

**MFES Measure Table (By Demonstration Year)**

Model Core Measures	Year 1	Year 2	Year 3
All Cause Hospital Readmission (Plan All Cause Readmission NQF #1768) <i>Claim-based Measure</i>	Reporting	Benchmark	Benchmark
Ambulatory Care-Sensitive Condition Hospital Admission (PQI Composite #90) <i>Claim-based Measure</i>	Reporting	Benchmark	Benchmark
ED Visits for Ambulatory Care-Sensitive Conditions (Rosenthal) <i>Claim-based Measure</i>	Reporting	Benchmark	Benchmark
Follow-Up after Hospitalization for Mental Illness (NQF #0576) <i>Claim-based Measure</i>	Reporting	Benchmark	Benchmark
Depression screening and follow-up care (#0418) <i>Partially Claim-based Measure</i>		Reporting	Benchmark
Care transition record transmitted to health care professional (NQF #648) <i>Partially Claim-based Measure</i>		Reporting	Reporting
Screening for fall risk (NQF #0101) <i>Partially Claim-based Measure</i>			Reporting
Initiation and engagement of alcohol and other drug dependent treatment: (a) initiation, (b) engagement (NQF #0004) <i>Partially Claim-based Measure</i>			Reporting
<b>State-Specific Process Measures: State must select the Care Plan and Training Process Measures, and select at least one other process measure</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
Care Plan Measure: To be proposed by State (Required)	Reporting	Benchmark	Benchmark
Training Measure: To be proposed by State (Required)	Reporting	Benchmark	Benchmark

**Comment [A30]:** Flag for revision. To be completed after feedback from the state and discussion with CMS.  
Schedule focused call on this topic, once state has thought about measures.

**Comment [A31]:** Flag for updating

Discharge Follow-up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit	Reporting	Reporting or Benchmark	Benchmark
Real Time Hospital Admission Notifications: Percentage of hospital admission notifications occurring within specified timeframe	Reporting	Reporting or Benchmark	Benchmark
Percentage of providers with an agreement to receive data from beneficiaries' Medicare Part D Plans	Reporting	Reporting or Benchmark	Benchmark
State-Specific Demonstration Measures - State must select at least 3, but no more than 5	Year 1	Year 2	Year 3
State-Specific Demonstration measures - Must include at least one LTSS and/or community integration measure	Reporting	Benchmark	Benchmark

Comment [A32]: Flag for updating

*\*CMS will adapt base measures to incorporate a denominator relative to the Demonstration specific populations at a State level.*

**Timing:**

For the purposes of quality measurement under the Demonstration:

- Complete reporting means that all parts/elements of the measure must be reported in order for it to be considered “complete.” Even if the answers are ‘no’ a certain action was not done or if clinical values are unfavorable, full credit would be given because all parts of the measure were reported completely.
- Accurate reporting means that all parts of the measure are reported truthfully. All quality measures reported should accurately reflect medical record data, non-medical data and other information contained in the source data systems. Even if reported values are unfavorable, credit is given because the measure was reported accurately.

**Demonstration Year 1** - In the first year of the Demonstration, the State, working with a CMS contractor, will be required to use Medicare data to completely and accurately report core measures.

Demonstration Core Measures (Year 1):

- Plan all cause hospital readmission - (Plan All Cause Readmission NQF #1768)
- Ambulatory care-sensitive condition hospital admission - (PQI Composite #90)
- Number of emergency department visits for ambulatory sensitive conditions - (Rosenthal)
- Follow-up after hospitalization for mental illness - (NQF #0576)

State-specific Process Measures: Also, beginning in Year 1, State performance on process measures will be tracked for the life of the Demonstration. There will be two mandatory process measures:

- Care Plans: Measure proposed by State
- Training: Measure proposed by State

The State also must select at least one of the following process measures:

- Discharge Follow-up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit
- Real Time Hospital Admission Notifications: Percentage of hospital admission notifications occurring within specified timeframe

State-Specific Demonstration Measures: The State will select, and CMS will approve, between three and five State-specific Demonstration measures. These measures must be tailored to the State's target population and overall Demonstration. The State must select at least one measure that will address community integration and/or long-term care rebalancing. The State will determine, subject to CMS approval, the specifications for these measures. CMS will determine the benchmarks for these measures.

**Demonstration Year 2** - In Year 2, CMS and the State will transition from reporting to measurement for the year 1 core measures; transition from reporting to measurement for process measures; and add core measures for reporting listed below.

New Demonstration Core Measures: CMS will work with Connecticut to begin preparations for reporting these measures in year 1 to assure complete and accurate reporting as these measures require information from sources beyond the claims record:

- Depression screening and follow-up care - (NQF #0418)
- Care transition record transmitted to health care professional - (NQF #648)

Reporting and measurement for the State-specific Process Measures and State-specific Demonstration Measures will continue.

**Demonstration Year 3** - In Year 3, CMS and the State will continue the transition from reporting to measurement for the core measures; continue measurement for process measures; and add core measures for reporting listed below.

New Demonstration Core Measures: CMS will work with Connecticut to begin preparations for reporting these measures in Years 1 and 2 to assure complete and accurate reporting as these measures require information from sources beyond the claims record:

- Screening for fall risk - (NQF #0101)
- Initiation and engagement of alcohol and other drug dependent treatment:  
(a) initiation, (b) engagement - (NQF #0004)

Reporting and measurement for the State-specific Process Measures and State-specific Demonstration Measures will continue.

Other Related Activities: In addition to the quality measures noted above and the activities noted in Appendix 7, Section 4, CMS and the State will undertake the following activities to collect and evaluate the experience of beneficiaries in this Demonstration:

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS):** In order to assess beneficiary experience, the State will work with CMS and its contractors to implement beneficiary and caregiver surveys (including the CAHPS survey).
- **Medicaid Statistical Information System (MSIS) Data:** The State will submit both historical MSIS data and continue to submit all ongoing MSIS data in a timely manner.
- **Connecticut has received Medicare data from CMS and has contracted with JEN Associates to produce a data profile of Medicare-Medicaid enrollees' service utilization and diagnostic/demographic features through an initial data integration process. The State intends to continue to contract with JEN to perform data integration services in support of the HNs**

**4. Connecticut Health Neighborhood Requirements:** This section describes Connecticut's requirements for the HNs that the State will procure to participate in this Demonstration. The State's requirements will include but are not limited to: