  - Help with Transportation

- **Physical Health**
  - Diabetes Care –Eye Exam
  - Diabetes Care –Kidney Disease Monitoring
  - Rheumatoid Arthritis Management

- **Medication/Medicare Part D**
  - Medication Reconciliation After Discharge from Inpatient Facility
  - Part D Call Center – Pharmacy Hold Time
  - Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability
  - Part D Appeals Auto–Forward
  - Part D Enrollment Timeliness
  - Part D Complaints about the Drug Plan
  - Part D Participant Access and Performance problems
  - Part D Participants choosing to leave the plan
  - Part D MPF Accuracy
  - Part D High Risk Medication
  - Part D Diabetes Treatment
  - Part D Medication Adherence for Oral Diabetes Medications
  - Part D Medication Adherence for Hypertension (ACEI or ARB)
  - Care for Older Adults – Medication Review

- **Health Plan**
  - Plan Makes Timely Decisions about Appeals
  - Part D Appeals Upheld
  - Non-Part D Appeals Upheld
  - Call Center - Foreign Language Interpreter and TTY/TDD availability
  - Percent of High Risk Residents with Pressure Ulcers (Long Stay)
  - Participant Governance Board
  - Assessments
  - Complaints about the Plan
  - Participant Access and Performance Problems
  - Participants Choosing to Leave the Plan

Underline = first time to review measure

Aligning with existing OPWDD efforts

- Extensive stakeholder engagements involving OPWDD Program staff, IT staff, Providers, and self-advocates
  - Compiled performance measures from all known sources (including FIDA, HEDIS, QARR, SAMM, MAP Part D, etc.)
  - Finalized measures for each Waiver Assurance that comply with CMS requirements for 2014 Waiver Renewal

- Our focus: Individual Level
  - Goal: Help individuals lead richer lives

OPWDD Quality Oversight Measures and Monitoring Mechanisms

- CAS/UAS Assessment
- Care Coordination Data Dictionary (CCDD)

- Site Visits and Surveys

- HCBS Waiver/CMS Reports
- Evaluation Plan
- Commissioner Dashboards

- MC Contract
- External Quality Review

OPWDD Waiver and Managed Care (MC) Oversight Measures – Under Development

Performance Area	Measure/Benchmark	
Waiver – Process Measures	• Administrative Oversight • Level of Care • Service Planning	• Qualified Provider • Health and Welfare • Financial Accountability

Waiver – Person Centered Measures	• Supportive Employment/Sheltered Workshops, Self Direction, Transition to Most Integrated Setting:
	  • **Number and % of Waiver Participants Who Receive Supported Employment and are Working in the Community**
	  • **Number and % of Waiver Participants Who Self-Direct Their Supports and Services with either Budget Authority, Budget Authority, or Both**
	  • **Number and % of Individuals in Sheltered Workshops who Transition to Integrated Community Based Employment**
	  • **Number and % of Individuals who Transition from More Restrictive to Less Restrictive Settings**
	• Health/Preventative Health Screenings, Physician Visits:
	  • Number and % of Male Waiver Participants who Have Received Colorectal Cancer Screening in Accordance with HEDIS
	  • Number and % of Female Waiver Participants who Have Received a Breast Cancer Screening in Accordance with HEDIS
	  • Number and % of Waiver Participants who Had a Primary Care Doctor Visit for Annual Physical in Last 12 Months
	• CQL POMS:
	  • % MC/Care Coordination Entity Implements CQL POMs as Component of the QI Plan in Accordance with the OWPDD Contract Requirements	

Measures in **bold** overlap with group exercise
Underline = first time to review measure

OPWDD Waiver and Managed Care (MC) Oversight Measures – Under Development

Performance Area	Measure/Benchmark

Satisfaction Survey Administered to Individuals Served by MC Entity (MC/Care Coordination Entity Oversight)	• Access:
	  • % Sampled Reported Receiving Information in Own Language
	• Satisfaction:
	  • Service Coordinator/Care Coordinator Provides Needed Help
	  • Service Coordinator/Care Coordinator is Responsive
	  • Service Coordinator/Care Coordinator is Respectful
	  • Person Likes/Is Satisfied with Service Providers
	• Rights:
	  • % of Managed Care Enrollees Sampled Informed of and Understand Their Grievance and Appeals Rights

Care Coordination Review (MC/Care Coordination Entity Oversight)	• Choice:
	  • **% Sampled Reported Having Choice of Service Providers in Managed Care Network for Each Waiver Service in Their Plan**
	  • **% Sampled Reporting Having Option to Change Lead Care Coordinator**
	• Rights:
	  • % of Managed Care Enrollees Sampled Informed of and Understand Their Grievance and Appeals Rights (Year 2)

Measures in **bold** overlap with group exercise
Underline = first time to review measure

OPWDD Waiver and Managed Care Oversight Measures – Under Development

Performance Area	Measure/Benchmark

CAS/CCDD (MC/Care Coordination Entity Oversight)	• Access:
	  • % of Managed Care Enrollees with Care Plans Developed within 20 Days of DISCO Enrollment
	• Preventative Health/Safety:
	  • % of Enrollees with Preventative Visits in Past Year (Physical, OB/GYN, Dental, Flu Vaccine)
	  • Managed Care Entity Implementation of CQL POMs
	• Timeliness to Be Served:
	  • <u>New Service Documented in ISP/EISP versus Timeframe to Receive Services (First Encounter)</u>

NCI (MC/Care Coordination Entity Oversight)	• Proportion of NCI Respondents Who:
	  • **Reported That They Choose or Help to Decide Their Daily Schedule**
	  • **<u>Choice or Had Some Input into Choosing Their Roommate If Not in Family Home</u>**
	  • **<u>Have an Integrated Job in the Community</u>**
	  • **<u>Do Not Have an Integrated Job in the Community, but Would Like One</u>**
	  • Reported on Adult Consumer Survey that Services and Supports Meet Their Needs
	  • **Reported Helping to Make their Service Plan**

Measures in **bold** overlap with group exercise
<u>Underline = first time to review measure</u>

CQL: Personal Outcome Measures®

- Initially introduced in 1993, the tool and the information gathered through the interview process has helped to pave a path to outcomes based decision making in human services.

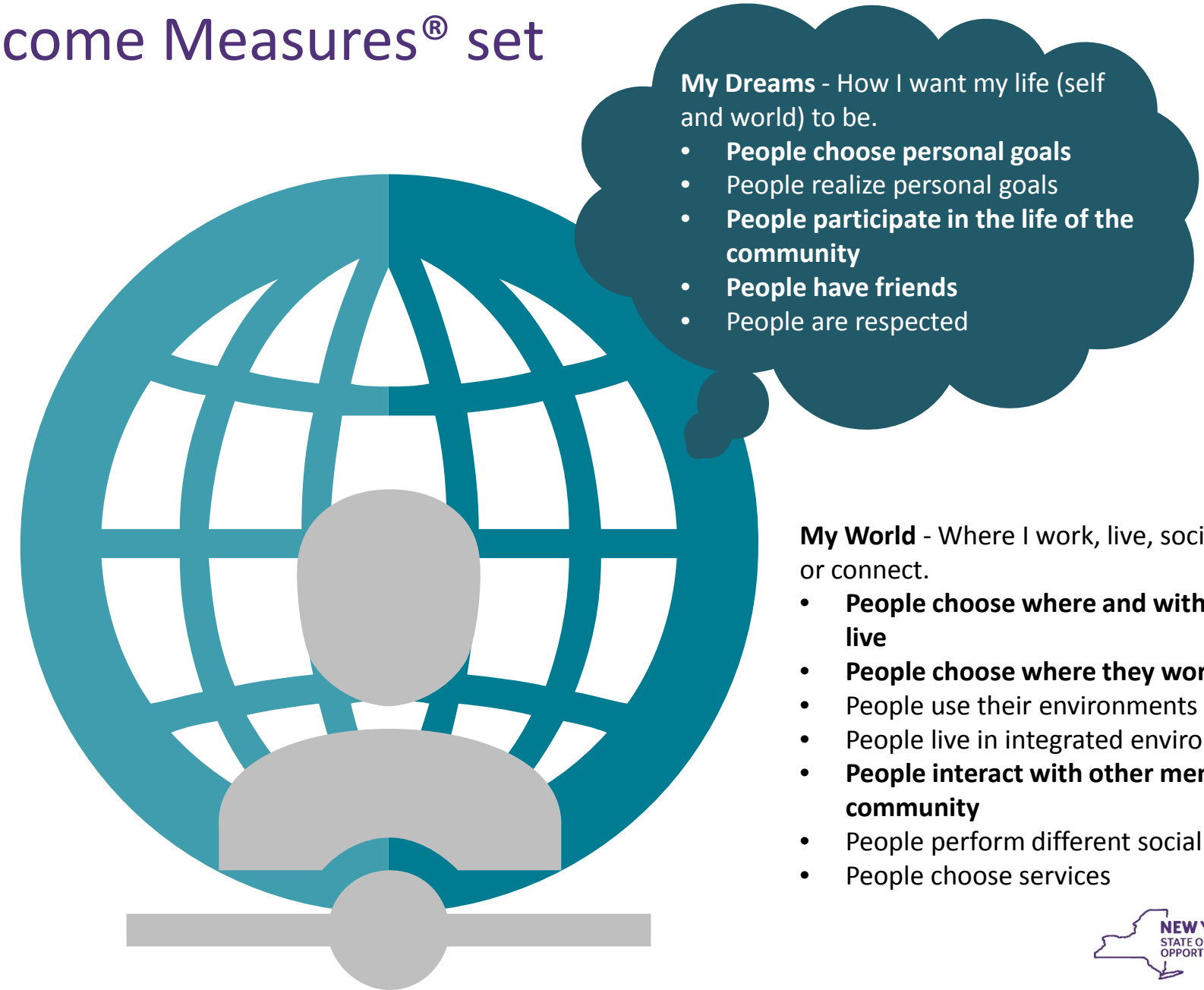
- What Sets CQL POMS® Apart:
  - The focus on the person
  - Service action is based on the person's criteria
  - Services and supports are designed for the person
  - Expectations for performance are defined by the person

- Instead of looking at the quality of how the services are being delivered, Personal Outcome Measures® look at whether the services and supports are having the desired results or outcomes that matter to the person.

Source: http://www.c-q-l.org/the-cql-difference/personal-outcome-measures

CQL: Personal Outcome Measures® set

- **My Self** - *Who I am as a result of my unique heredity, life experiences and decisions.* Person-Centered Life Plans
- People are connected to support networks
- People have intimate relationships
- People are safe
- People have the best possible health
- People exercise rights
- People are treated fairly
- People are free from abuse and neglect
- People experience continuity and security
- People decide when to share personal information



My Dreams - How I want my life (self and world) to be.

- **People choose personal goals**
- People realize personal goals
- **People participate in the life of the community**
- **People have friends**
- People are respected

My World - Where I work, live, socialize, belong or connect.

- **People choose where and with whom they live**
- **People choose where they work**
- People use their environments
- People live in integrated environments
- **People interact with other members of the community**
- People perform different social roles
- People choose services

Measures in **bold** overlap with group exercise

NEW YORK STATE OF OPPORTUNITY. Department of Health

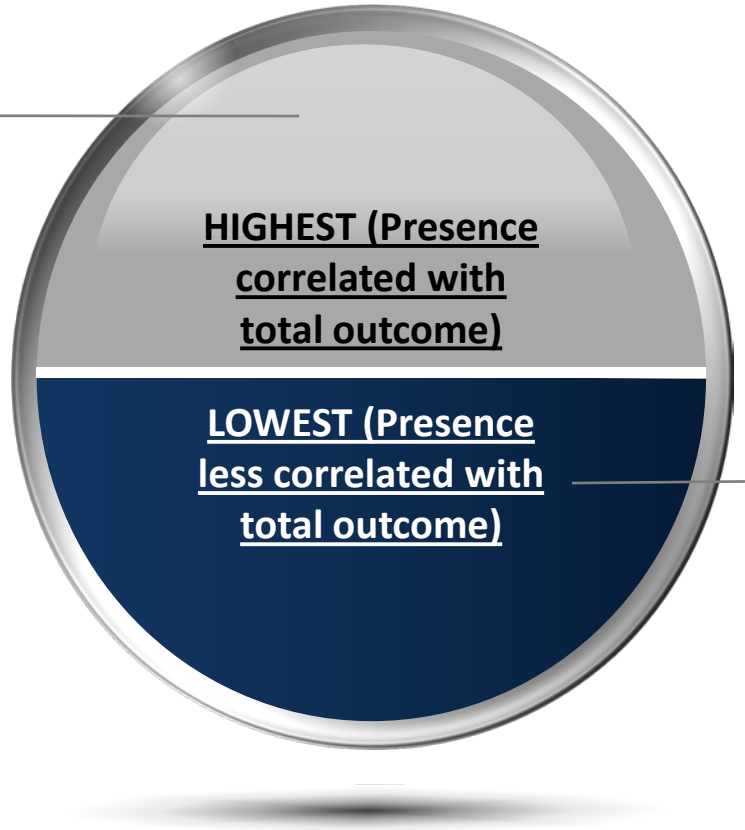
CQL Database: Presence of Outcome

Personal Outcome Measures® January 2010 (N=7,879)	
People are Safe	86.5%
People are Free From Abuse and Neglect	84.0%
People Realize Personal Goals	82.7%
People are Respected	78.7%
People Experience Continuity and Security	78.5%
People Decide When to Share Personal Information	78.2%
People Use Their Environments	76.7%
People have the Best Possible Health	74.4%
People Interact with Other Members of the Community	72.2%
People have Intimate Relationships	70.4%
People Participate in the Life of the Community	70.0%
People Remain Connected to Natural Support Networks	61.7%
People have Friends	56.3%
People are Treated Fairly	55.7%
People Choose Personal Goals	51.3%
People Choose Services	50.3%
People Exercise Rights	49.8%
People Choose Where and With Whom they Live	46.2%
People Choose Where they Work	40.6%
People Live in Integrated Environments	37.5%
