MEASURE APPLICATIONS PARTNERSHIP

Measuring Healthcare Quality for the Dual Eligible Beneficiary Population

FINAL REPORT TO HHS

JUNE 2012

NATIONAL QUALITY FORUM

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EXECUTIVE SUMMARY

There are nine million people, often referred to as dual eligible beneficiaries, who are enrolled in both Medicare and Medicaid as their sources of health insurance coverage. This group is defined by the happenstance of two overlapping public insurance programs, rather than a disease, a care setting, or other factor.

The diverse dual eligible population includes some of the sickest and most vulnerable individuals covered by either Medicare or Medicaid. Eighty-six percent of dual eligible beneficiaries have incomes below 150 percent of the federal poverty level and 49 percent are in fair or poor health compared to 22 percent of other Medicare beneficiaries.[1] The population also generates disproportionate medical costs relative to their numbers; in 2008 they comprised 20 percent of Medicare enrollees but 31 percent of Medicare spending, and 15 percent of the Medicaid population but 39 percent of Medicaid spending.[2] Total Medicare spending on dual eligible beneficiaries in 2008 was $132 billion.[3]

Given two large, overlapping public insurance programs—with different benefits, providers, rules, and limits—a system intended to protect the vulnerable is instead fraught with confusion. Communication and data do not easily, reliably, or accurately flow with the beneficiary as they navigate the health care system. These fissures frustrate providers, add to already high costs, and expose beneficiaries to potential harm.

Rapid improvement in caring for dual eligible beneficiaries would in some ways represent the perfect "bull's-eye" of achieving the National Quality Strategy goals of healthier people, better care, and more affordable care. Performance measures are central to understanding our progress in improving quality. The right measures can provide valuable information to providers, public and private sector payers, beneficiaries, and their caregivers.

To develop this national measurement strategy for the dual eligible population, the Department of Health and Human Services (HHS) engaged the Measure Applications Partnership (MAP), a multi-stakeholder group of public and private-sector organizations and experts convened by the National Quality Forum (NQF). This is the fifth in a series of reports authored by MAP in its advisory role to HHS, and the only final report focused exclusively on a population rather than a specific setting or provider. It keys off an October 2011 interim report, which advances a comprehensive, patient-centered vision for evaluating care received by dual eligible beneficiaries.

The focus on a population—particularly one where an innovative approach is needed—creates both opportunities and challenges with respect to measurement. Although there is increased awareness that the next generation of performance measurement should more nimbly follow a patient through many care experiences, rather than one disease in one setting at a time, this measurement vision will take time to achieve. This report presents a measurement roadmap to assessing care for complex populations across multiple types of settings and providers.

MAP's vision for high-quality care seeks to address the fragmented and episodic nature of the care the dual eligible population receives. Measurement alone will not fix underlying inadequacies in the healthcare system, but it can set expectations and provide powerful incentives for change. MAP seeks to create better care "connectedness" that will be meaningful and tangible to patients,

families, and other stakeholders. Accordingly, the partnership identifies the following core aspects of care it believes could provide high-value signals of improvement over time:

- Individuals' **quality of life** and **functional status**—including symptom control, progress toward treatment and recovery goals and, in time, psychosocial factors such as level of engagement in community activities.
- Individuals' **preferences** and **experience** of care, and **engagement** in decisions about their care;
- The **coordination of care** among multiple providers and facilities, particularly when a dual eligible beneficiary transitions from one care setting to another (from a hospital to a nursing home or home care, for example);
- The continual need for **follow-up care** and the availability of **community support** services and systems; and
- The ongoing **management of chronic health conditions** and the risks for chronic conditions.

Within these and other areas, MAP identifies a set of specific measures that are sensitive to the unique needs of dual eligible beneficiaries. Notably, they include measures of detecting and treating depression, screening older adults for fall risk, and the widespread use of surveys that allow patients to give their own views of the care they receive. MAP also identified unplanned hospital readmissions within 30 days of an initial stay as a key measure of quality for the dual eligible population. In total, MAP lays out a core set of 26 specific measures (see Appendix G), including a "starter set" of seven that are most ready for immediate implementation in the field.

The measure development community has a major role to play in advancing the universe of measures available to assess care for dual eligible beneficiaries. Specifically, MAP outlines suggestions for improving and broadening many existing measures to make them more applicable to this population. For example, MAP notes that it would be interested in measures of functional status, but many functional status measures have a curative orientation. Dual eligible beneficiaries are likely to have care goals that emphasize maintaining function or slowing decline; the measures should accommodate those trajectories.

Measure development is also needed to provide new measures that would address additional issues identified by MAP. These gaps in available measures need to be filled in order to obtain a full and accurate snapshot of beneficiaries' experiences. Among those considered most pressing are measures that assess person-centered care planning, connections between the healthcare system and community supports, a beneficiary's sense of autonomy, and screening for poor health literacy. Measures regarding the costs of care are also an important gap. The desire to improve the affordability of care guided much of the strategic approach to measurement, but MAP found that the few measures currently available cannot be used with the dual eligible population.

MAP intends for this report to inform the many constituents that are critical to the successful implementation of an aligned measurement strategy for dual eligible beneficiaries. These include the newly established Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare and Medicaid Services (CMS), state health and Medicaid officials, health plans, providers, and research organizations. These findings may prove to be helpful contributions to those pondering quality measurement and improvement initiatives for other populations with shared characteristics such as low income, complex chronic conditions, disability, and advanced age.

MAP BACKGROUND

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment programs, and other purposes. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with the "consensus-based entity" (i.e., NQF) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[4]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures HHS will receive varied and thoughtful input on performance measure selection. In particular, the ACA-mandated annual publication of measures under consideration for future federal rulemaking allows MAP to evaluate and provide upstream input to HHS in a more global and strategic way.

MAP is designed to facilitate alignment of public- and private-sector uses of performance measures to further the National Quality Strategy's (NQS's) three-part aim of creating better, more affordable care, and healthier people.[5] Anticipated outcomes from MAP's work include:

- A more cohesive system of care delivery;
- Better and more information for consumer decision-making;
- Heightened accountability for clinicians and providers;
- Higher value for spending by aligning payment with performance;
- Reduced data collection and reporting burden through harmonization of measurement activities across public and private sectors; and
- Improvement in the consistent provision of evidence-based care.

Further information about MAP's coordination with other quality efforts, function, timeline, and deliverables is provided in Appendix A.

INTRODUCTION

MAP has been charged with providing multi-stakeholder input on performance measures to assess and improve the quality of care delivered to individuals who are enrolled in both Medicare and Medicaid. The dual eligible population is notable for its heterogeneity, the particularly intense service needs and health risks of some sub-groups, and the fragmented nature of healthcare and supportive services they receive.

The most recent data available show that more than 9.1 million people are dually eligible for and enrolled in both the Medicare and Medicaid programs.[6] Low-income seniors make up roughly two-thirds of the dual eligible population, and people under age 65 with disabilities account for the remaining third.[7] The population includes many of the poorest and sickest individuals covered by either Medicare or Medicaid. The two programs were created separately and for different purposes, leaving beneficiaries, providers, health plans, and other stakeholders struggling to navigate differing rules, provider networks, and a bifurcated benefits structure. These misalignments can complicate care coordination, lead to cost-shifting, and severely undermine the quality of care.

MAP considered quality measurement for dual eligible beneficiaries specifically, but some findings could be generalized to populations with similar characteristics such as low income, complex chronic conditions, disability, and advanced age.

MAP regarded the Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare & Medicaid Services (CMS) as the primary audience for this work. Established under ACA, the MMCO has many goals related to assessing and improving the quality of dual eligible beneficiaries' care and will be a primary user of measures that MAP supports for use with the dual eligible population. In addition, the MMCO is currently working with states to design and implement demonstration programs to better integrate and coordinate care for dual eligible beneficiaries. This report also considers the measurement needs of states and local stakeholders in evaluating their success in improving beneficiaries' experience of care and controlling costs.

Terminology

For purposes of this report, a *dual eligible beneficiary* is an individual who is enrolled in health insurance through both Medicare and Medicaid. The term is policy centric to allow reference to a specific group of people who qualify for a particular array of public benefits. Although these benefits fundamentally influence how a dual eligible beneficiary interacts with the health system, most individuals with this status would not readily identify themselves as such. Furthermore, providers of care and supports may not be aware of an individual's dual eligible status or the associated implications for service delivery. Lacking a more precise alternative, MAP refers to "dual eligible beneficiaries" and "individuals who are dually eligible" throughout this report.

Methods

The MAP Dual Eligible Beneficiaries Workgroup advised the MAP Coordinating Committee on the development of a strategic approach to performance measurement and recommended measures for use with the dual eligible population. The MAP Dual Eligible Beneficiaries Workgroup is a 27-member, multistakeholder group (see Appendix B for the workgroup roster, Appendix C for the Coordinating Committee roster). The workgroup held four public in-person meetings and one web meeting to fully develop the contents of this final report. The agendas and materials for these meetings can be found on the **NQF website**.

MAP has an annual role in providing pre-rulemaking input on the selection of performance measures for use in a range of federal healthcare programs. In addition, MAP has issued a series reports that detail measurement coordination strategies for specific subjects. The process of developing this strategic report on measuring quality in the dual eligible beneficiary population informed, and was informed by, MAP's pre-rulemaking deliberations on the use of measures for other specific applications.

MAP's task to identify performance measures appropriate for use with the dual eligible population was divided into two phases. An October 2011 **interim report** described the first phase, which focused on understanding the unique qualities of the population, identifying deficits in quality that affect the group, defining a strategic approach to measurement, and characterizing appropriate measures.[8] The second phase of the work is described in this final report. Building on the strategic approach to measurement, MAP prioritized current measures, proposed potential modifications to existing measures, and considered critical gaps in available measures. A draft of this report was made available online in April 2012, and NQF Members and the public were invited to submit comments. Key messages and themes from those comments are discussed throughout the report; the complete comments are reproduced in Appendix D.

STRATEGIC APPROACH TO PERFORMANCE MEASUREMENT FOR DUAL ELIGIBLE BENEFICIARIES

Vision for High-Quality Care

MAP established a vision for high-quality care for dual eligible beneficiaries to provide the foundation for the strategic approach to performance measurement:

> *In order to promote a system that is both sustainable and person- and family-centered, individuals eligible for both Medicare and Medicaid should have timely access to appropriate, coordinated healthcare services and community resources that enable them to attain or maintain personal health goals.*

As a part of the vision and the strategic approach to performance measurement, MAP espouses a definition of health that broadly accounts for health outcomes, health determinants, and personal wellness. The far-reaching nature of the vision and its multifactorial view of health are both fundamental to MAP's overall approach to quality measurement for the dual eligible population. Similarly, the vision is person- and family-centered. It aspires to high-value care that is centered on the needs and preferences of an individual and that relies on a range of supports to maximize function and quality of life. This is especially important given the complex range of mental, physical, and socioeconomic challenges facing the dual eligible population.

Guiding Principles

In considering how to achieve the desired vision, MAP established guiding principles for the strategic approach to measurement. Although measurement alone cannot fix the underlying fragmentation in the health system, it can signal the aspects of person-centered care that are most highly valued. The guiding principles inform and direct the design of measurement programs. Once a program has been established, the guiding principles and MAP's Measure Selection Criteria (Appendix E) can be applied to potential measures in order to indicate their appropriateness for meeting the program's goals. Because the guiding principles were previously presented in MAP's interim report, they are briefly summarized in Table 1 and fully discussed in Appendix F.

TABLE 1: GUIDING PRINCIPLES FOR MEASUREMENT IN THE DUAL ELIGIBLE BENEFICIARY POPULATION

Desired Effects of Measurement	Promoting Integrated Care
	Ensuring Cultural Competence
	Health Equity / Reducing Disparities
Measurement Design	Assessing Outcomes Relative to Goals
	Parsimony
	Cross-Cutting Measures
	Inclusivity
	Avoiding Undesirable Consequences of Measurement
Data Platform Principles	Data Sharing
	Using Data for Multiple Purposes
	Making the Best Use of Available Data

High-Leverage Opportunities for Improvement Through Measurement

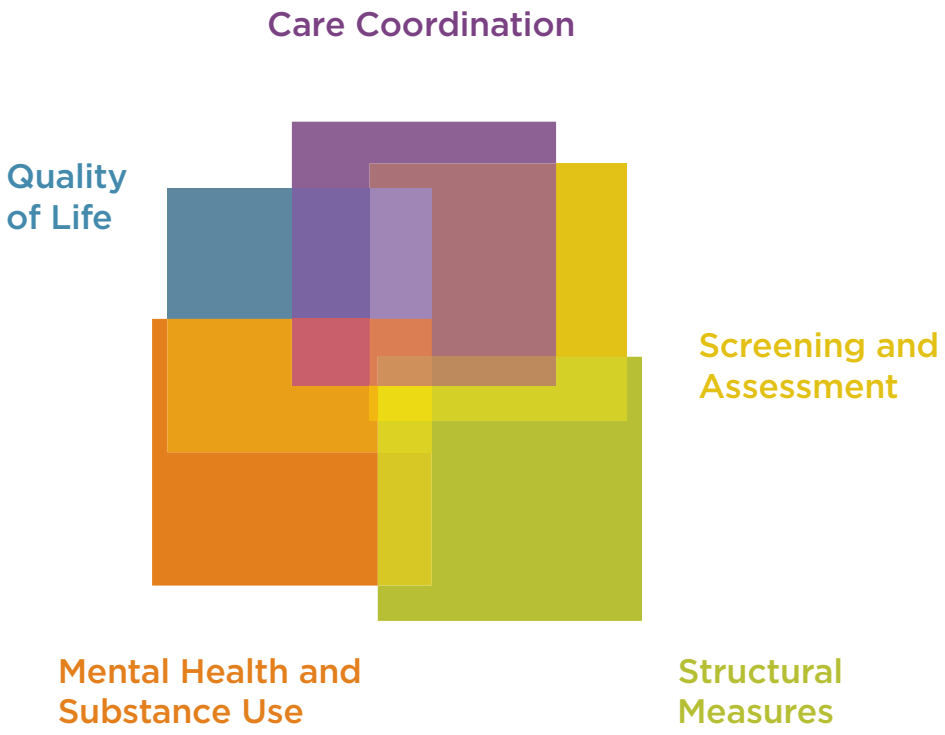
Countless opportunities exist to improve the quality of care delivered to dual eligible beneficiaries. In recognition that a measurement strategy should be parsimonious and focused on areas with substantial room for improvement, MAP reached consensus on five domains in which measurement can drive significant positive change: quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures. As depicted in Figure 1, the domains are heavily interrelated. Person-centered care is best enabled at the nexus of these overlapping domains. Addressing these high-leverage opportunity areas will improve beneficiaries' experiences of care as well as its overall costs.

MAP concluded that, wherever possible, the selection of measures to fit these areas should drive broad improvements in healthcare delivery and community supports by promoting shared accountability, addressing affordability along with quality, encouraging health information technology (HIT) uptake, and pushing toward longitudinal measurement.

Quality of Life

The measurement strategy should promote a broad view of health and wellness, encouraging the development of a person-centered plan of care that establishes goals and preferences for each individual. Ideally, that care plan and its goals would form the basis for measurement. For example, in situations in which an individual has stated health-related goals oriented toward maintenance of function instead of aggressive restorative treatments, the measurement strategy should accommodate that choice.

FIGURE 1. HIGH-LEVERAGE OPPORTUNITIES FOR IMPROVEMENT THROUGH MEASUREMENT



Measures in this care domain should focus on outcomes, such as functional status. Other facets of quality of life might include an individual's ability to choose where he or she lives, participate in the community, develop meaningful relationships, and meet employment and education goals. MAP also considered measures related to comfort, pain management, and symptom control under this domain. Although some quality-of-life measures may be more difficult to determine for dual eligible beneficiaries who have communication difficulties or who cannot self-report objectively, assessing progress toward treatment or recovery goals remains appropriate.

Care Coordination

Care coordination is a vital feature of high-quality care for dual eligible beneficiaries. NQF has previously endorsed preferred practices and performance measures related to care coordination.[9] MAP agreed that measures in this domain should promote coordination across multiple dimensions, such as care settings, provider types, and Medicare and Medicaid program benefit structures, and between the healthcare system and community supports.

To ensure adequate care coordination, measures should address the desired components of such coordination. MAP emphasized the importance of a shared plan of care developed jointly between providers and patients, comprehensive and proactive medication management and monitoring, access to an inter-professional team that crosses care settings and includes community resources, advance care planning, and palliative care. A thorough approach to care coordination would account for patient engagement and relevant factors (e.g., symptom control) during the span between encounters with the health system.

Measurement in this area could be oriented to identifying missed opportunities or breakdowns in care. Examples of warning signs of poor care coordination are incidents in which patients are transferred across settings without complete medical records, a long-term care case manager has not been notified that a beneficiary has been hospitalized, or a clinician has prescribed a medication contraindicated by the plan of care.

Screening and Assessment

Approaches to screening and assessment should be thorough and tailored to address the complex care needs of the dual eligible beneficiary population. The measurement approach should encourage providers to screen for factors that particularly affect vulnerable populations, such as poor nutrition, drug and alcohol use, housing insecurity, falls, underlying mental and cognitive conditions, and HIV/AIDS. MAP also considered the role of routinely recommended clinical preventive screenings and vaccinations. Although preventive care is generally necessary, the appropriateness of any test or procedure should be carefully considered in the context of an individual's health goals.

Assessment goes hand in hand with screening but does not have to occur in a single encounter. The ongoing assessment process should use person-centered principles and go beyond the basics to account for the home environment, economic insecurity, availability of family and community supports, capacity of formal and informal caregivers, caregiver stress, access to healthful food, and transportation. In addition, the assessment process should consider whether a beneficiary is receiving care in the most appropriate, least restrictive setting. After screening and assessment are complete, the results should be incorporated into the beneficiary's person-centered plan of care. Simple documentation of risks or other factors is not sufficient; the hallmark of high-quality care is a team of health professionals and support providers working together with a beneficiary to address known risks and monitor their progression over time.

Mental Health and Substance Use

Mental health conditions such as depression are highly prevalent in the dual eligible population.

Other serious psychiatric conditions such as schizophrenia are less common but heavily concentrated in the dual eligible population under the age of 65.

Mental health conditions commonly co-occur with substance use disorders and chronic medical conditions such as diabetes and cardiovascular disease. As such, behavioral health cannot be considered and measured in isolation. MAP echoed a recommendation from the Institute of Medicine (IOM) that mental health and substance abuse treatment should be more closely coordinated with primary care.[10] MAP also discussed that measures in this domain should be able to evaluate care across the continuum, including screening, treatment, outcomes, and patient experience. Approaches to both treatment and performance measurement should be grounded in the recovery model, as appropriate.

Structural Measures

Structural measures are necessary to provide a sense of the capacity, systems, and processes that exist to provide care and supports for dual eligible beneficiaries. In particular, MAP views structural measures as a high-leverage area and a critical part of a parsimonious measure set because they can assess disconnects between Medicare, Medicaid, and the other supports that are necessary for the well-being of high-need beneficiaries. It will be necessary to identify the extent of current problems and to fix the underlying structures and processes before providers and other stakeholders will be comfortable with being held accountable for outcome measures in the other high-leverage opportunity areas.

Structural measures can reflect the presence of elements that relate to other high-leverage opportunities such as quality of life and care coordination. For example, structural elements related to quality of life include the availability of Medicaid-funded home- and community-based services (HCBS) within a state and an individual's ability to self-direct those services. Additional structural measures related to care coordination might assess the presence of contracts between states' Medicaid agencies and Medicare Advantage Special Needs Plans (SNPs) to coordinate care, health IT uptake among Medicaid providers in a region, or capacity for information sharing within and across health provider and community support services organizations.

During the NQF Member and public comment period for this report, some stakeholders expressed concern that structural measures reflect minimum standards and, in some cases, have a tenuous link to improved outcomes. MAP recognizes this concern while emphasizing that many of the quality problems faced by dual eligible beneficiaries are the direct result of poor system structures, misaligned incentives, fumbled handoffs, and conflicting policies. MAP members believe structural measures that evaluate known areas of concern are needed to catalyze quality improvement for this population. For example, MAP examined one structural measure that assesses a practice's capacity for supporting patient self-management as well as providing enhanced access and communication with the team of providers.

Additional Themes from Public Comment

Comments from NQF Members and the public supported MAP's person-centered approach and the high-leverage opportunity areas defined above. Some comments requested additional emphasis on affordability, which is an element of the NQS three-part aim for high-quality healthcare. The NQS guides all of MAP's work to provide input to HHS, and MAP concurs that the NQS aims, priorities and goals are centrally important. MAP discussed potential approaches to assessing affordability as well as cost-effectiveness. It became clear that application of these concepts to the strategy for measuring the dual eligible population is especially complex. Consideration

of affordability from the varying but equally valuable perspectives of an individual beneficiary, a provider, a health plan, a state Medicaid program, and the Medicare program yields different results.

Although affordability of care has not been explicitly defined as a high-leverage opportunity area, the desire to improve affordability guided much of the strategic approach to quality measurement for dual eligible beneficiaries. MAP is monitoring related activities that seek to reduce overuse of services, including the work of the NQF-convened National Priorities Partnership and the American Board of Internal Medicine Foundation's Choosing Wisely initiative.[11] Resource use measures are further discussed in the following section, Addressing Gaps in Measurement.

Public comment also requested that MAP recognize the effects of specific health conditions within the dual eligible population. In particular, commenters sought more emphasis on measures for end stage renal disease (ESRD), cardiovascular disease, and pulmonary conditions. Rather than attempt to evaluate the impact of specific conditions in this diverse population, MAP sought to include high-leverage measures that would be relevant to as many beneficiaries as possible. This preference for cross-cutting measures is stated in MAP's guiding principles.

Stakeholders also cited a preference for a quality measurement strategy that minimizes new data collection and reporting requirements. Comments suggested capitalizing on information available through administrative data and Healthcare Effectiveness Data and Information Set® (HEDIS) measures, which is consistent with MAP's guiding principles for making the best use of available data and using such data for multiple purposes.

APPROPRIATE MEASURES FOR USE WITH THE DUAL ELIGIBLE BENEFICIARY POPULATION

In the interim report *Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries,* MAP presented a set of illustrative measures to highlight the high-leverage measurement opportunities. Building on that work, MAP undertook a series of activities to generate a list of available measures appropriate for use with the dual eligible beneficiary population. MAP examined hundreds of currently available measures, gradually winnowing and revising the set until a core of 26 measures emerged (Appendix G). A draft version of the core set was used as an input to MAP's pre-rulemaking process.

It is important to note that unlike other measurement programs for which MAP has provided input, no single federal measurement program is devoted to monitoring the quality of care for dual eligible beneficiaries. Thus, MAP anticipates that its guidance regarding measures appropriate for use with this population may be applied to multiple programs. Stakeholders are still in the process of defining the purpose, goals, data platform, and levels of analysis for new initiatives. MAP encourages integration of new and existing programs to minimize the effort required for front-line practitioners to participate in multiple quality measurement and improvement initiatives.

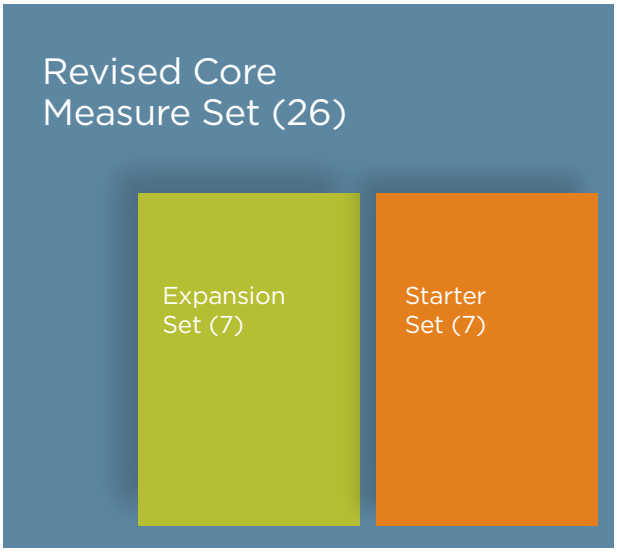
Because it was not compiled with a single application in mind, the set covers each of the five high-leverage opportunity areas, a range of measure types, and many settings of care. Some measures could be applied to the care delivered to all or most dual eligible beneficiaries. Others are primarily important for a significant subgroup of the population, such as individuals receiving hospice care or with serious mental illness. In the future, greater fit-for-purpose might be achieved by generating a measure set with specific program goals and capabilities in mind. Until these details emerge, MAP emphasizes the importance of the quality issues addressed by each of the core measures, presented in Table 2.

TABLE 2. QUALITY ISSUES ADDRESSED BY REVISED CORE MEASURE SET

High-Leverage Opportunity Area	Measure Topics
Quality of Life	Functional Status Assessment Health-Related Quality of Life Palliative Care
Care Coordination	Care Transition Experience Communication Between Healthcare Providers Communication with Patient/Caregiver Hospital Readmission Medication Management
Screening and Assessment	BMI Screening Falls Management of Diabetes Pain Management
Mental Health and Substance Use	Alcohol Screening and Intervention Depression Screening Substance Use Treatment Tobacco Use Screening and Cessation Treatment
Structural Measures	Health IT Infrastructure Medical Home Adequacy Medicare/Medicaid Coordination
Other	Patient Experience

Within the revised core measure set, MAP identified subsets of measures with potential for either short-term (Starter Set) or phased (Expansion Set) implementation. The Starter Set suggests a starting place for measurement. The Expansion Set is intended to supplement the Starter Set once suggested modifications have been explored. Other measures in the revised core measure set can also be used in specific programs, as appropriate, to address important quality issues facing dual eligible beneficiaries. Figure 2 illustrates the relationship among the three sets of measures. The following sections describe the process and results of MAP's further deliberations. All of the measure sets have been updated in response to public comments received.

FIGURE 2. APPROPRIATE MEASURES FOR USE WITH THE DUAL ELIGIBLE BENEFICIARY POPULATION: THREE RELATED SETS



Starter Set of Measures

MAP concluded that a small number of measures within the core measure set should be called out as the most promising for use in the short term. MAP considered measures that would work well as they are currently specified, with minimal modification. This process balanced MAP's desire to be thorough and inclusive with its desire to provide HHS with a specific, actionable, and parsimonious list of measures. Table 3 presents MAP's recommendations for a Starter Set of Measures.

TABLE 3. STARTER SET OF MEASURES

Measure Name, NQF Measure Number, and Status	Data Source	High-Leverage Opportunities	Setting of Care	Level of Analysis	Use in Current Programs
Screening for Clinical Depression and Follow-Up Plan **0418 Endorsed**	Administrative Claims and Other Electronic Clinical Data	Screening and Assessment, Mental Health/ Substance Use	Ambulatory Care, Hospital, PAC/LTC Facility	Clinician	Finalized for use in PQRS, Medicare Shared Savings Program, Medicaid Adult Core Set. Proposed for Meaningful Use Stage 2
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement **0004 Endorsed**	Administrative Claims, EHR, and Paper Records	Care Coordination, Mental Health/ Substance Use	Ambulatory Care	Clinician, Health Plan, Integrated Delivery System, Population	Finalized for use in PQRS, Meaningful Use, Value Modifier, Medicaid Adult Core Set, and Health Homes Core
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey **Multiple Endorsed: 0005, 0006, 0007, 0009, 0258, 0517**	Patient Survey	N/A	Various, including: • Health Plan • Clinician and Group • Experience of Care and Health Outcomes (ECHO) for Behavioral Health • Home Health Care • Hospital • In-Center Hemodialysis • Nursing Home • Supplemental Item Sets, topics including: – People with Mobility Impairments – Cultural Competence – Health IT – Health Literacy – Patient-Centered Medical Home	Clinician, Facility, Health Plan, Integrated Delivery System, Population	Multiple programs, depending on version
3-Item Care Transition Measure (CTM-3) **0228 Endorsed**	Patient Reported	Care Coordination	Hospital	Facility	Proposed for Hospital Inpatient Reporting as part of HCAHPS

Measure Name, NQF Measure Number, and Status	Data Source	High-Leverage Opportunities	Setting of Care	Level of Analysis	Use in Current Programs
Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) **1789** **Endorsed**	Administrative Claims	Care Coordination	Hospital/Acute Care Facility	Facility	Proposed for Inpatient Quality Reporting
Plan All-Cause Readmission **1768** **Endorsed**	Administrative Claims	Care Coordination	Hospital/Acute Care Facility, Behavioral Health/ Psychiatric: Inpatient	Health Plan	
Falls: Screening for Fall Risk **0101 Endorsed**	Administrative Claims	Screening and Assessment	Ambulatory Care, Home Health, Hospice, PAC/LTC Facilities	Clinician	Finalized for use in PQRS, Medicare Shared Savings Program, and Value Modifier. Proposed for Meaningful Use Stage 2

In recommending the measures, MAP considered their suitability for addressing the needs of the heterogeneous dual eligible population. Priority measures also needed to capture complex care experiences that extend across varied care settings and types of healthcare providers. Considered broadly, the prioritized list captures concepts of critical importance to the dual eligible population: care that is responsive to patients' experiences and preferences, the need for follow-up, treatment for behavioral health conditions, and ongoing management of health conditions and risks.

Most chronic conditions have significantly higher prevalence rates in the dual eligible population than in the general Medicare population.[12] Some conditions such as diabetes, cardiovascular disease, and depression are especially common. Each affects more than 20 percent of dual eligible beneficiaries. Other conditions such as multiple sclerosis, cerebral palsy, and end stage renal disease are less common but disproportionately affect dual eligible beneficiaries. Moreover, a majority of dual eligible beneficiaries live with multiple chronic conditions (MCCs).[13] Clinical practice guidelines that inform the development of performance measures typically focus on the management of a single disease, and strict adherence to disease-specific guidelines can potentially result in harm to patients with MCCs.[14, 15, 16] A separate NQF project has developed a measurement framework for MCCs.[17]

This heterogeneity complicates efforts to select a small number of measures that would accurately reflect dual eligible beneficiaries' care experiences. MAP followed its guiding principle that a parsimonious measure set should rely primarily on cross-cutting measures and use condition-specific measures only to the extent that they address critical issues for high-need subpopulations. The Starter Set does not attempt to include all valid measures of effective clinical care for these and other chronic diseases.

The first measure in the Starter Set is Screening for Clinical Depression and Follow-up Plan (Measure 0418). This measure addresses the two high-leverage opportunity areas of screening and assessment as well as mental health and substance use. It can be applied to many care settings in which dual eligible beneficiaries receive services.

Furthermore, use of this measure would promote alignment with other measurement programs in which it is used, including the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and the Medicare Shared Savings Program.

MAP also recommends that CAHPS® surveys be used in every care setting for which a survey is available. These patient experience surveys capture actionable feedback from patients and their families and are deemed vital to promoting a person- and family-centered measurement enterprise. The Agency for Healthcare Research and Quality (AHRQ) is actively enhancing CAHPS tools, including efforts to draft and test a CAHPS survey for Medicaid HCBS. Once complete, a participant experience survey of HCBS would complement the more typical measures of the clinical aspects of long-term supports and services.

Public comments supported the concept of gathering information about the quality of care from beneficiaries and their families but urged caution with fielding the surveys and interpreting their results. Stakeholders noted that the high prevalence of cognitive impairment and language barriers in the dual eligible population will complicate efforts to collect valid and reliable data. Furthermore, comments on the CAHPS family of surveys explained that individual providers may not treat a large enough number of dual eligible beneficiaries to provide sufficient sample size to calculate the measures. Similar comments were raised in reference to the CTM-3 measure. Acknowledging that these instruments have room for improvement, MAP advises that they be considered for broad use and that the data be stratified to compare the dual eligible population to other populations, and to itself over time. MAP considered issues of case mix and risk adjustment, acknowledging the potential methodological difficulty inherent in comparing results across health plans or states, given underlying demographic differences.

Other recommended measures touch on the important topics of care coordination and patient engagement. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Measure 0004) was also recognized for addressing critical steps in identifying and treating substance use conditions. This measure not only encourages the initial referral to treatment, but also evaluates the individual's continued engagement in treatment over time.

Finally, measures of hospital readmission rates were thought to be important proxies for the level of care coordination, communication, and community supports available to dual eligible beneficiaries. NQF recently endorsed two similar measures of 30-day hospital readmissions. One measure is designed to be applied at the hospital level, and one measure is designed to be applied at the health plan level. Which of the two measures is preferred will depend on the specific goals of the measurement program being considered. Regardless of the specific measure selected, MAP sought to emphasize the primary importance of this topic when evaluating the "connectedness" of care for dual eligible beneficiaries.

The Starter Set provides a necessary sense of prioritization, but evaluating it against the NQS priorities and MAP's own high-leverage opportunity areas reveals important shortcomings. For example, no available measures were thought to adequately address the NQS goal of affordable care. Limited availability of cost data that encompass both Medicare and Medicaid expenditures is a major factor. In addition, information on beneficiaries' out-of-pocket expenses is not routinely collected. Although a few elements within the CAHPS surveys touch on quality of life, the Starter Set may not adequately address this high-leverage opportunity area. These and other gaps in available measures will be more fully discussed in a later section of this report.

Expansion Set of Measures Needing Modification

MAP also sought to provide specific guidance regarding opportunities to improve existing measures. MAP members offered many suggestions for broadening and improving measures' specifications for use with dual eligible beneficiaries. The members first performed an initial ranking to yield the Starter Set, then performed a second ranking to identify the measures that would be preferred *if the suggested modifications could be made*. This measure set would build on the Starter Set, expanding the range of quality issues addressed. Table 4 presents the results from the prioritization as an Expansion Set of Measures.

TABLE 4. EXPANSION SET OF MEASURES NEEDING MODIFICATION

Measure Name, NQF Measure Number, Status, and Steward	Measure Description	Suggested Modifications and Other Considerations
Assessment of Health-Related Quality of Life (Physical & Mental Functioning) **0260 Endorsed** Steward: RAND Corporation	Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year. • Data Source: Patient Reported • Care Setting: Dialysis Facility • Current Programs: MAP supported for ESRD Quality Incentive Program	• MAP emphasized this measure for its consideration of quality of life, a rarity among available measures. • Current survey is dialysis specific and therefore inappropriate to use more broadly. Comments suggested that it remain unmodified. Rather, it should be used as a template for the development of a related measure of general health-related quality of life. • Construction of this concept as a process measure is not ideal.
Medical Home System Survey **0494 Endorsed** Steward: National Committee for Quality Assurance	Percentage of practices functioning as a patient-centered medical home by providing ongoing coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a) Improved access and communication, b) Care management using evidence-based guidelines, c) Patient tracking and registry functions, d) Support for patient self-management, e) Test and referral tracking, and f) Practice performance and improvement functions • Data Source: Provider Survey, EHR, Other Electronic Clinical Data, Paper Records, and Patient Reported Data • Care Setting: Ambulatory Care • Current Programs: None	• Care management might be appropriately conducted by other parties besides primary care physician (e.g., family member, clinical specialist, PACE site). • A health home's approach to care management must consider both Medicaid and Medicare benefits. • Measure may have broader application in shared accountability models such as ACOs and health homes. • It may be more important to measure whether the beneficiary has access to a usual source of primary care rather than the primary care provider's ability to meet these standards.
HBIPS-6: Post-Discharge Continuing Care Plan Created **0557 Endorsed** Steward: The Joint Commission	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). • Data Sources: Administrative Claims, Paper Records, Other Electronic Clinical Data • Care Setting: Hospital, Behavioral Health/ Psychiatric: Inpatient • Current Programs: Proposed for Inpatient Psychiatric Facility Quality Reporting	• This type of transition planning and communication is universally important. • Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox. • This measure is paired and should be used in conjunction with HBIPS-7: Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge.

Measure Name, NQF Measure Number, Status, and Steward	Measure Description	Suggested Modifications and Other Considerations
HBIPS-7: Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge **0558 Endorsed** Steward: The Joint Commission	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). • Data Sources: Administrative Claims, Other Electronic Clinical Data, and Paper Records • Care Setting: Hospital, Behavioral Health/ Psychiatric: Inpatient • Current Programs: Proposed for Inpatient Psychiatric Facility Quality Reporting	• This type of transition planning and communication is universally important. • Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox. • Information should be transmitted to both nursing facility and primary care provider, if applicable. • This measure is paired and should be used in conjunction with HBIPS-6: Post- Discharge Continuing Care Plan Created.
Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment **0209 Endorsed** Steward: National Hospice and Palliative Care Organization	Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours. • Data Sources: Patient Reported • Care Setting: Hospice • Current Programs: Finalized for Use in Hospice Quality Reporting	• Give consideration to operationalizing this measure as pain assessment across settings; at a minimum it could be applied more broadly to other types of palliative care. • Comments suggested that advance care directives are equally important to ensure high-quality, patient-centered care.
Change in Daily Activity Function as Measured by the AM-PAC **0430 Endorsed** Steward: CREcare	The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified, which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing. • Data Sources: Other Electronic Clinical Data • Care Setting: Hospital, PAC/LTC Facilities, Home Health, Ambulatory Care • Current Programs: None	• MAP emphasized this measure for its consideration of functional status, a rarity among available measures. • Broaden beyond post-acute care. • Measure has curative orientation. Include maintenance of functional status if this is all that can be realistically expected. If the goal of care is to slow the rate of decline, then this measure may not be appropriate. • Address floor effects observed when tool is applied to very frail/complex patients. • Incorporate community services in supporting post-acute recovery. • The measure may present a relatively larger data collection burden; brief surveys are preferred.

Measure Name, NQF Measure Number, Status, and Steward	Measure Description	Suggested Modifications and Other Considerations
Optimal Diabetes Care **0729 Endorsed** Steward: MN Community Measurement	The percentage of adult diabetes patients (18-75) who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated. • Data Sources: Electronic Health Record, Other Electronic Clinical Data, Paper Medical Records, Registry • Care Setting: Ambulatory Care • Current Programs: Components for this composite are finalized for use in Medicare Shared Savings and Value Modifier. Under consideration for PQRS (MAP Supported)	• Although the all-or-none composite measure is considered to be the gold standard that reflects the best patient outcomes, the individual components may be measured as well. • Comments considered this measure to be resource intensive because it requires review of medical charts and proposed that diabetes measures in the HEDIS set would be less burdensome to report. • Stakeholders expressed concerns that the individual targets within the measure may be too aggressive, especially for individuals who are older and/or have multiple chronic conditions.

The concepts and best practices represented within the Expansion Set measures are merely a starting point in the long path toward developing a comprehensive set of appropriate measures. MAP's discussion of the expansion set revealed a range of shortcomings in existing measures from the perspective of measuring quality in a defined population. Many of the proposed modifications involved broadening the denominator populations of measures to increase their applicability to other patient groups. MAP also proposed expansion of measures to account for multiple settings of care and community supports, as well as emphasizing functional outcomes.

MAP has supported the concept of a health home for dual eligible beneficiaries from the outset of its deliberations. Reflecting that desire, the structural measure Medical Home System Survey (Measure 0494) was ranked highly by MAP members because it is one of the few available measures to promote health homes and reflect core concepts such as the presence of a registry and enhanced care coordination. Stakeholders have raised concerns with the wide-scale implementation of this measure, as described in the table above. For example, one comment noted that requiring primary care providers to complete an extensive survey could have the unintended consequence of providers refusing to participate in Medicare or Medicaid, thereby exacerbating existing network sufficiency problems. MAP moved Measure 0494 from the Starter Set to the Expansion Set to acknowledge these and other challenges. Comments suggested that assessing the number of beneficiaries with access to a primary care provider could be a more reliable and easily administered metric.

Each subset of MAP's recommended measures contains one or more measures related to care transitions, a vital quality issue in the dual eligible population. The Expansion Set contains two process measures specified for use in behavioral health (Measures 0557 and 0558) that are conceptually similar to two measures specified for a general hospital admission (Measures 0647 and 0648) that appear in the larger core set. Some of these measures may be candidates for harmonization or expansion. Short of that, MAP

urges that quality measures be applied to all care transitions for which they are available, including discharges to home, to/from a nursing facility, or to/from any other setting.

Because the majority of available performance measures were developed for specific programs or purposes, there is difficulty in retrospectively applying them to care for dual eligible beneficiaries. MAP anticipates that making the suggested revisions will be challenged by shortcomings in clinical evidence and data availability. Measure developers are asked to consider MAP's suggested modifications and evaluate the feasibility of the proposed changes.

Additional Themes from Public Comment

One stakeholder suggested that a measure of nursing facility utilization be added to the Starter Set, noting that inappropriate or avoidable nursing facility use is equally as important to quality and cost as inappropriate or avoidable hospital use. MAP generally agrees that this is an important area for measurement and intervention. No measures of nursing facility utilization have yet been endorsed by NQF, which is highlighted as a measurement gap.

Comments suggested increased emphasis on measures of health outcomes. For example, one comment proposed the use of the outcome measure Depression Remission at Six Months (Measure 0710) in addition to or in place of the process measure Screening for Clinical Depression and Follow-up Plan (Measure 0418). Although outcome measures are preferred in many cases, MAP members first wanted to ensure that the basic steps of identifying depression and formulating a plan for treatment had been achieved. In addition, Measure 0418 has been selected for use in several other important programs such as the Medicare Shared Savings Program to test Accountable Care Organization (ACO) models. MAP will consider the suggested outcome measure for inclusion in a future iteration of the core measure set.

Several comments addressed the topics of medication reconciliation and medication management. The measure Drugs to Be Avoided in the Elderly (Measure 0022) was highlighted as applying to a noted gap in medication management. This measure assesses the percentage of individuals 65 years of age and older who received at least one high-risk medication, and the percentage who received at least two different high-risk medications. The measure is in the process of being revised to reflect updated clinical guidelines. In response to this suggestion, MAP added Measure 0022 to the revised core measure set. Comments also noted the need to harmonize current measures of medication reconciliation, which is discussed in the following section, Addressing Gaps in Measurement.

Finally, several comments raised the issue of denominator exclusions. Comments sought the flexibility to exclude individuals from measures when they are not applicable or appropriate, citing risks of over-treatment. It was suggested that exclusion criteria should refer to people over age 85, with life-limiting conditions, or participating in hospice programs. MAP's principle of person-centeredness dictates that a beneficiary and his or her team of providers should be able to decide an appropriate level of treatment, and the measurement approach should remain flexible enough to maintain accountability but accommodate that choice.

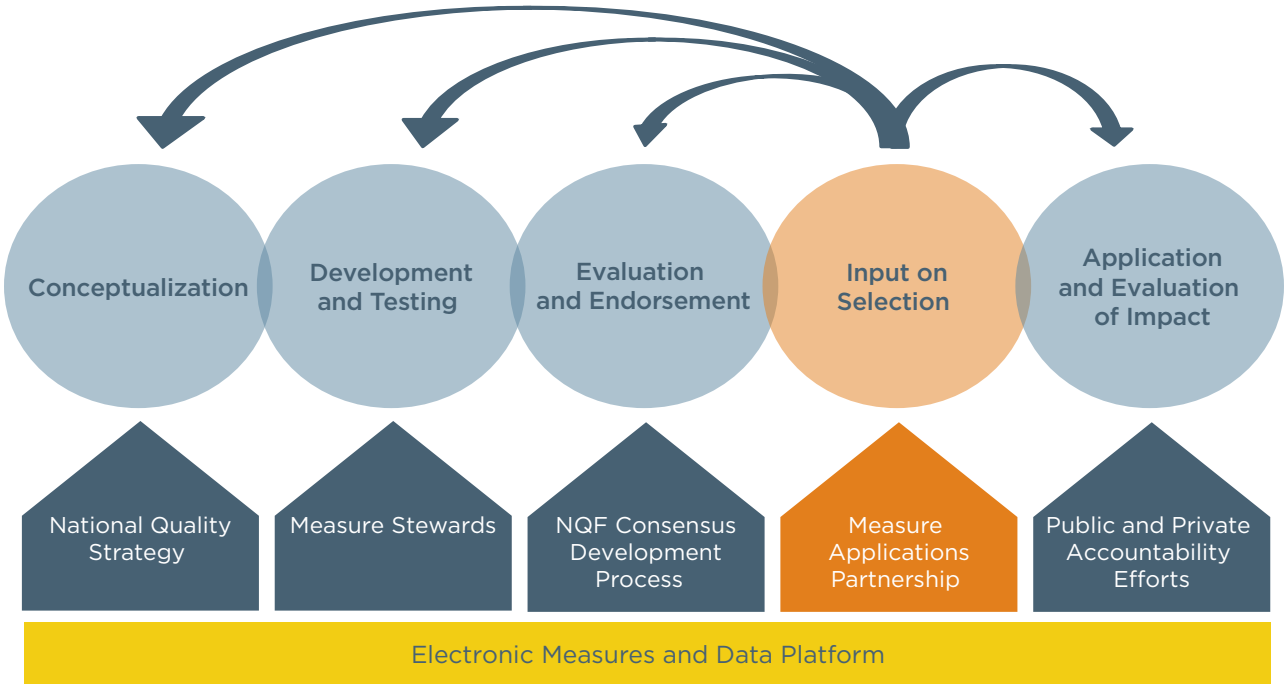
ADDRESSING GAPS IN MEASUREMENT

MAP's activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality through performance measurement. Measure development and standardization of measures are essential upstream inputs to these efforts. Figure 3 broadly depicts the pathway from the conceptualization and development of measures through their selection for specific applications by MAP.

The NQS provides national priorities and goals for quality improvement, influencing the conceptualization of measures that would evaluate progress in each area. Once measurement priorities are clear, measure developers and stewards must secure funding for development, explore the evidence base, develop numerator and denominator statements, identify data, specify the measures, and test measures to ensure reliability and validity of the measures. Measure stewards then submit their measures to NQF for endorsement as consensus standards. Endorsement provides an avenue for harmonization with related measures while also enhancing measures' credibility and likelihood of adoption. Finally, recommendations from MAP influence the application of individual measures in specific public- and private-sector programs. Gaps and suggested modifications revealed by MAP processes can also follow multiple avenues to inform preceding steps in the pathway.

MAP's effort to compile a set of performance measures appropriate for assessing and improving the quality of care for dual eligible beneficiaries was constrained by gaps in available measures. This report documents many suggested modifications to existing measures, but countless other areas one might wish to evaluate cannot currently be measured.

FIGURE 3. MEASURE DEVELOPMENT AND APPLICATION



Measure gaps identified by MAP consist of two general types:

- **Development Gaps.** Desired measures do not currently exist or are extremely limited in scope. For example, MAP would like to evaluate the quality and comprehensiveness of an individual's person-centered plan of care, but no measures are available to do so.
- **Implementation Gaps.** Appropriate measures exist but are not included in a given performance measurement program. For example, standardized measures of patient experience are available but not currently applied in many public reporting and performance-based payment programs.

Gaps in measurement can be found at any stage of measure development and implementation. Most measure gaps for dual eligible beneficiaries are development gaps. Because dual eligible beneficiaries are defined by the happenstance of two overlapping public insurance programs, they have had fewer traditional interest groups to advocate for their unique needs related to healthcare quality. This sharply contrasts with well-organized medical boards, specialty societies, providers, quality alliances, and consumer groups that have promoted and funded measurement in specific areas, such as cardiovascular care, pharmacy, and renal dialysis, to name a few. Although measures have proliferated in other areas, the specific measurement needs of dual eligible beneficiaries have gone largely unaddressed.

In considering the landscape of currently available measures applicable to dual eligible beneficiaries, MAP identified and categorized a large number of measure development gaps (Table 5).

TABLE 5. CATEGORIZED MEASURE GAPS APPLICABLE TO DUAL ELIGIBLE BENEFICIARIES

Structural Measures	Ability to capture encounter data with health IT
	Access to services (e.g., transportation, appointment availability)
	Capacity to serve as a medical home or health home
	Frequency of change in Medicaid or health plan eligibility
	Harmonization of program benefits
	Level of beneficiary assistance navigating Medicare/Medicaid
	Presence of coordinated or blended payment streams
	Provider cultural competence
	Rating system for level of integration between health and long-term services and supports
	Workforce capacity
Care Coordination	Ability to obtain follow-up care
	Appropriateness of hospitalization (e.g., avoidable admission/readmission)
	Coordinating care across Medicare and Medicaid benefits
	Effective communication (e.g., provider-to-patient/family, provider-to-provider)
	Fidelity to care plan
	Goal-directed, person-centered care planning and implementation
	System structures to connect health system and long-term supports and services
	Timely communication of discharge information to all parties (e.g., caregiver, primary care physician)

Quality of Life	Caregiver support
	Choice of support provider
	Community inclusion/participation
	Life enjoyment
	Optimal functioning (e.g., improving when possible, maintaining, managing decline)
	Pain and symptom management
	Sense of control/autonomy/self-determination
Mental Health and Substance Use	Initiation of pharmacotherapy after diagnosis of substance abuse or dependence
	Medication adherence and persistence for all behavioral health conditions
	Regular assessment of weight/BMI for all patients on anti-psychotic medication
	Suicide risk assessment for any type of depression diagnosis
	Tobacco cessation outcomes
Screening and Assessment	Appropriate follow-up intervals
	Appropriate prescribing and comprehensive medication management
	Assessment for rehabilitative therapies
	More "optimal care" composite measures (e.g., NQF #0076)
	Safety risk assessment
	Screening for cognitive impairment and/or poor psychosocial health
	Screening for poor health literacy
	Sexual health screenings for disenfranchised groups
Other	Consideration of global costs
	Patient activation
	Utilization benchmarking (e.g., outpatient/ED/nursing facility)

The lengthy list of measure development gaps reveals that many concepts considered core to improving the quality of care and supports for dual eligible beneficiaries are not yet measurable. Few of the desired measurement topics with gaps apply to specific diseases or conditions. Indeed, few desired topics are fully within the purview of a single entity in the health system. Instead the measurement gaps reflect MAP's desire to emphasize cross-cutting aspects of high-quality care.

MAP acknowledged the resource-intensive nature of measure development and prioritized the measure gaps to provide the measure development community with more specific guidance and a sense of importance. The highest priority gaps are presented in Table 6.

TABLE 6: PRIORITIZED MEASURE GAPS

Measure Development Gap Concepts
Goal-directed person-centered care planning/ implementation
System structures to connect health system and long-term supports and services
Appropriate prescribing and comprehensive medication management
Screening for cognitive impairment and poor psychosocial health
Appropriateness of hospitalization (e.g., avoidable admission/readmission)
Optimal functioning (e.g., improving when possible, maintaining, managing decline)
Sense of control/autonomy/self-determination
Level of beneficiary assistance navigating Medicare/ Medicaid
Presence of coordinated or blended payment streams
Screening for poor health literacy
Utilization benchmarking (e.g., outpatient/ED/ nursing facility)

Given that Assessing Outcomes Relative to Goals is one the guiding principles for this measurement framework, it is not surprising that MAP members prioritized measurement around goal-directed care planning and implementation of that plan of care. Similarly, MAP expressed a strong desire for structure and process measures to assess connections between the health system and the long-term supports and services system, including Medicaid HCBS. These topics are emblematic of the comprehensive, coordinated care that would benefit high-need beneficiaries. However, these types of measure gaps present particularly significant challenges to measure developers. In many ways, the gaps reflect MAP's aspiration to measure aspects of integrated healthcare that are still the exception rather than the rule in clinical practice. Similarly, the evidence base may be limited, workflows may be non-standard, and the data sources may be inconsistent or non-existent.

Other topics more amenable to measure development are also considered to be of high priority. For example, the concepts of appropriate prescribing behavior and medication management to reduce poly-pharmacy risks could be operationalized as process measures. MAP also recommended routine screening of dual eligible beneficiaries for cognitive impairment and psychosocial risk factors. Screening tools are available, but measures need to be constructed to encourage their use in clinical workflows. While it may be challenging to define a denominator population for these types of measures, the experience of developing and using screening and referral measures in other areas will be instructive.

Measures of Quality in Home and Community-Based Services (HCBS)

MAP separately considered measures of quality in Medicaid-funded home and community-based services as a major development gap area. Nationally, more than 300 Medicaid waiver programs provide services to more than 1.2 million participants, with expenditures exceeding $27 billion annually.[18] Moreover, policymakers are making concerted efforts to expand access to HCBS. More than two out of every three HCBS recipients are dual eligible beneficiaries.

Because HCBS are largely non-medical, they necessarily operate within a different quality paradigm than the health system. Many of the primary domains of high-quality, person-centered HCBS can be traced back to the disability rights movement and the historical need to assure adequate quality of life for individuals with disabilities leaving institutional care settings. Dominant constructs include access to services, community inclusion, choice and control, respect and dignity, cultural competence, and safety.

Compared to quality measurement in clinical settings, performance measures in HCBS are in the early stages of development and standardization.

Many factors contribute to the limited availability of measures. Variation across states in eligibility standards, diagnoses of enrollees, the service package each beneficiary receives, the settings in which supports are delivered, the providers who furnish services, and the mix of formal and informal supports involved have made it impossible to apply measures across states or across HCBS subpopulations to date.

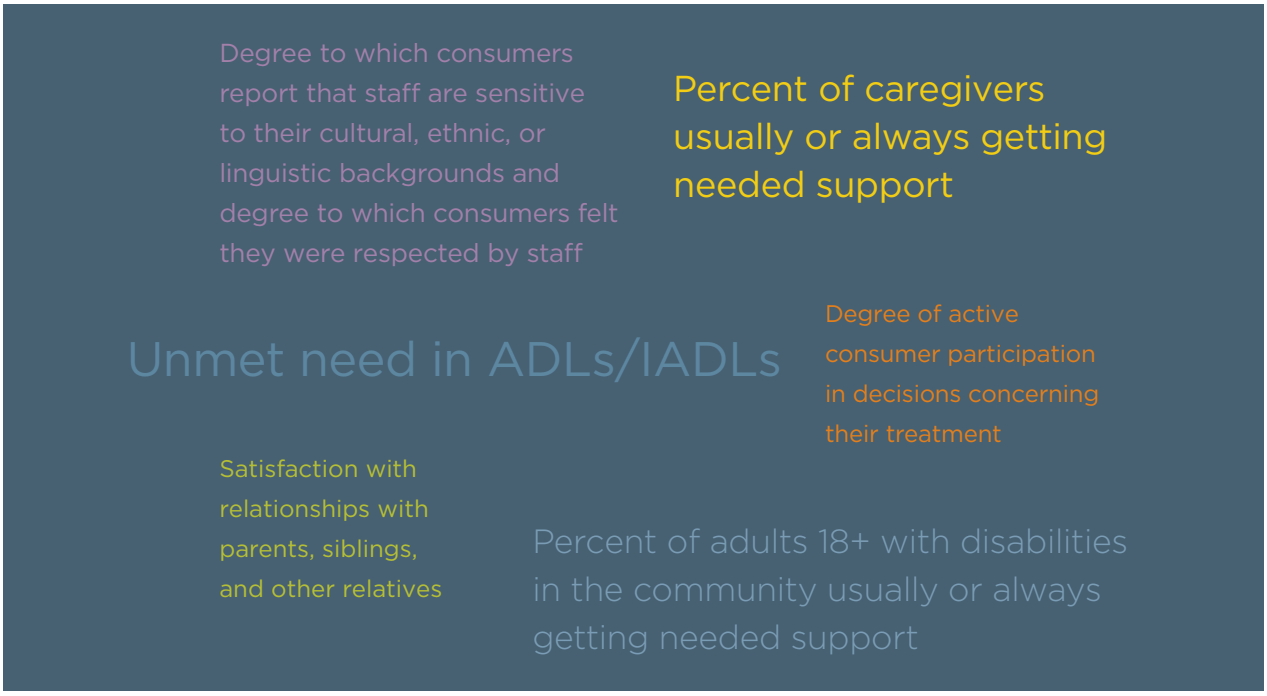
Government and private-sector research efforts are gradually pushing the field forward. For example, AHRQ has funded an effort to develop indicators of potentially avoidable hospitalizations for the HCBS population.[19] As risk-adjustment models become more sophisticated, this promising work can be taken much further. A number of prominent measure scans have also demonstrated that valid measures exist across a wide range of domains, but further development and testing will be required to broaden their applicability.

MAP suggests that HHS explore the feasibility of funding an NQF measure endorsement effort for HCBS measures. Measure developers may need significant support in broadening and standardizing current metrics. To provide more specificity around this request, MAP examined a total of 148 potential HCBS measures from three primary sources:

- Environmental Scan of Measures for Medicaid Title XIX Home and Community-Based Services (June 2010)[20]
- Raising Expectations: A State Scorecard on LTSS for Older Adults, People with Disabilities, and Family Caregivers (September 2011)[21]
- National Balancing Indicator Contractor (October 2010)[22]

Following a stepwise approach that considered the five high-leverage opportunity areas, the inclusiveness of the potential measures, and their possible applicability to dual eligible beneficiaries, MAP narrowed the universe to 24 potential measures particularly worthy of further attention (Appendix H). Though they rely on surveys and attestations as data sources, many of the potential measures reflect concepts that ring true for evaluating quality in the dual eligible population (Figure 4).

FIGURE 4. POTENTIAL HCBS MEASURES SHOW PROMISE FOR APPLICATION TO THE DUAL ELIGIBLE POPULATION



Comments received from NQF Members and the public sought clarification around the potential endorsement and use of HCBS measures. Noting that many of the potential measures rely on survey data provided by beneficiaries and/or their family members, comments recommended the use of objective data to complement self-reports. Health plans, in particular, expressed concern that current data collection strategies would have to be enhanced in order to implement measures of quality in HCBS. In response, MAP further emphasizes that the potential HCBS measures under examination are not NQF-endorsed and are not being recommended for wide-scale implementation at this time. However, they provide useful illustrations of person-centered concepts that were considered core to the provision of high-quality care and supports. In addition, MAP anticipates that analysis of HCBS quality is most likely to take place at the state or population level.

Measures of Functional Status

Appropriate functional status measures comprise a second major gap area. As outcome indicators, they are fundamental to demonstrating high-quality care. MAP is interested in measuring an individual's level of ability in multiple physical, mental, and social domains. A small number of functional status measures are currently available, but they failed to gain MAP's support for use with dual eligible beneficiaries. For example, six measures are specified for use in home health care: assessing improvement in bathing, bed transferring, management of oral medications, status of surgical wounds, dyspnea, and ambulation/locomotion. In the context of assuring home health care quality, the existing measures are adequate. However, the assumption that an individual would *improve* might be inappropriate if these home health functional status measures were broadly applied to the heterogeneous and medically complex dual eligible population. Individuals who are older and/or who have advanced diseases are likely to have care goals that emphasize maintenance of function or slowing of decline. Moreover, the home health measures of functional status rely on an assessment tool that is not intended for use in any other context.

Comments suggested looking to the National Institutes of Health's Patient Reported Outcomes Measurement Information System® (PROMIS) tools for other measures of functional status.[23] PROMIS is a system to assess patient-reported health status for physical, mental, and social well–being. The many PROMIS tools can be used across a wide variety of chronic diseases and conditions and in the general population. Development of performance measures based on the well-validated PROMIS tools is needed. This challenge will be addressed through the upcoming NQF Patient-Reported Outcomes workshop.

MAP would also be interested in composite measures that combine separate indicators into a single score that conveys an overall sense of functional status. Although not currently specified or endorsed as a performance measure, the Medicare Payment Advisory Commission (MedPAC) has published a calculation that approximates this concept. Using the Health Outcomes Survey (HOS) and the Medicare Advantage population, MedPAC calculated the percentage of enrollees "Improving or maintaining physical health" and "Improving or maintaining mental health."[24] If the data source and denominator population can be altered, this construct may be useful in broadly assessing functional status. Such global measures may be especially useful for policymakers and consumers interested in understanding patterns in dual eligible beneficiaries' overall quality of care rather than any specific dimension.

Measure Gaps Revealed by Environmental Scan

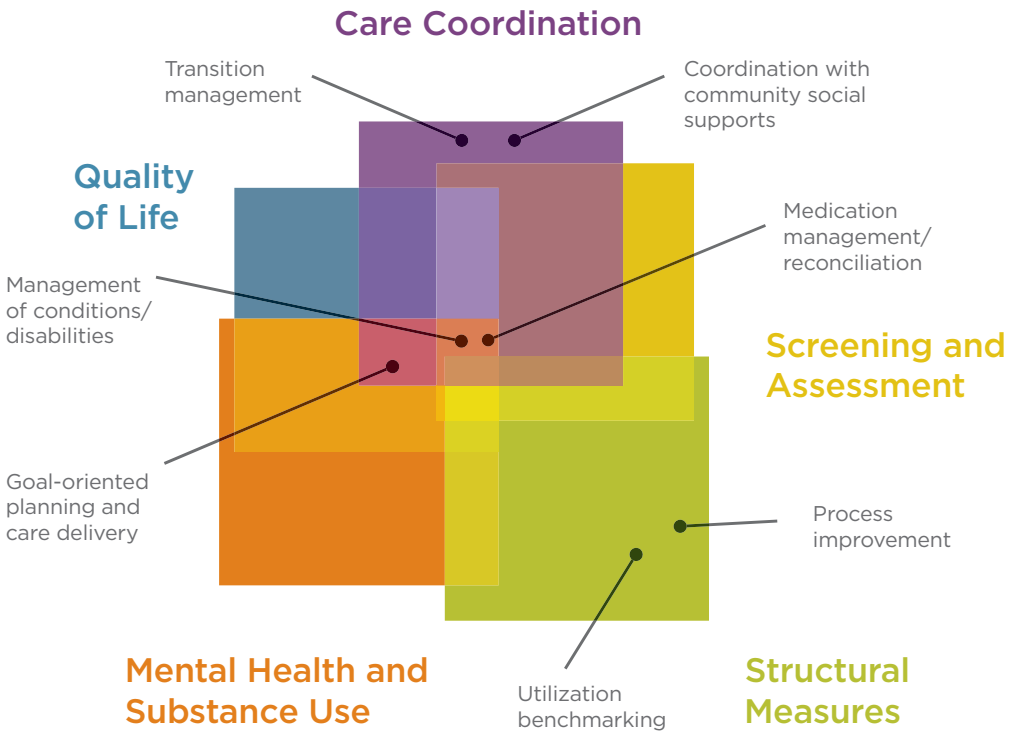
NQF contracted with Avalere Health, LLC and L&M Policy Research, LLC to conduct an environmental scan to glean further insights regarding the future direction of measurement in the dual eligible

beneficiary population. This scan included a series of expert stakeholder discussions and a targeted literature review. Findings corroborated many of the themes of MAP's deliberations. Using seven areas of focus listed below, the environmental scan highlighted example measures, measure gaps, implementation barriers, and recommendations.

- **Consumer-based assessment of goal-oriented planning and care delivery**: patient/caregiver/family perception of extent to which care plan and care delivered reflect goals and desires of the individual
- **Management and monitoring of specific conditions and disabilities**: provider and patient active awareness of and engagement with signs and symptoms related to conditions to achieve care plan goals
- **Medication management/reconciliation across settings**: management of medications by both provider and patient/caregiver to optimize appropriate use of medication and minimize negative drug interactions
- **Transition management**: interactions that occur within and across care settings (between patients, families, and providers) to ensure individuals receive comprehensive and streamlined care without duplication
- **Integration and coordination of community social supports and health delivery**: ability to identify need for and ultimately integrate community social supports into care plan based on individual/caregiver needs
- **Utilization benchmarking**: ability to gauge the extent of service use among dual eligible beneficiaries and beneficiary subpopulations across settings
- **Capacity for process improvement across settings**: ensure quality improvement programs are in place within and across settings and organizations that serve dual eligible beneficiaries

The seven areas of focus relate to MAP's five high-leverage opportunity areas as depicted in Figure 5. Environmental scan findings are further summarized in Appendix I.

FIGURE 5. IMPORTANT MEASURE GAPS IN MAP'S FIVE HIGH-LEVERAGE OPPORTUNITY AREAS



Resolving Prioritized Measure Gaps

Many measurement gaps exist because of the difficulties inherent in measurement. The field is still evolving strategies to address data reliability, risk adjustment, small sample sizes, insufficient or evolving evidence base, reporting burden, and other challenges. Resolving the gaps will require a mix of short-term and long-term strategies. NQF and MAP offer multiple avenues through which the quality measurement enterprise can be guided to be more responsive to the needs of vulnerable populations. These avenues include new calls for measures through the NQF **Consensus Development Process** (CDP), annual measure updates, and measure maintenance reviews. Appendix J provides further information about those processes.