People Perform Different Social Roles	32.5%

Source: CQL data compendium available at http://www.c-q-l.org/app/webroot/files/DOCUMENTS/DQ%20-%20Personal%20Outcome%20Measures%20National%20Database.pdf

CQL Analysis: Some Outcomes Correlate Better with Total Care

Exercise rights	.537
Choose where and with whom they live	.528
Treated fairly	.521
Choose where to work	.507
Interact with other members of the community	.500
Perform different social roles	.487



Decide when to share personal information	.332
Have the best possible health	.309
Free from abuse and neglect	.287
Experience continuity and security	.276
Are safe	.189

*Not a surprising result as these are reported with lower frequency and are typically harder to achieve

CQL: Life Plan and POMS® incorporation into FIDA I/DD demonstration

- **Life Plans (LP or Individual Service Plan (ISP)) –** are individualized person-centered care and service plans, collaboratively developed with the participant, his or her family/caregivers, and other IDT members to address the full continuum of covered and non-covered physical, behavioral, and long-term services and supports.

- **The Council on Quality and Leadership (CQL) Personal Outcome Measures (POMS®) will be used to monitor/reassess the effectiveness of a participant's LP** to determinate whether his or her goals are being met and valued outcomes achieved.

- An interview with the participant by a certified interviewer who is employed by the FIDA I/DD Plan will be completed for a State defined sample. The results of the POMS® interviews will inform individual planning and organizational quality improvement activity and will be provided to OPWDD for quality oversight data.

Source: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMOUIDD.pdf

Next steps to incorporate POMS® into FIDA I/DD demonstration

01 Identify plan to expand use of POMS® tool to I/DD providers

02 Identify measures within POMS to focus upon

03 Highlight issues & discrepancies for providers to focus on improvement

Medicare ACO Measure set

- **Patient/Caregiver Experience**
  - Getting Timely Care, Appointments, and Information (ACO #1)
  - How Well Your Doctors Communicate (ACO #2)
  - Patients' Rating of Doctor (ACO #3)
  - Access to Specialists (ACO #4)
  - Health Promotion and Education (ACO #5)
  - Shared Decision Making (ACO #6)
  - Health Status/Functional Status (ACO #7)

- **Care Coordination/Patient Safety**
  - Risk Standardized, All Condition Readmissions (ACO #8)
  - ASC Admissions: COPD or Asthma in Older Adults (ACO #9)
  - ASC Admission: Heart Failure (ACO #10)
  - Percent of PCPs who Qualified for EHR Incentive Payment (ACO #11)
  - Medication Reconciliation (ACO #12)
  - Falls: Screening for Fall Risk (ACO #13)

- **Preventive Health**
  - Influenza Immunization (ACO #14)
  - Pneumococcal Vaccination (ACO #15)
  - Adult Weight Screening and Follow-up (ACO #16)
  - Tobacco Use Assessment and Cessation Intervention (ACO #17)
  - Depression Screening (ACO #18)
  - Colorectal Cancer Screening (ACO #19)
  - Mammography Screening (ACO #20)
  - Proportion of Adults who had blood pressure screened in past 2 years (ACO #21)

Underline = first time to review measure

Medicare ACO Measure set (cont.)

- **At-Risk Population**
  - Diabetes (*make up Diabetes Composite)
    - Hemoglobin A1c Control (HbA1c) (<8 percent)* (ACO #22)
    - Low Density Lipoprotein (LDL) (<100 mg/dL)* (ACO #23)
    - Blood Pressure (BP) < 140/90* (ACO #24)
    - Tobacco Non Use* (ACO #25)
    - Aspirin Use* (ACO #26)
    - Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent) (ACO #27)
  - Hypertension
    - Percent of beneficiaries with hypertension whose BP < 140/90 (ACO #28)
  - IVD
    - Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl (ACO #29)
    - Percent of beneficiaries with IVD who use Aspirin or other antithrombotic (ACO #30)
  - Heart Failure
    - Beta-Blocker Therapy for LVSD (ACO #31)
  - CAD (composite)
    - Drug Therapy for Lowering LDL Cholesterol (ACO #32)
    - ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD (ACO #33)

Underline = first time to review measure

Areas of Additional Measurement

Measure	Description	Source
Antipsychotic Polypharmacy Monitoring of three or more agents	Percentage of individuals on three or more antipsychotics for longer than 90 days	EMedNY
Psychotropic polypharmacy Monitoring	Percentage of individuals receiving 4 or more psychotropic's for longer than 90 days	EMedNY

Underline = first time to review measure

I/DD VBP Advisory Group Meeting # 4

Meeting 4:

- Quality Measure Wrap-Up
- FIDA-IDD Demonstration Discussion

NEW YORK STATE | Department of Health | Medicaid Redesign Team

Appendix

Group Exercise

Defining Value for the Individual

Group Exercise – Quality Measure Domains

	Identified Domains	
	Want employment/Personal goals/Meaningful day/Activities	**Life in Community**
Identified Value	Increase employment opportunities.	Effectiveness – amount of time a person is engaged in community.
	Do I have a job?	Transition to less restrictive settings.
	Employment vocation.	Are you apart of your community (society)?
	Satisfying work.	Patterns of care.
	Am I satisfied with my job?	Time in community.
	Want employment.	Increased time in community integration (patterns of care).
		Friends not paid to be with them.
		It least restrictive desired
		Am I feeling included in a community of my choosing?
		Friends – true relationships.
		Friendships/ employment/ community investment.
		Do you have friends? Do you want friends?

Group Exercise – Quality Measure Domains

	Identified Domains	
	Social Roles	**Life Goal Attainment/Satisfaction**
Identified Value	3rd level facility, social network & connect.	Person satisfaction: - Likes day/employment - Where they live - Social life - Happy with staff
	Participation & activities with non-paid staff.	Self-image & confidence.
	Have relationships with and outside of paid staff.	What makes you happy?
	Do I have friends?	It is about well-being outcomes for an individual: - Positive emotion - Engagement - (Positive) relationships - Meaning - Accomplishments
	4th level social role development, employment, volunteer-associated life.	Life goal attainment.
	People should be happy: - Treated with respect - Job is volunteer experience	Achievement of personal goals.
		Customer satisfaction.
		Happiness/well-being.
		Satisfaction (via CAHPS from NCQA).
		Constantly stretching & re-evaluating with circle on the goals & desired outcomes & learning what's possible.