Additional Themes from Public Comment

Comments from NQF Members and the public reinforced the importance of filling gaps in available measures, particularly in the areas of access to care, patient-centered care coordination, and team-based accountability. Comments also noted the quality improvement opportunity and measure gap related to timely referral to specialist care, particularly for nephrology care before kidney failure.

As previously discussed, comments requested more emphasis on measures to address the affordability of care. NQF has recently endorsed a set of resource use measures; however, the population-oriented measures of total resource use and total cost are designed to be used in a commercially insured population in which each beneficiary is assigned a primary care provider. MAP recognizes this as an important measure gap, and future work is expected to focus more explicitly on cost, efficiency, and appropriateness of resource use.

Comments also noted a potential implementation gap because of the existence of multiple measures of medication reconciliation. These measures target different points in the continuum of care and differ with respect to timeframes, age groups, and types of medications reconciled. Comments suggested that measure developers work to harmonize these elements so that the related measures can be used together more reliably. Despite the existence of these measures of medication safety, others are needed to expand the focus to a more comprehensive and ongoing process of medication management. MAP members voiced strong support for measure development that would capture the success of regularly conducted assessments of individuals' medications. Comprehensive medication management was proposed to include a determination that each medication is appropriate, effective, safe in the context of co-morbidities and other drug, and able to be accessed and taken as intended over time.

MAP identified "Suicide risk assessment for any type of depression diagnosis" as a gap area in Table 5, above. One comment clarified that this gap is in the process of being addressed. The American Medical Association-convened Physician Consortium for Performance Improvement (AMA-PCPI) is updating its depression measure set, and one measure is expected to focus on suicide risk assessments involving a new diagnosis or recurrent episode of depression.

LEVELS OF ANALYSIS AND POTENTIAL APPLICATIONS OF MEASURES

MAP's work in identifying appropriate measures for use with the dual eligible population has been challenged by the fact that there are many potential ways to apply measures. Each potential use of measures has its own purpose, resource constraints, type of authority or influence, and data capabilities. Although the MMCO will play a dominant role in directing large-scale quality improvement activities for the foreseeable future, no single entity is fully accountable for the delivery of care to dual eligible beneficiaries. Given the diffuse accountability, MAP has grappled with the questions of where and how measurement currently occurs and might occur in the future to align incentives and create shared accountability. A number of likely scenarios have emerged.

Federal Government

At the federal level, the MMCO has expressed multiple needs for measurement. MAP proposes the measures presented in this report as candidates for these initiatives. Primarily, the MMCO will continue to pursue its Congressional mandate to improve the experience of care for dual eligible beneficiaries. It is likely to use year-over-year comparisons and other methods to monitor progress and direct continuing activities to the most fruitful areas.

Efforts have been under way at CMS to link a comprehensive database of Medicare and Medicaid claims data from which to draw measurement information. The MMCO has also proposed the addition of 13 new condition flags in the CMS Chronic Condition Warehouse (CCW). These new flags will allow for a better understanding of conditions particularly affecting the dual eligible population, including many major mental illnesses, substance use, and HIV/AIDS. Because information about dual eligible beneficiaries is generally captured in Medicare and Medicaid quality data reported to CMS, the MMCO may also consider stratifying information about dual eligible beneficiaries within measures reported to CMS for other programs. Current programs collect and publish quality data from nursing homes, dialysis facilities, home health agencies, and many other types of care providers.

The MMCO and selected states have also established demonstration grants to integrate care and improve quality for the dual eligible population. As an accompaniment to a broader evaluation strategy that will assess cost-effectiveness, measures that evaluate the success of the new models and ensure that beneficiaries are not negatively affected by the new programs will be needed. In parallel with national efforts, individual states are likely to use individualized sets of measures for quality assurance. Each state is expected to select measures that reflect the unique design of its demonstration and its data capabilities. This is an important opportunity for state initiatives to serve as test beds for evaluating new and emerging quality measures.

National Research Entities

To date, most of the strongest research and analyses on dual eligible beneficiaries and their care have been performed by independent national organizations. For example, MedPAC has begun to routinely publish data on this population as part of its role in advising Congress on Medicare payment policy. These rich analyses have drawn on claims data, surveys, site visits, and other sources. Similarly, private foundations such as The Henry J. Kaiser Family Foundation, The SCAN Foundation, and The Commonwealth Fund have also taken up the charge to monitor beneficiaries' access, quality of care, and expenditures to inform policymakers.

The foundation of gray literature and background information generated by these organizations was indispensable to MAP's early deliberations and understanding of the quality issues affecting the dual eligible population. MAP is hopeful that the recommendations in this report will, in turn, inform their future work.

State Governments

The cost-sharing and long-term care benefits provided by Medicaid are crucial to dual eligible beneficiaries. However, state governments have been particularly challenged in identifying quality measurement strategies. Resources are strictly limited, and healthcare insurance and delivery systems are in the process of being thoroughly redesigned. States often have their own data collection tools, surveys, forms, and procedures. Many may even use homegrown quality measures. States also lacked the ability to access Medicare Parts A, B, and D data until very recently and are beginning the process of exploring and integrating this information to facilitate care coordination for dual eligible beneficiaries.

Although each state's approach will need to be customized based on the local environment, MAP offers the information in this report as a potential framework and a starting place for measure selection. In addition, this report begins to provide a foundation for aligning improvement efforts and developing the ability to benchmark outcomes. States are encouraged to focus on measures related to long-term supports and services, beginning with those that are already publicly reported, before branching into other areas.

Health Plans and Providers

Private-sector entities such as health plans and provider networks work in partnership with Medicare and Medicaid to serve dual eligible beneficiaries. Emerging accountable care organizations offer promising models for serving dual eligible beneficiaries in a coordinated, integrated way. Managed care plans, particularly Medicare Advantage SNPs that target this population, are also important partners in assuring high-quality care. Current measurement activities in SNPs are focused on applying HEDIS and Structure and Process Measures established by the National Committee for Quality Assurance (NCQA). One of those measures, SNP 6: Coordination of Medicare and Medicaid Coverage, is included in the core measure set with the suggestion that the concept be examined for potential use in other health plans, delivery systems, and other applications.

Comments received from health plan stakeholders urged that the approach to measuring the quality of care received by dual eligible beneficiaries not duplicate current reporting requirements. Stakeholders suggested that CMS may need to re-evaluate current programs in light of emerging models, noting that many HEDIS measures currently used to evaluate SNPs are better suited for the commercially insured population than the complex and heterogeneous dual eligible population.

Additional Themes from Public Comment

As described above, MAP considered many scenarios for applying performance measures to the dual eligible beneficiary population. Comments revealed that this issue is also very important to health plans, practitioners, and other stakeholders. The issues of shared accountability and attribution deserve careful consideration; comments asked that measures only be assigned to an entity that has significant opportunity to affect the result. At the same time, comments acknowledged the complicated context in which measurement operates. A seemingly infinite list of factors influences population health outcomes. For dual eligible beneficiaries these factors include socioeconomic concerns, variation in state Medicaid benefits, provider networks, ease of navigating the eligibility system, and disease burden, to name a few. Identifying a valid comparison population or baseline will be difficult. One comment requested that data on the dual eligible beneficiary population be compared to a matched set of similar individuals.

MEASURE ALIGNMENT ACROSS FEDERAL PROGRAMS

Contributions of the Dual Eligible Beneficiary Perspective to MAP's Pre-Rulemaking Deliberations

HHS identified the dual eligible population as a priority consideration for MAP's first round pre-rulemaking deliberations, published in February 2012. Although this is just one of many populations that could greatly benefit from a purposeful person- and family-centered approach to care and quality measurement, the perspective of the dual eligible population provided an enlightening case study in promoting aligned performance measurement.

Federal measurement programs have traditionally focused on a single setting or type of healthcare, such as inpatient hospital care or skilled nursing facility care, rather than a population of consumers. Recognizing that numerous, isolated programs have limited ability to reflect healthcare quality across the continuum, newer initiatives such as the Medicare Shared Savings Program have expanded the scope of measurement across settings and time while promoting shared accountability for a defined population. This is the beginning of a vital shift toward integrated healthcare delivery and performance-based payment policy.

Dual eligible beneficiaries are served in every part of the healthcare and long-term care systems, but there is not currently a dedicated federal measurement program to monitor the overall quality of their care. Many measures are applied to care provided to the dual eligible population, but they are deployed through a variety of isolated programs run by government entities and private health plans. While CMS' MMCO and state demonstration grantees explore measurement options, MAP has helped to drive alignment across existing programs by considering the population's needs across settings of care. Specifically, MAP has examined measures under consideration for addition to 18 existing programs and favored the use of those relevant to dual eligible beneficiaries. This guidance was summarized in MAP's pre-rulemaking input to HHS.[25] In its continuing role of providing pre-rulemaking input annually, MAP will pursue alignment across federal programs while ensuring that the unique needs of Medicare-Medicaid dual eligible beneficiaries receive attention and measurement.

Complementing Efforts on Medicaid Adult Measures

Until recently, federal performance measurement programs have primarily related to the Medicare program. In an important step forward, ACA required HHS to establish an initial core set of healthcare quality measures for Medicaid-eligible adults. Seeking to complement, but not duplicate, efforts in Medicaid measurement, MAP followed the progress of this initiative from the outset. After publication of the Medicaid adult core measure set in January 2012, MAP further considered the relationship between the two efforts.[26]

Although any effort to measure Medicaid beneficiaries would involve the dual eligible population by definition, it is important to note that individuals who are dually eligible account for fewer than one in three Medicaid enrollees. Logically, the initial core measure set for Medicaid reflects the different healthcare needs of low-income adults in addition to more complex dual eligible beneficiaries. For example, the set includes four measures of reproductive health services that are very important to Medicaid-only enrollees but of limited utility in the dual eligible population. In terms of overlap between the two sets of measures, five measures appear in both the Medicaid adult core list and MAP's

list of appropriate measures for dual eligible beneficiaries (NQF Measures 0004, 0006/0007, 0418, 0576, 0648). Where possible, MAP recommends stratification of these measures to enable comparison between dual eligible beneficiaries and Medicaid-only beneficiaries. Stratification is a strategy also supported by stakeholders in their submitted comments.

A second consideration for the Medicaid measurement effort is that it is largely focused on ambulatory and hospital services, including prevention and health promotion, management of acute conditions, and management of chronic conditions. However, dual eligible beneficiaries generally receive coverage for those services through Medicare. Medicaid serves as the primary payor for long-term services and supports. This benefit design complicates the availability of data to evaluate dual eligible beneficiaries' care experiences through the Medicaid quality measurement program. There are no long-term care measures in the Medicaid adult core set.

Additional Themes from Public Comment

Comments strongly recommended that state and federal measurement programs should be consistent across programs and levels of analysis. In addition, policymakers should ensure that reporting requirements are not duplicated. Stakeholders participating in MAP shared these concerns. MAP's input to HHS seeks to identify measures and measurement approaches that support alignment, which may be particularly important with emerging programs including Meaningful Use incentives, health home initiatives, accountable care organizations, and other efforts described in MAP's work.

Stakeholders also recognized the need to align measurement for dual eligible beneficiaries with measurement being implemented in end stage renal disease (ESRD) facilities. Citing different sources, comments noted that between 25 percent and 40 percent of ESRD patients are dual eligible beneficiaries. MAP has separately recommended a set of measures for use in the ESRD Quality Incentive Program (QIP) that considered the unique needs of the dual eligible population.[27] In addition to the condition-specific measures that comprise the bulk of that set, MAP recommended the use of a measure that asks providers to assess individuals' health-related quality of life. That measure is identified in this report as a part of the core measure set, bridging the two efforts. MAP agreed with comments indicating that the care of beneficiaries with ESRD should be evaluated with separately adopted renal measures. It would be informative to stratify ESRD QIP and other data to separately examine the experience of dual eligible beneficiaries compared to other populations.

Future Opportunities

Much work remains before MAP's vision for high-quality care for dual eligible beneficiaries will be fully realized. Understanding the limitations of the current environment, this report seeks to jump-start a long-term effort to ensure that all major points in the healthcare system accessed by dual eligible beneficiaries are using performance measures that motivate providers to address the unique needs of this population.

Going forward, MAP will seek to provide more clarity around program alignment and the current and potential uses of measures in the field, updating its guidance as necessary to inform the many stakeholders working to improve quality. MAP will continue to search for answers to implementation questions, increasing transparency around why, where, and how public- and private-sector stakeholders use measures to improve quality. With concerted effort, one day it will be possible to form a complete picture of the quality of care that dual eligible beneficiaries receive, drawing on measures from different sources and combining them into a meaningful whole.

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APPENDIX A:
MAP Background

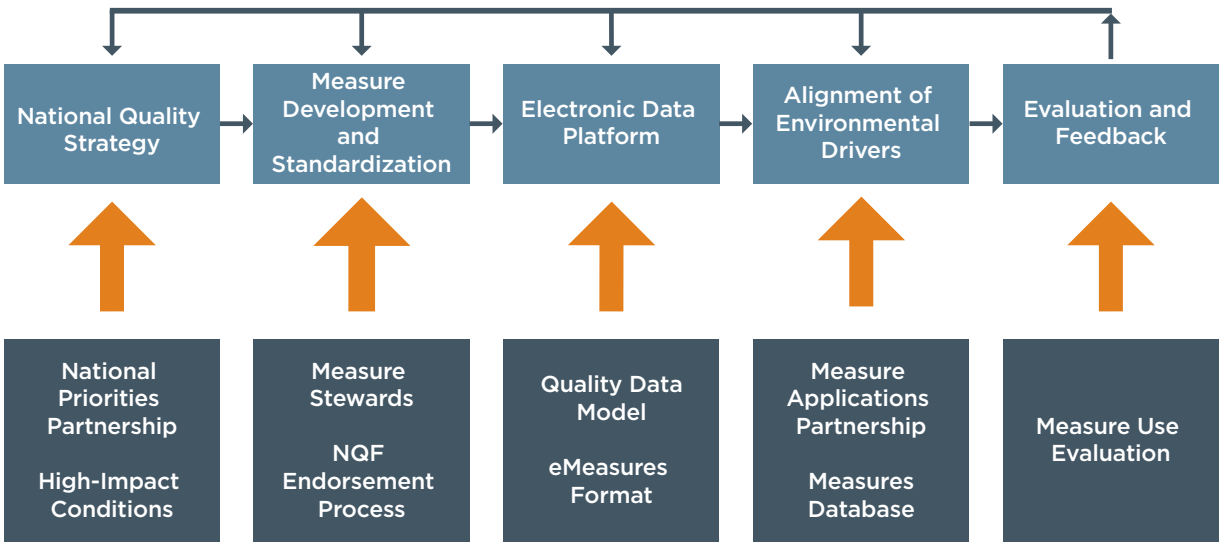
Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency, aligning payment with value, rewarding providers and professionals for using health information technology (HIT) to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare.

Foundational to the success of all of these efforts is a robust "quality measurement enterprise" (Figure A-1) that includes:

- Setting priorities and goals for improvement;
- Standardizing performance measures;
- Constructing a common data platform that supports measurement and improvement;
- Applying measures to public reporting, performance-based payment, health IT meaningful use programs, and other areas; and
- Promoting performance improvement in all healthcare settings.

FIGURE A-1. FUNCTIONS OF THE QUALITY MEASUREMENT ENTERPRISE



The National Priorities Partnership (NPP) is a multi-stakeholder group convened by NQF to provide input to HHS on the NQS, by identifying priorities, goals, and global measures of progress.[1] Another NQF-convened group, the Measure Prioritization Advisory Committee, has defined high-impact conditions for the Medicare and child health populations.[2] Cross-cutting priorities and high-impact conditions provide the foundation for all of the subsequent work within the quality measurement enterprise.