Group Exercise – Quality Measure Domains

	Identified Domains	
	Choice & Self-Determination/Flexibility	**Safety & Health**
Identified Value	Care in a least restrictive environment (LRE).	Workforce performance measures/stability.
	Live where they choose.	Well-trained workforce.
	Voice choice.	Have you received all/most recommended preventive health services or screenings?
	Informed decision-making.	Have you, through the care coordination & services received, ben able to avoid a preventable hospitalization or visit to the E.R.?
	Connected to job of choice & satisfaction.	Happy, comfortable & safe people.
	Skills acquired that person elects.	Use of IOM quality measure – safe, timely, effectiveness, efficiencies, equitable, patient-centered.
	Provider creativity.	HEDIS.
	Can I do what I want to do in my life?	1st level foundational supports – housing, safety nutrition.
	2nd level degree to which we act in partnership with the person.	Reduction in unnecessary hospitalizations.
	Self-determination.	Have a healthy life.
	People should be provided with experiences they enjoy.	Stability of care.
	Does staff listen to me?	People should be healthy; receive coordinated health.
	People should have (informed) choice/community choice involvement.	Health – avoidance of over-treatment.
	Am I living where I want to?	
	Does staff listen to me?	
	Peoples' rights are honored.	
	Live in place of choice either alone or with others.	
	Real choice People should have individual rights.	

Group Exercise – Quality Measure Domains

	Identified Domain
	Service Matching Need/Flexibility
Identified Value	Assessment of needs – measure of: - Complexity - Behavioral Health
	Most complex & challenged persons have as much opportunity as others.
	Acuity of need complexity with need.
	Equity.
	(Reporting) How many providers are meeting quality metrics?
	(Reporting) In Year 2019-2020, how many providers receive an upside shared savings? What is the amount of shared savings?

FIDA-IDD Demonstration Measure Set

FIDA I/DD Demonstration measure set

Topic	Measure Name	Measure Description	Measure Steward
General/Holistic	Person-Centered Life Plans	Percent of Participants with care plans within 30 days of initial assessment.	CMS/State defined process measure
	Documentation of Care Goals	Percent of Participants with documented discussions of care goals.	CMS/State defined process measure
	Monitoring Physical Activity	Percent of senior Participants who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS/HOS
	Self-Direction Participant-level Measure	Percent of Participants, advocates and/or their legal guardians directing their own services through self-direction or the consumer-directed personal assistance option at the plan each Demonstration Year.	State-specified measure
	Improvement / Stability in Activities of Daily Living (ADL) Functioning	Participants in the FIDA-IDD Demonstration who remained stable or improved in ADL functioning between previous assessment and most recent assessment.	State-specified measure
	Care for Older Adults – Functional Status Assessment	Percent of Participants whose doctor has done a —functional status assessment to see how well they are doing —activities of daily living (such as dressing, eating, and bathing).	NCQA/ HEDIS
	Care for Older Adults – Pain Screening	Percent of Participants who had a pain screening or pain management plan at least once during the year.	NCQA/ HEDIS
Access and Care Coordination	Care Transition Record Transmitted to Health Care Professional	Percentage of Participants, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI
	Real Time Hospital Admission Notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure
	Risk stratification based on LTSS or other factors	Percent of risk stratifications using behavioral health (BH)/LTSS Data/indicators.	CMS/State defined process measure
	Discharge follow -up	Percent of Participants with specified timeframe between discharge to first follow-up visit.	CMS/State defined process measure

FIDA I/DD Demonstration measure set

Topic	Measure Name	Measure Description	Measure Steward
Access and Care Coordination	Long Term Care Overall Balance Measure	Reporting of the percent of Participants who did not reside in a nursing facility for a long stay at the time of enrollment and did not reside in a nursing facility for a long stay during the reporting period.	State-specified measure
	Nursing Facility Diversion Measure	Reporting of the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the NF during the previous year.	CMS
	Long Term Care Rebalancing Measure	Reporting of the number of Participants who were discharged to a community setting from a NF and who did not return to the NF during the current measurement year as a proportion of the number of Participants who resided in a NF during the previous year. Monthly Long Term Care Rebalancing Rate: Numerator: of those Participants in the denominator, those who were discharged to a community setting from a NF and did not return to the NF during the current measurement year. Denominator: Participants enrolled in a plan eleven out of twelve months during the current measurement year who resided in a NF for 100 continuous days or more during the previous year and were eligible for Medicaid during the previous year for eleven out of twelve months. Exclusions: Any Participant with a gap in enrollment of Medicaid eligibility of 30 days during the current measurement year.	State-specified measure
	Participants Referred to OPWDD Regional Office or Money Follows the Person (MFP) Program	Percent of Participants in the FIDA-IDD Demonstration who reside in a nursing facility, wish to return to the community, and were referred to OPWDD Regional Office or the MFP Program.	State-specified measure

FIDA I/DD Demonstration measure set

Topic	Measure Name	Measure Description	Measure Steward
Behavioral Health	Antidepressant Medication Management	Percentage of Participants 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult Participants with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of Participants 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 Participants who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	NCQA/HEDIS
	Follow-up After Hospitalization for Mental Illness	Percentage of discharges for Participants 6 years of age and older who were hospitalized for treatment of selected mental healthdisorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS
	Improving or Maintaining Mental Health	Percent of all Participants whose mental health was the same or better than expected after two years.	CMS HOS
Medicare ACO	CAHPS, Health Plan plus supplemental items/questions (TBD): Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly Participants can get appointments and care. A. In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? B. In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? C. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	AHRQ/CAHPS
	Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists	AHRQ/CAHPS

FIDA I/DD Demonstration measure set

Topic	Measure Name	Measure Description	Measure Steward
Medicare ACO	Health Status/Function Status	Percent of Participants who report their health as excellent.	AHRQ/CAHPS
	Plan All-Cause Readmissions	Percent of Participants discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/ HEDIS
	Comprehensive Medication Review	Percentage of Participants who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA) Part D Reporting Data
	Reducing the Risk of Falling	Percent of Participants with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS
	Influenza Immunization (Annual Flu Vaccine)	Percent of Participants who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data
	Screening for Clinical Depression and Follow-up Care	Percentage of Participants ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS
	Colorectal Cancer Screening	Percent of Participants aged 50-75 who had appropriate screening for colon cancer.	NCQA/ HEDIS
	Breast Cancer Screening	Percent of female Participants aged 40-69 who had a mammogram during the past 2 years.	NCQA/ HEDIS
	Controlling Blood Pressure	Percentage of Participants 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/ HEDIS
	Diabetes Care –Blood Sugar Controlled	Percent of Participants with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	NCQA/ HEDIS
	Part D Medication Adherence for Cholesterol (Statins)	Percent of Participants with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data

FIDA I/DD Demonstration measure set

Topic	Measure Name	Measure Description	Measure Steward
CAHPS, Health Plan plus supplemental items/questions (TBD)	Getting Information about Prescription Drug Coverage and Cost	The percent of the best possible score that the plan earned on how easy it is for Participants to get information from their plan about prescription drug coverage and cost. A. 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? B. In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs? C. In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered? D. 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? Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?	AHRQ/CAHPS
	Getting Needed Prescription and Non-Prescription Drugs	The percent of best possible score that the plan earned on how easy it is for Participants to get the prescription drugs and non-prescription drugs they need using the plan. A. In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed? B. In the last six months, how often was it easy to use your health plan to fill a prescription or obtain a non-prescription drug at a local pharmacy?	AHRQ/CAHPS
	Getting Needed Care	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists. A. In the last 6 months, how often was it easy to get appointments with specialists? B. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan? C. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?	AHRQ/CAHPS

FIDA I/DD Demonstration measure set

Topic	Measure Name	Measure Description	Measure Steward
CAHPS, Health Plan plus supplemental items/questions (TBD)	Overall Rating of Health Care Quality	Percent of best possible score the plan earned from Participants who rated the overall health care received. A. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	AHRQ/CAHPS
	Overall Rating of Plan	Percent of best possible score the plan earned from Participants who rated the overall plan. A. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health plan?	AHRQ/CAHPS
	Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. A. In the last 6 months, how often did your health plan's customer service give you the information or help you needed? B. In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? C. In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS
	Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS
	Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS
	Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS
Physical Health	Diabetes Care –Eye Exam	Percent of Participants with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/ HEDIS
	Diabetes Care –Kidney Disease Monitoring	Percent of Participants with diabetes who had a kidney function test during the year.	NCQA/ HEDIS
	Rheumatoid Arthritis Management	Percent of Participants with Rheumatoid Arthritis who got one or more prescription(s) for an anti rheumatic drug.	NCQA/ HEDIS