Measure development and standardization of measures are necessary to assess the baseline relative to the NQS priorities and goals, determine the current state and opportunities for improvement, and monitor progress. The NQF endorsement process meets certain statutory requirements for setting consensus standards and also provides the resources and expertise necessary to accomplish the task. A platform of data sources, with increasing emphasis on electronic collection and transmission, provides the data needed to calculate measures for use in accountability programs and to provide immediate feedback and clinical decision support to providers for performance improvement.

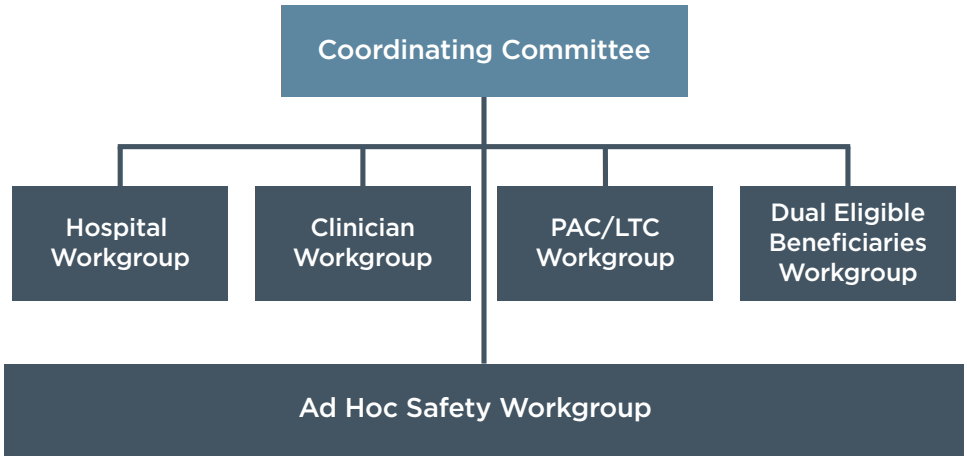
Alignment around environmental drivers, such as public reporting and performance-based payment, is MAP's role in the quality measurement enterprise. By considering and recommending measures for use in specific applications, MAP will facilitate the alignment of public- and private-sector programs and harmonization of measurement efforts under the NQS.

Finally, evaluation and feedback loops for each of the functions of the quality measurement enterprise ensure that each of the various activities is driving desired improvements.[3,4] Further, the evaluation function monitors for potential unintended consequences that may result.

Function

Composed of a two-tiered structure, MAP's overall strategy is set by the Coordinating Committee, which provides final input to HHS. Working directly under the Coordinating Committee are five advisory workgroups responsible for advising the Committee on using measures to encourage performance improvement in specific care settings, providers, and patient populations (Figure A-2). More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies (*ex officio* members) are represented on the Coordinating Committee and workgroups.

FIGURE A-2. MAP STRUCTURE



The NQF Board of Directors oversees MAP. The Board will review any procedural questions and periodically evaluate MAP's structure, function, and effectiveness, but will not review the Coordinating Committee's input to HHS. The Board selected the Coordinating Committee and workgroups based on Board-adopted selection criteria. Balance among stakeholder groups was paramount. Because MAP's tasks are so complex, including individual subject matter experts in the groups also was imperative.

All MAP activities are conducted in an open and transparent manner. The appointment process included open nominations and a public comment period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

MAP decision making is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the high-impact conditions determined by the NQF-convened Measure Prioritization Advisory Committee, the NQF-endorsed® Patient-Focused Episodes of Care framework,[5] the HHS Partnership for Patients safety initiative,[6] the HHS Prevention and Health Promotion Strategy,[7] the HHS Disparities Strategy,[8] and the HHS Multiple Chronic Conditions framework.[9] Additionally, the MAP Coordinating Committee has developed measure selection criteria to help guide MAP decision making.

One of MAP's early activities was the development of measure selection criteria. The selection criteria are intended to build on, not duplicate, the NQF endorsement criteria. The measure selection criteria characterize the fitness of a measure set for use in a specific program by, among other things, how closely they align with the NQS's priority areas and address the high-impact conditions, and by the extent to which the measure set advances the purpose of the specific program without creating undesirable consequences.

Timeline and Deliverables

MAP's initial work included performance measurement coordination strategies and pre-rulemaking input on the selection of measures for public reporting and performance-based payment programs. Each of the coordination strategies addresses:

- Measures and measurement issues, including measure gaps;
- Data sources and health IT implications, including the need for a common data platform;
- Alignment across settings and across public- and private-sector programs;
- Special considerations for dual eligible beneficiaries; and
- Path forward for improving measure applications.

On October 1, 2011, MAP issued three coordination strategy reports. The report on coordinating readmissions and healthcare-acquired conditions focuses on alignment of measurement, data collection, and other efforts to address these safety issues across public and private payers.[10] The report on coordinating clinician performance measurement identifies the characteristics of an ideal measure set for assessing clinician performance, advances measure selection criteria as a tool, and provides input on a recommended measure set and priority gaps for clinician public reporting and performance-based payment programs.[11] An interim report on performance measurement for dual eligible beneficiaries offers a strategic approach that includes a vision, guiding principles, characteristics of high-need subgroups, and high-leverage opportunities for improvement, all of which informed the content of this final report.[12]

On February 1, 2012, MAP submitted the *Pre-Rulemaking Final Report* and the *Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement Report*. The

Pre-Rulemaking Final Report provided input on more than 350 performance measures under consideration for use in nearly 20 federal healthcare programs.[13] The report is part of MAP's annual analysis of measures under consideration for use in federal public reporting and performance-based payment programs, in addition to efforts for alignment of measures with those in the private sector. The *Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement* report made recommendations on aligning measurement, promoting common goals for PAC and LTC providers, filling priority measure gaps, and standardizing care planning tools.[14]

Additional coordination strategies for hospice care and cancer care will be released in June 2012, concurrent with this report.

Endnotes

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APPENDIX B:
Roster for the MAP Dual Eligible Beneficiaries Workgroup

CHAIR (VOTING)
Alice Lind, MPH, BSN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
Better Health Greater Cleveland	Patrick Murray, MD, MS
Center for Medicare Advocacy	Patricia Nemore, JD
National Health Law Program	Leonardo Cuello, JD
Humana, Inc.	Thomas James, III, MD
L.A. Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National PACE Association	Adam Burrows, MD

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Substance Abuse	Mady Chalk, MSW, PhD
Emergency Medical Services	James Dunford, MD
Disability	Lawrence Gottlieb, MD, MPP
Measure Methodologist	Juliana Preston, MPA
Home & Community-Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Medicare-Medicaid Coordination Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
HHS Office on Disability	Henry Claypool
Substance Abuse and Mental Health Services Administration	Rita Vandivort-Warren, MSW
Veterans Health Administration	Daniel Kivlahan, PhD

MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

APPENDIX C:
Roster for the MAP Coordinating Committee

CHAIR (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Gerald Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Doris Peter, PhD
Federation of American Hospitals	Chip N. Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Association of Medicaid Directors	Foster Gesten, MD
National Partnership for Women and Families	Christine Bechtel, MA
Pacific Business Group on Health	William Kramer, MBA

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Joseph Betancourt, MD, MPH
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services	Patrick Conway, MD MSc
Health Resources and Services Administration	Ahmed Calvo, MD, MPH
Office of Personnel Management/FEHBP	John O'Brien
Office of the National Coordinator for HIT	Kevin Larsen, MD

ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
American Board of Medical Specialties	Christine Cassel, MD
National Committee for Quality Assurance	Peggy O'Kane, MPH
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

APPENDIX D:
Public Comments Received on Draft Report

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Report	Academy of Managed Care Pharmacy	Edith Rosato	The Academy of Managed Care Pharmacy commends the Measure Application Partnership for developing this report, which takes a comprehensive, person-centered approach to the dual-eligible population. The report presents both the opportunities and challenges inherent in measuring care received by Medicare-Medicaid enrollees. As noted by the MAP, measurement alone cannot fix the fragmentation in the health care system but measurement will serve as a signaling system to emphasize aspects of care that are in need of improvement.
General Comments on the Report	American Nurses Association	Maureen Dailey	The ANA compliments this comprehensive, thoughtful report developed under the skillful leadership of Alice Lind in leading the MAP's Dual Eligible workgroup. There are high-leverage opportunities for improvement through measurement. The ANA supports the five identified opportunity areas by the MAP for this population: quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures. The ANA respectfully requests that the MAP use clinician neutral language throughout the document to replace discipline-centric language (e.g., "Capacity for a physician practice to serve as a medical home", p.2) to reflect national targets to improve access, quality, and cost efficiency a noted in the recent IOM report. To maximize the opportunities to improve quality, patient engagement, and reduce cost, it is important for the MAP to catalyze filling the measure gaps, particularly in the areas of patient-centered care coordination and team-based accountability for screening and assessment and harm reduction (e.g., avoidable conditions such as falls, pressure ulcers).
General Comments on the Report	American Psychiatric Institute for Research and Education	Robert Plovnick	The APA is pleased with the inclusion of mental health and substance use as a high-leverage opportunity area with corresponding measure topics. We also strongly support the identification of appropriate screening measures with the acknowledgement of the need for follow-up and treatment for behavioral health conditions. The APA strongly supports the use of NQF #0557: HBIPS-6 Post discharge continuing care plan created and NQF #0558: HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge, but suggests they should only be implemented and reported as a pair. It is within the discharging hospital's control that the discharge continuing care plan be included in the patient's chart upon departure. However, transmission of these records, while critical for quality, is dependent on receipt by the next setting of care and is therefore partially beyond the institution's direct control. By pairing these measures, accountability and quality improvement are better balanced. It might be of interest to know that of the measure gaps listed in Table 5, one gap area "Suicide risk assessment for any type of depression diagnosis" should hopefully be addressed soon. PCPI is currently in the process of updating its MDD measure set and creating new MDD measures, one of which will focus on suicide risk assessments involving new diagnosis or a recurrent episode of depression.

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General Comments on the Report	America's Health Insurance Plans	Carmella Bocchino	We applaud the effort by the Measures Application Partnership (MAP) to bring together experts from many disciplines in the development of this strategic framework for dual eligible performance measures. Overall, this is an important initiative that has the potential to improve health outcomes while also reducing the rate of healthcare spending among the dual eligibles, a population that includes some of the highest utilizers of healthcare resources and drives much of the current public sector healthcare costs. We believe this report is an excellent first step in attempting to establish a longitudinal analysis for the quality of care for this population and an opportunity to move away from programs that have focused on site of care or disease specific conditions. AHIP supports the final report of the MAP to Performance Measurement for Dual Eligible Beneficiaries to better facilitate achievement of the three-part aim for this population. For this initiative to be successful effective engagement of providers and patients is critical. This can be achieved through a number of interventions including patient outreach and education, appropriate provider incentives, and value-based benefit design.
General Comments on the Report	Association for Community Affiliated Plans	Mary Kennedy	The Association for Community Affiliated Plans (ACAP) is pleased to submit this letter of comment and support for the Measures Application Partnership (MAP) on "Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS". We like the thoughtful "person-centered not program -centered" approach. We recognize that the primary audience for this report is the Medicare-Medicaid Coordination Office (MMCO) and recommend that the MMCO promote the report and its recommendations throughout CMS. Like the development of HHS' core set of health quality measures for adults, we note the attempt to be parsimonious and urge CMS to not make this approach for duals additive to other measurement approaches. We especially urge that the STARS measurement in Medicare Advantage for D-SNPs and the SNP Structure and Process Measures be completely re-evaluated in line with this report. We support the MAP's discussion about the relationship to some, but not all, of the Adult Core Measures for the Duals population and agree that stratification by Medicaid-only and Dual eligible is appropriate for the overlapping measures. We are concerned that the report includes many provider level measures, but only three at the health plan level. Health plan measures used now to evaluate SNPs are not well tailored to the dual population. Thank you for convening such an expert panel and preparing such a thorough report.
General Comments on the Report	Federation of American Hospitals	Jayne Chambers	The Federation of American Hospitals commends the Workgroup for its thorough evaluation of the many challenges facing the dual eligible beneficiary population. We support the vision for high-quality care, agree that the starter set of measures should be limited and coordinated with measures used in other programs, and encourage additional work be done to improve coordinate across settings. Our experience in developing quality measurement programs in other settings is that a focused, limited set of measures that sets a framework for reporting and measurement is essentially for establishing long-term program that will produce positive change over time. Any new quality program will need to be adjusted as implementation challenges are encountered. We also support the the Guiding Principles outlined in the report. In particular, the stratification of measures will be very important for understanding the effects of quality improvement efforts.

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General Comments on the Report	Metropolitan Jewish Health System	Jeannie Cross	MJHS, which has over a century of experience caring for frail, chronically ill elderly persons in the New York City metro area, applauds the performance measurements for dual eligibles proposed through the Measure Applications Partnership (MAP) of the National Quality Forum (NQF) with one recommended addition. Besides providing skilled nursing, home health, hospice, palliative and adult day health care, MJHS encompasses a Medicaid Managed Long Term Care Plan (MLTCP), Medicare Advantage, MA Special Needs Plans and Medicaid Advantage Plus.. OVerall, we serve more than 40,000 individuals annually. Based on our long and deep experience serving dual eligibles, we support the MAP principles and proposals for performance measurements for dual eligibles and have recommended that the proposed Starter Set be incorporated into New York State's application for the federal demonstration in integrated care for dual eligibles. However, we wish to also recommend that a nursing home utilization measure be added to the Starter Set. Preventing and/or delaying nursing home use is at least as important an indicator of good care management as reducing unnecessary hospitalizations. Furthermore, it is a measure that is comparable to fee-for-service care.
General Comments on the Report	National Kidney Foundation	Dolph Chianchiano	The report notes that navigating two differing health insurance benefit structures is a challenge to individuals who are Dually Eligible. As a result of Medicare's new "bundled" prospective payment system for dialysis services, that challenge has recently become more complicated for Dual Eligibles with kidney failure who rely on chronic dialysis treatments to survive. To the extent that there is a disconnect between the new Medicare reimbursement policy and Medicaid benefits, quality of care and quality of life may be affected. This could be exacerbated when certain oral drugs that are currently available under the Medicare prescription drug program with "extra help" are shifted to the bundled prospective payment system in 2014.
General Comments on the Report	National Patient Advocate Foundation	Nancy Davenport-Ennis, Rene Cabral-Daniels	NPAF encourages MAP to consider its recommendations and to recognize they are submitted with great respect for the patient-centric approach. In 2011, millions of individuals contacted PAF for assistance in accessing quality care, and PAF resolved more than 110,000 patient cases. Although insured, dual eligible beneficiaries reported considerable debt crisis and challenges in receiving covered insurance benefits. Debt crisis/cost of living issues reported by almost half of dual eligible beneficaires included inability to afford transportation, utilities, housing, food, and medical supplies not covered by insurance. The measurement of healthcare quality should include the challenges the dual eligible population faces in accessing the medical services that they need. The approach assumes the dual eligible population is receiving the care they need and does not account for barriers in accessing care. For example, the prioritized list demonstrates concepts of critical importance to the dual eligible population: care that is responsive to patients' experiences and preferences, the need for follow-up, treatment for behavioral health conditions, and ongoing management of health conditions and risks. Each concept assumes the patient has been successful in accessing necessary care.

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General Comments on the Report	Pacific Business Group on Health	Christine Chen	CPDP appreciates the workgroup's emphasis on patient values, health status, care coordination, health equity, and other critical areas. We encourage the workgroup to take a more proactive stance on the need for measures of cost and efficiency of resource use. One way to do that would be for cost and resource use issues to be incorporated into the report's guiding principles. We agree that appropriate screening and assessment are important. However, while it is important that patients are assessed for a variety of considerations (e.g., pain, mobility, quality of life), it isn't enough just for a provider to document that an assessment took place as it tells us little about the quality of care. Instead the goal needs to be to capture the results from the assessment -i.e., the patient's actual health status. That way, providers and others can better understand whether patients are improving and/or, in other cases (e.g., dementia) whether a disease's progression is at least slowing down. We ask the work group to include these points in the report.
General Comments on the Report	Pacific Business Group on Health	Christine Chen	We are concerned about the recommendation on structural measures. There are some structural measures -- such as those related to care coordination -- which may help advance organization of care in doctors' offices, medical care groups and hospitals in a way that better supports patient-centered care. However, structural measures often reflect minimum standards, i.e. the necessary qualifications, rather than the standards that would be sufficient to ensure or foster meaningful improvements in the quality of care. We ask the work group add language in the report to reflect these concerns with structural measures.
General Comments on the Report	PhRMA	Jennifer Van Meter	PhRMA supports the initial Core Set of measures that the MAP identified for the dually eligible patient populations. We agree that the measures target high leverage areas that, with improvement, can result in improved quality of care, quality of life and health outcomes.
General Comments on the Report	Renal Physicians Association	Robert Blaser	RPA urges the MAP to recognize the large percentage of dual eligible patients with end stage renal disease (ESRD). Per 2009 USRDS data, dual eligible patients made up slightly more than 25% of the total ESRD population - 147,223 of 571,414 patients (including transplant patients). Thus, this is an important group that should be identified in the MAP's report.
General Comments on the Report	SNP Alliance (NHPG)	Valerie Wilbur	Ensure measures aren't layered on top of existing reporting requirements. promote core measures, consistent with principle of parsimony. Give more emphasis to aligning existing measures between Medicare and Medicaid. Investigate use of outcome measures as a complement to starter set, including hospitalization rates, emergency room visits, adverse drug events, and long-stay nursing home use. Identify different ways to reward performance. Link report to NQF MAP work on multiple chronic conditions and critical importance of aligning with dual measures. Allowing care system or plan to exclude individuals from measures when they are not applicable or appropriate and may be harmful. Many clinical measures are not applicable as a single disease and need to take into account impact of comorbidities on outcomes. Burden and risks of over-treatment must be considered in relation to outcome markers. MAP recommendation on need for optimal composite measures must include qualifier that there be an ability to have a different endpoint for treatment of frail and significantly functionally impaired. Existing HEDIS measures are an example of a bad fit for duals. Must consider unintended consequences of over treatment with no added value.

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General Comments on the Report	WellCare Health Plans, Inc.	Elizabeth Goodman	In absence of a comprehensive measurement set that addresses the complexity of health issues and support services common to those in LTC settings, the use of a subset of NCQA endorsed metrics, particularly HEDIS metrics, is the preferred approach. These valid and reliable measures can be applied to Acute, LTC or Community Based Settings. The majority of the 24 proposed HCBS measures rely on member perception to measure performance. While we understand the importance of including member perception measures, we recommend that any validated set of HCBS metrics include a mix of process, screening, and outcome measures, based on objective provider or health plan data. WellCare recommends NQF support a 2-step strategy for identifying an endorsed measurement set for HCBS. For current MLTC and Duals programs, use a subset of nationally recognized HEDIS measures that plans are already collecting to address short term quality measurement needs for HCBS participants (e.g. use of a subset of HEDIS measures that focus on preventive care screenings and care delivery processes for common health conditions like diabetes, cardiovascular disease, alcohol or other drug dependence, and mental illness). For future programs support a thorough, transparent, and population focused approach to develop new HCBS metrics. Identify and utilize the best available measures currently in use across the acute, chronic, and LTC delivery continuum.
General Comments on the Report		Clement McDonald	These are thoughtful and in many cases useful measures, but many of them will require nurse or provider time which in total could represent major time and expenses. Primary and geriatric care providers work under very tight resource constraints and they could be fiercely stretched if they had to absorb all of this additional time/dollar cost. Many of the proposed measures require additional data collection but the proposal does not report the number of new fields that would have to be completed or the effort that might be needed to collect them so it is not possible to quantify the size of the new load. If the cost of this load exceeds more than a few percentage points of the income obtained from the care provided, it could have serious effects on provider sign up for meaningful use -- which would be a shame because of the many advantages that other portions of the Meaningful use guidelines could produce. It would also cause more care providers to withdraw from the care of Medicaid and/or Medicare patients.
General Comments on the Report		Clement McDonald	Of course some of the report presents very general and laudable goals; some are very actionable, and practical (e.g. efforts to reduce smoking), but are already part of the proposed measures in the proposed rule. It would ease the burden of commenters if the items being proposed could be segregated into those that are unique to the dual eligible population, versus those that are already part of general meaningful use.
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	American Geriatrics Society	Susan Sherman	The American Geriatrics Society (AGS) believes that the workgroup has presented a solid conceptual framework in this draft report. We support inclusion of the transitions measure, as well as the focus on measuring readmissions and medical homes. These measures are critical for the complex comorbid population that the American Geriatrics Society serves. We think it would be beneficial to list the goals of care for the Dual Eligibles population, just as the draft report on Hospice and Palliative Care has done. These goals include: Access and Availability of Services; Patient- and Family- Centered Care; Goals and Care Planning; Care Coordination; Provider Competency; and lastly, Appropriate/Affordable Care.

Comment Category	Commenter Organization	Commenter Name	Comment
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	America's Health Insurance Plans	Carmella Bocchino	We support the high leverage areas identified and recommend addition of cost of care and resource use measurement. Certain measures such as 0418, 0729, and 0101, require chart review and are resource intensive. Measures relying on chart review should be administered as part of existing data collection efforts e.g. HEDIS. While we support inclusion of measure 0028, the patient survey needs to be available in different languages to address needs of a diverse population. Measure 0494 is valuable, but the complexity of the survey may make consistent and reliable data collection challenging. While measure 0209 is valuable, effect of patient preferences in pain management needs to be monitored to identify additional future exclusions. Implementing interventions that result in an improvement in measure 0430 is challenging. Also, data for patients such as those with Alzheimer's will need to be collected from caregivers. Currently, multiple measures of medication reconciliation assess reconciliation at different points along the care continuum. These measures differ with respect to timeframes, age groups, and medications reconciled. Measure developers need to harmonize these elements across different measures. While the HCBS measures that assess friendships are important, plans do not have the capabilities for implementing such measures. HCBS metrics should include process and outcome measures based on objective data.
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	AMGEN Inc.	Sharon Isonaka	The KDQOL-36 measure is a valid and reliable instrument used to measure health-related quality of life (HRQOL) for individuals with end-stage renal disease (ESRD) undergoing dialysis. Dialysis often necessitates significant life-style changes, altering patients' eating and sleeping habits as well as daily activities and therefore significantly affects patients' day to day quality of life. HQROL scores have shown to be a predictor of hospitalization and death among dialysis patients (Lowrie 2003, Mapes 2003, DeOreo 1997) and therefore, are a critical outcome in ESRD care. As such, CMS now requires dialysis facilities to assess dialysis patient HRQOL yearly using the KDQOL-36 measure as part of their Medicare Conditions for Participation. Altering the measure or instrument may diminish the power and usefulness of the instrument. Therefore, the measure (#0260) should not be expanded beyond ESRD. Amgen does agree that to be meaningful the KDQOL-36 should be reconstructed as an outcome measure. Amgen also recommends NQF task a measure steward to develop a new HRQOL instrument and measure that could include other types of care as appropriate for measuring HRQOL in the dual-eligible patient population using the KDQOL survey as a template.
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	Association for Community Affiliated Plans	Mary Kennedy	ACAP supports the framework of a starter set of measures. We are concerned that not all measures are the standard HEDIS approach. For example, the diabetes measure is not the NCQA measure, but pulled from another measure set that is not widely used, We also have concerns about including CAHPS in this set rather the expansion set .There are serious limitations in the CAHPS system for duals including the underlying downward case-mix adjustment to the raw satisfaction scores of all duals. This is problematic if a plan has an all- dual enrollment and is being compared to a plan with only some duals. And, it is quite possible that duals are enrolled in plans with better customer service and care management approaches that deserve the more positive response. We urge that CMS work with AHRQ to look more closely at that case-mix adjustment. We also note that CAHPS is not available in languages other than Spanish and English; D-SNP plans enroll a large number of duals who do not speak either language and are unable to complete the CAHPS. CAHPS is also problematic for people with limited literacy, cognitive impairment or advanced illness.

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Appropriate Measures for Use with the Dual Eligible Beneficiary Population	Association for Community Affiliated Plans	Mary Kennedy	All measures should have clear guidelines on populations which should be excluded It is crucial that exclusion criteria refer to those over age 85, those with life limiting conditions and on hospice or formal palliative care programs. These latter groups should not be expected to continue otherwise age appropriate screening measures and evidence based treatment. The balance of benefit vs. burden and member-centeredness requires that these subsets of dual members not be included in the denominator for comparing duals with non-dual plans and also that dual-to-dual comparison be adjusted by excluding those over age 85, those in palliative care and in hospice.
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	Association for Community Affiliated Plans	Mary Kennedy	Screening and Assessment Good screening and assessment tools are key to balancing consumer needs with available funding for care especially in consumer directed models. We urge more development work in this area. Mental Health and Substance Abuse We liked that the MAP report recognizes serious psychiatric conditions as well as the co-occurring chronic conditions. Crisis intervention services are also a crucial factor in good care for this population.
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	GlaxoSmithKline	Deborah Fritz	GSK supports the proposed measurement domains for evaluating care in the dual eligible population and supports the proposed Core Set and Starter Set of measures. We are pleased to see the inclusion of patient-oriented Quality of Life (functional status), care transitions, medication reconciliation, hospital readmissions, prevention and chronic disease. To strengthen the measures we strongly recommend transition from medication reconciliation to Comprehensive Medication Management (CMM) measures to improve patient progress to clinical goals of therapy that could result in overall cost reductions. CMM ensures each patient's medications are individually assessed to determine that each medication is: appropriate for the patient, effective for the medical condition, safe given the co-morbidities and other medications being taken, and able to be taken by the patient as intended. CMM is a process of monitoring the patient's progress to clinical goals. Comprehensive Medication Management includes medication reconciliation but does not stop there.
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	Highmark, Inc.	Leslie Boltey	Highmark appreciates the focused approach to the dual beneficiary population. The dual population represents unique challenges in care coordination and accountability, we support the high leverage opportunities identified for measurement intervention.

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Appropriate Measures for Use with the Dual Eligible Beneficiary Population	National Kidney Foundation	Dolph Chianchiano	As noted, kidney failure or ESRD disproportionately affects Dual Eligible beneficiaries. It is estimated that 40% of U. S. dialysis patients have both Medicare and Medicaid. Therefore, measures monitoring interventions to prevent or delay ESRD should have high priority. Since, according to the CDC, diabetes accounts for 44% of new cases of ESRD, optimal diabetes care should be in the recommended starter set of measures. However, Dual Eligibles with diabetes or hypertension should also be screened for Chronic Kidney Disease (CKD), because CKD is asymptomatic in its early stages but there is an independent, graded association between reduced kidney function, and the risk of death, cardiovascular events, and hospitalization. (A. S. Go, et al. CKD and Risks of Death, Cardiovascular Events, and Hospitalization. NEJM 351:13; September 23, 2004.) NKF's Kidney Early Evaluation (KEEP) program suggests that screening for CKD provides an opportunity to reduce morbidity and mortality in Dual Eligible individuals. KEEP is a health risk assessment program provided at no charge to persons with risk factors for CKD (diabetes, hypertension, or family history of CKD). Since 2000, there were 5,320 KEEP participants with both Medicare and Medicaid coverage. 27.48% of that cohort had lab results indicating reduced kidney function at the level of Stage 3 CKD. 85.3% of those Dual Eligible individuals with reduced kidney function had not had a prior diagnosis of CKD.
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	National Patient Advocate Foundation	Nancy Davenport-Ennis, Rene Cabral-Daniels	While NPAF concurs with MAP's stratified approach, it encourages MAP to consider the merit of an approach that considers impactful measures and the impact should be measured in a patient-specific manner rather than an approach noted for its parsimony. An impactful measure would be one that elicits data regarding how best to restructure the Medicare and Medicaid programs to best serve dual eligible patients by assuring they receive coordinated, quality care. An example would be consistency in benefit eligibility administrative processes.
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	Pacific Business Group on Health	Christine Chen	Starter set We support many of the measures in the starter set (i.e., CAHPS, 3-Item Care Transition Measure, and Optimal Diabetes Care, Plan All-Cause Readmission, and Hospital-Wide All-Cause Unplanned Readmission). The report misses the opportunity to support the National Quality Strategy's focus on cardiovascular care. We recommend that the work group fill this gap by applying either of the following measures: Minnesota Community Measurement's Optimal Vascular Care (NQF #0076) or NCQA's "Controlling High Blood Pressure" (NQF #0018). We urge the work group to add the "Depression Remission at Six Months" (NQF 0710) measure into the final report. The measure was in the interim report and reflects many of the workgroup's priorities (e.g., patient-reported outcomes, mental health, and longitudinal care). It isn't enough to just to screen and create a care plan. We need to measure whether the patient is getting better.
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	PhRMA	Jennifer Van Meter	PhRMA agrees that the five measurement domains identified by the MAP are appropriate for evaluating care in the unique dually eligible patient populations. PhRMA supports the measures that the MAP identified in the Core Set and the Starter Set of measures. We believe that addressing care transitions, medication reconciliation, hospital readmissions, mental health, and chronic disease within this population is critical to improving quality for these beneficiaries. In support of quality of life and population health, we also suggest adding appropriate immunization measures, such as influenza and pneumococcal vaccine measures, as these are both important wellness promoters within older and sicker populations.

Comment Category	Commenter Organization	Commenter Name	Comment
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	Renal Physicians Association	Robert Blaser	The measures for this population of ESRD patients should not be any different than for other ESRD patients. Measures should include the physician-level renal measures developed by AMA PCPI and approved by NQF in 2012: 1666: Patients on Erythropoiesis Stimulating Agent (ESA)--Hemoglobin Level>12.0 g/dL 1667: (Pediatric) ESRD Patients Receving Dialysis: Hemoglobin Level<10g/dL 13 1668: Laboratory Testing (Lipid Profile) 0323: Hemodialysis Adequacy: Solute 0321: Peritoneal Dialysis Adequacy: Solute Additionally, Measure 0041: Influenza Vaccination - while it does not specifically refer to the renal population, is appropriate for use with this population. Furthermore, the MAP should consider measures on the following: Adequacy of Volume Management, Arteriovenous Fistula Rate, Catheter Use at Initiation of Hemodialysis, Catheter Use for ≥ 90 Days, Referral to Nephrologist, Transplant Referral, Advance Care Planning, Advance Directives Completed, Referral to Hospice.
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	SNP Alliance (NHPG)	Valerie Wilbur	The SNP Alliance applauds the work of NQF on dual measurement and is supportive of the goals/anticipated outcomes, guiding principles, high-leverage opportunities and most of the core measures identified in Appendix F. Specific comments: (1) add to anticipated outcomes "better alignment" of measures and methods needs of specific populations. (2) Theme of "maintenance" of health status or goals, in addition to improvement, should be expanded to include the notion of slowing the rate of decline as some beneficiaries such as frail elderly, those with late stage conditions/end of life may not even be capable of maintaining status quo. (3) If care coordination is one high leverage goal, we recommend adding 3 additional measures to "starter set" including medication management which a top priority for high-risk people with multiple chronic conditions on multiple medications and potentially no single case manager; functional status, a core chronic care, disability and LTC measure; and degree of program integration as measured preliminarily by SNP S&P 6 Coordination of Medicare and Medicaid, but overtime by more robust measure of integration. (4) Re Quality Issues, functional status assessment is as important to screening and assessment as it is to quality of life; in our over-medicalized works, the impact of functional impairment on health care needs and interdependence with medical care needs is woefully neglected.