FIDA I/DD Demonstration measure set

Topic	Measure Name	Measure Description	Measure Steward
Medication/Medicare Part D	Medication Reconciliation After Discharge from Inpatient Facility	Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	NCQA/HEDIS
	Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the plan's pharmacy help desk	CMS/Call Center data
	Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were Available when needed by Participants who called the plan's customer service phone number.	CMS/Call Center data
	Part D Appeals Auto–Forward	How often the plan did not meet Medicare's deadlines for timely appeals decisions. This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto forwarded to the IRE) / (Average Medicare Part D enrollment)] *10,000.	IRE
	Part D Enrollment Timeliness	The percentage of enrollment requests that the plan transmits to the Medicare program within 7 calendar days of receipt of a completed enrollment request.	Medicare Advantage Prescription Drug System (MARx)
	Part D Complaints about the Drug Plan	How many complaints Medicare received about the drug plan. For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 /(Number of Days in Period).	CMS/CTM data
	Part D Participant Access and Performance problems	To check on whether Participants 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 Participants directly. A higher score is better, as it means Medicare found fewer problems.	CMS/Administrative data
	Part D Participants choosing to leave the plan	The percent of Participants who chose to leave the plan in 2013.	CMS/Medicare Participant Database Suite of Systems

FIDA I/DD Demonstration measure set

Topic	Measure Name	Measure Description	Measure Steward
Medication/Medicare Part D	Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan.
	Part D High Risk Medication	The percent of the Participants who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data
	Part D Diabetes Treatment	Percentage of Medicare Part D Participants who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS PDE data
	Part D Medication Adherence for Oral Diabetes Medications	Percent of Participants with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data
	Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of Participants with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS PDE data
	Care for Older Adults – Medication Review	Percent of Participants whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and nonprescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	CMS/State defined process measure

FIDA I/DD Demonstration measure set

Topic	Measure Name	Measure Description	Measure Steward
Health Plan	Plan Makes Timely Decisions about Appeals	Percent of Participants who got a timely (per timelines in section IX) response when they made a written appeal to the plan about a decision to refuse payment or coverage.	FIDA-IDD Administrative Hearing Unit
	Part D Appeals Upheld	How often an independent reviewer agrees with the plan's decision to deny or say no to a Participant's Part D appeal. This measure is defined as the percent of IRE confirmations of upholding the plans' Part D decisions. This is calculated as: [(Number of Part D cases upheld) / (Total number of Part D cases reviewed)] * 100.	IRE
	Non-Part D Appeals Upheld	How often an Integrated Administrative Hearing Officer agrees with the plan's non-Part D decision to deny or say no to a Participant's non-Part D appeal. This measure is defined as the percent of FIDA Administrative Hearing Unit confirmations of upholding the plans' decisions. This is calculated as: [(Number of non-Part D cases upheld) / (Total number of non-Part D reviewed)] * 100.	FIDA Administrative Hearing Unit
	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 Participants who called the plan's customer service phone number.	CMS Call Center Data
	Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed
	Participant Governance Board	Establishment of Participant advisory board or inclusion of Participants on governance board consistent with contract requirements.	CMS/State defined process measure
	Assessments	Percent of Participants with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure

FIDA I/DD Demonstration measure set

Topic	Measure Name	Measure Description	Measure Steward
Health Plan	Complaints about the Plan	How many complaints Medicare received about the health plan. Rate of complaints about the plan per 1,000 Participants. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30/ (Number of Days in Period).	CMS CTM data
	Participant 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 Participants directly. A higher score is better, as it means Medicare found fewer problems.	CMS Participant database
	Participants Choosing to Leave the Plan	The percent of Participants who chose to leave the plan in 2014.	CMS