Comment Category	Commenter Organization	Commenter Name	Comment
Appropriate Measures for Use with the Dual Eligible Beneficiary Population	WellCare Health Plans, Inc.	Elizabeth Goodman	A measure's appropriateness for the Dual Eligible Population partly depends on measure application and its tie to quality improvement results. Quality measurement and related data collection should be meaningful, cost efficient, and clearly linked to delivering quality improvement results. The Starter Set of measures should rely on administrative data collection where possible. Until EHR is widely available, measures relying on claims or other administratively available data are critical to minimizing dollars spent on data collection rather than directly improving quality. Measures relying on record review should be administered on a sample basis to coordinate with existing HEDIS data collection activities (e.g. the Optimal Diabetes Care metric should be administered this way). If administered for the total diabetic population, the assessment of tobacco and aspirin use should be removed. We seek clarity on how the 3-item Care Transition measure was validated; there may be more appropriate metrics for assessing care transitions. Regarding the Medical Home measure that utilizes the NCQA accreditation survey, the number of individuals with access to a primary care provider would be a more reliable and administrable metric. It is unclear who would oversee the survey and how it can be efficiently administered. Requiring Medicaid providers to execute the survey could exacerbate existing network sufficiency issues.
Appropriate Measures for Use with the Dual Eligible Beneficiary Population		Clement McDonald	Page 11 - consumer assessment No one can argue with the value of feedback from consumers. But the promoters of such instruments should consider the time required by patients to complete these instruments and of care systems to analyze and provide feedback to their providers. The proposal explicitly states that these measures should be by clinician. They should also be aware of problems of sample size when applied to individual physicians, because the number of such patients cared for by a specific physician will often be too small to produce any meaningful data. Somewhere along the line, the number of questions to be asked across the host of surveys that might be included in the first row, should be counted and the time to complete them measured, before they are frozen in regulations. In many cases (e.g. the 36-question survey) shorter versions (e.g. 12 questions) exist, with very similar predictive power. One should not assume any amount of added documentation can be absorbed by patients or providers. Further one should be careful about the expectation from these surveys. Many have no benefit for guiding the care of an individual patient. They are useful for studying populations. So they might be useful for assessing the status of a whole practice. Finally, proponents should be very thoughtful about the inclusion of questions about pain control. The medical literature has shown a surge in accidental deaths due to medications (most due to narcotics) from 2010 to 2012. The death rate has nearly tripled to a level that approaches car accident deaths. This increase has paralleled the movement to assess pain status at every visit and patient satisfaction instruments that ding providers who withhold narcotics. Since these instruments are often used by care systems to decide pay levels, the net effect is that physicians are reluctant to withhold narcotics from people they think are abusers. I strongly recommend that pain management questions and/or their analysis be restricted to patients with metastatic cancer and rheumatoid arthritis, end-of-life care, etc which qualifications are mostly present in the quality measures in CMS's proposed rule.

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Appropriate Measures for Use with the Dual Eligible Beneficiary Population		Clement McDonald	Some of the rows seem to be exact duplicates. NQF measure 004 is listed as the first item at the top of page 1 and page 2 of appendix f. Many other NQF measures repeat. Functional status measures have many good uses, but the proposals include no qualifications on the frequency with which they should be applied or conditions in which they are not known to be usable or helpful (e.g. Patients who cannot communicate because of obtundation, patients for whose disability precludes gradation on the kinds of questions asked.) Again while considering all of the surveys that might be desirable, some proposers should count the number of questions that have to be asked, calculate the amount of time to complete the questionnaire, consider use of shorter validated alternatives when they are available, and prioritize to choose the most important ones when the total numbers of question and time of patients to fill them out (and nursing or physician staff to help the patient complete the form) will place a significant burden on practice or patient. In the few cases where the CMS quality measures have selected a specific survey instrument, e.g. PHQ- they have tended to pick short ones.
Addressing Gaps in Measurement	Academy of Managed Care Pharmacy	Edith Rosato	AMCP is pleased that the MAP identified "appropriate prescribing and medication management" as a priority for measurement. AMCP disagrees with the MAP assertion that there are not adequate measures in this area. An NQF-approved measure, the NCQA "Drugs to be Avoided in the Elderly (DAE)" measures, already exists. This measures assesses the percentage of members 65 years of age and older who received at least one high-risk medication, and the percentage who received at least two different high-risk medications. This measure also exists as the PQA "Use of High-Risk Medications in the Elderly (HRM)" measure. The DAE/HRM measures have been revised recently to reflect updated American Geriatrics Society Beers Criteria. AGS updated the previous Beers Criteria using a comprehensive, systematic review and grading of the evidence on drug-related problems and adverse drug events in older adults. The PQA HRM measure is a highly-weighted component within the Centers for Medicare & Medicaid Services (CMS) Star Ratings. The five-star rating system used by CMS is a relative quality and performance scoring method used for Medicare Advantage (MA) plans and Part D prescription drug plans (PDPs) offered to Medicare beneficiaries. Rather than identifying this area as a "prioritized gap measure," AMCP recommends that MAP add the DAE/HRM measure to the starter set of measures developed by the MAP.
Addressing Gaps in Measurement	American Geriatrics Society	Susan Sherman	Overall, AGS applauds the workgroup for its attention to care transitions, as the multimorbid population has the most difficult of transitions - from hospitals, to skilled nursing facilities, to the home, most often involving homecare. Due to the complexity of this process, we appreciate the amount of detail provided around this issue; however, we have highlighted several areas that we believe could be further clarified: How to measure coordination of acute care and community services Advanced Care Directives Optimal composite measures Reference the work of the NQF Measurement Applications Partnership on Multiple Chronic Conditions Cognitive Screening Electronic Medical Records Disparities

Comment Category	Commenter Organization	Commenter Name	Comment
Addressing Gaps in Measurement	America's Health Insurance Plans	Carmella Bocchino	We concur that the identified gaps in measurement set forth in the report are important; however, higher prevalence conditions such as behavioral health, cardiovascular, pulmonary, and renal diseases are only partially reflected. Additional work needs to be undertaken to identify high prevalence areas so that the screening and assessment category may be expanded to specifically address these conditions.
Addressing Gaps in Measurement	Association for Community Affiliated Plans	Mary Kennedy	We have some concerns about whether beneficiary assistance navigating Medicare and Medicaid is a "measure" in the same way as the other measures. State variation on Medicaid benefits, payment, network and even stability and friendliness of the eligibility system could make use of this measure difficult for plan comparison. Eligibility is especially problematic because the systemic issues, particularly the churning experienced by duals, may emanate from Social Security Administration and/or State Medicaid and is out of the plans' control. We recognize that a measure in this area is essential to the MMCO's responsibility to improve the "experience" of the dual eligible, but it should be clear what entity is accountable for this assistance. We support the need for measures in the Home and Community Based Services area. Another area that should be explored further is in the area of dental care especially as the evidence shows a link between poor oral health and cardiovascular disease.
Addressing Gaps in Measurement	GlaxoSmithKline	Deborah Fritz	GSK strongly recommends the development and use of measures for Comprehensive Medication Management (CMM) and for medication adherence. GSK also strongly recommends adding COPD in the measure sets. COPD is the fifth most common reason for hospitalization of Americans over 65 and the third-leading cause of death.[i],[ii] COPD is associated with multiple co-morbidities (e.g., cardiovascular) as well as increases in healthcare resource utilization and spending.[iii] We recommend starting with the addition of existing NQF endorsed COPD measures. A comprehensive set of COPD measures should include: prevention--tobacco cessation (in the core set); diagnosis -using the confirmation of symptom-based diagnosis with spirometry testing (NQF measure); treatment; medication management; medication adherence; COPD exacerbation (NQF measure); and rehabilitation (current NQF measures). [i]Jemal A, Ward E, Hao Y, Thun M. Trends in the leading causes of death in the United States, 1970-2002. *JAMA*. 2005;294:1255-1259. [ii]Centers for Disease Control and Prevention. National Center for Health Statistics. Final Vital Statistics Report. Deaths: Final Data for 2008. Vol. 59, No. 10, December 2011. [iii]Dalal AA, Shah M, Lunacsek O, Hanania NA. Clinical and economic burden of patients diagnosed with COPD with comorbid cardiovascular disease. Respiratory Medicine. 2011. 105:10:1516-1522.

Comment Category	Commenter Organization	Commenter Name	Comment
Addressing Gaps in Measurement	National Kidney Foundation	Dolph Chianchiano	Dual Eligible Beneficiaries should have timely referral to specialist care. In particular, there should be a measure for nephrology care before kidney failure. See AHRQ National Healthcare Quality Report, 2011. "Early referral to a nephrologist is important for patients with progressive chronic kidney disease approaching kidney failure. Mindful management during the transition to ESRD permits informed selection of renal replacement therapy, placement and maturation of vascular access, and workup for kidney transplantation. Patients who begin nephrology care more than a year before kidney failure are less likely to begin dialysis with a catheter, experience infections related to vascular access, or die during the months after dialysis initiation." See also the performance measurement and quality management recommendations from the Final Report of Stakeholder Work Group: "Integrating Care for People Eligible for Both Medicare and Medicaid," February 2012, (Prepared for Michigan Department of Community Health by Public Sector Consultants.
Addressing Gaps in Measurement	National Patient Advocate Foundation	Nancy Davenport-Ennis, Rene Cabral-Daniels	Limited availability of cost data that encompasses both Medicare and Medicaid expenditures is a major factor. Similarly, information on beneficiaries; out-of-pocket expenses is not routinely collected. NPAF notes the limited availability of data on costs, particularly beneficiary out-of-pocket expenses is troubling. The inability to assure this financially and medically vulnerable population receives quality care for their out-of-pocket expenses is simply unconscionable. However, NPAF is certain that a protracted partnership between MAP and the patient community will elicit insightful patient cost data that will enhance the quality of the final report.
Addressing Gaps in Measurement	Pacific Business Group on Health	Christine Chen	As MAP moves forward on prioritized measure gaps we strongly support maintaining an outcome-oriented focus wherever possible. The report notes that "MAP expressed a strong desire for structure and process measures to assess connections between the health system and long-term supports and services systems, including Medicaid HCBS." Experiences of other patient populations show that structure and process measures often don't result in better health. The best way to identify how well the system is working for a patient is to measure the outcome. Evidence indicates that a heavy focus on structure and process may also inhibit innovation, as well as have unintended adverse consequences, if applied inappropriately. That being said, we do support the use of process measures for which there is an evidence-based proximal link to outcomes. We strongly support the focus on measures of functional status. We encourage MAP to integrate into the report the importance of considering how to leverage NIH's well-respected PROMIS instruments (which are cross-cutting) in this work.
Addressing Gaps in Measurement	PhRMA	Jennifer Van Meter	PhRMA supports the identified measure development gaps, particularly the gap in appropriate medication management. Studies demonstrate that better outcomes can be achieved with better use of medications, including physician and patient selection of the appropriate treatment for a given condition, patient adherence to the treatment instructions, and patient persistence with the treatment. We also note the value of appropriate medication management in those with multiple chronic conditions since adherence to therapy can lead to improved outcomes, including reduced hospital readmissions. Constructing appropriate measures for evaluation of medication management in the dually eligible patient populations is important to ensuring that these patients are receiving quality medical care.

Comment Category	Commenter Organization	Commenter Name	Comment
Addressing Gaps in Measurement	Renal Physicians Association	Robert Blaser	Gaps exist in the current NQF-endorsed measures (see appropriate measures above). Due to the current NQF submission process, untested measures were not able to be submitted and considered for endorsement during the last call for renal measures. However, they have been developed in conjunction with AMA-PCPI (e.g., Adequacy of Volume Management, Arteriovenous Fistula Rate, Catheter Use at Initiation of Hemodialysis, Catheter Use for ≥ 90 Days, Referral to Nephrologist, Transplant Referral, Advance Care Planning, Advance Directives Completed, Referral to Hospice). These address important gaps in measurement. Additionally, the lack of measures addressing progression of CKD (specifically blood pressure control and use of ACE inhibitors and angiotensin receptor blockers proteinuric CKD patients) are an important gap in measurement.
Addressing Gaps in Measurement	Renal Physicians Association	Robert Blaser	Further, measures of overuse should be considered. The recent Choosing Wisely campaign includes three areas of particular importance to this population: Don't perform routine cancer screening for dialysis patients with limited life expectancies without signs or symptoms. Avoid nonsteroidal anti-inflammatory drugs (NSAIDS) in individuals with hypertension or heart failure or CKD of all causes, including diabetes. Don't initiate chronic dialysis without ensuring a shared decision-making process between patients, their families, and their physicians.
Addressing Gaps in Measurement	SNP Alliance (NHPG)	Valerie Wilbur	SNP Alliance agrees with many gaps identified. Suggestions: (1) Biggest gap of all is failure to align specific measures and methods with specific populations served, as demonstrated by significant disconnects between standard MA measures and varied and significantly different needs of SNPs. Further, even though SNP-specific measures exist, few are part of plan ratings used on Medicare Compare and for quality bonus payments. (2) Structure - believe rating level of integration between health and community services is too narrow. Measures are needed to evaluate integration across all levels of primary, acute and long-term care as there are many "disconnects" across primary and acute care providers, and at multiple levels - care delivery, financing, administration and oversight. (2) Clarify gap in appropriateness of hospitalization as many articles published on avoidable hospitalizations via better management of ambulatory care sensitive conditions and the like. (3) Believe there are number of screens for cognitive impairment (e.g., SPMSQ), but perhaps not for psychosocial health. (4) Broad need for utilization benchmarking by type of plan/provider, by population and with appropriate risk adjustments for health risk, geography, socioeconomic status, etc. (5) Appropriate measures for persons with cognitive impairment, mental illness, behavioral problems and the like; self-report measure like CAHPS lack validity and reliability.
Addressing Gaps in Measurement		Clement McDonald	Page 11- re admission data. I am supportive of such data collection about admission; it should include capture of some of the system factors such as in-hospital care by hospitalists versus the primary care physicians. Many reports suggest that patients do not like the hospitalists system and that it leads to more re-admission due to problems of coordination (and it provides no net savings to the system). Perhaps the right kind of data collected could reverse what has been mad dash to only hospitalists providing in patient care to the benefit to fall.

Comment Category	Commenter Organization	Commenter Name	Comment
Addressing Gaps in Measurement		Clement McDonald	Appendix F page 1 and 2 There are lots of quality measures related to end-of-life, but nothing about any of the advance medical directives forms required for the family to help decide about it (e.g. Durable power of attorney, living will, or health care proxy), nor measures of expressing preferences for either end of life care or use of hospice. This seems a huge gap.
Levels of Analysis and Potential Applications of Measures	American Nurses Association	Maureen Dailey	The level of analysis for care coordination is needed at the team level, as indicated by the MAP Coordinating Committee, "care coordination is a team-based sport". Team-based care coordination measures are needed that focus on key assessments/risk screenings, related patient-centered goal setting, and comprehensive care planning. Team-based, integrated, interprofessional comprehensive care planning, enhanced through Meaningful Use (MU), can better ensure continuity of care with patient-centered goals, cue evidence-based (E-B) care, and capture outcomes at the point of care. It is essential the shared accountability with attribution to interprofessional team members be captured at the point of care to cue EB practice and inform research and the best mix of interprofessional team members and staffing to yield the best outcomes. Efficient measures that capture shared accountability supported by MU will better evaluate the interprofessional team members functioning to the top of their license. High functioning, competent teams will ensure timely access to needed efficient EB care as outlined in the recent IOM report.
Levels of Analysis and Potential Applications of Measures	America's Health Insurance Plans	Carmella Bocchino	In addition to the types of entities discussed in this section, Medical Homes and Health Homes should also be included as these models are being implemented nationwide to ensure increased quality and coordination of care for patients. When applying proposed measures to health plans, providers, and other relevant stakeholders, a plan or provider's ability to impact measures needs to be taken into account.
Levels of Analysis and Potential Applications of Measures	Highmark, Inc.	Deb Donovan	We agree with the important recognition that the current measurement structure, one that is setting and disease-state based, can through measure refinement , promote subset analysis of the dual population. This approach can assist in identifying structural deficiencies as we move towards integrated healthcare delivery models.
Levels of Analysis and Potential Applications of Measures	Renal Physicians Association	Robert Blaser	RPA anticipates the measures would be applicable for PQRS, Meaningful Use and the facility QIP.

Comment Category	Commenter Organization	Commenter Name	Comment
Levels of Analysis and Potential Applications of Measures	SNP Alliance (NHPG)	Valerie Wilbur	SNP Alliance supports Plan ratings F/U after hospitalization for mental illness, plan all cause readmissions, and Medicare/Medicaid coordination. We seek clarification about why NQF selected AOD as a condition for which plans should have responsibility. It is important to clarify which conditions plans should have responsibility for, e.g., systemic conditions requiring coordination of primary, acute and long-term for persons with frailty, disabilities, mental health issues, etc.; to clarify responsibilities of plans vs. providers; to permit plans to designate care related functions to providers, with oversight. Composite measure of multiple elements provides for "partial credit" where entity may have greatest ability to impact. Plans are concerned about ability to identify those in need of treatment due to federal privacy laws; getting patients in for treatment and compliance; and that significant efforts might not produce immediate results. Concerns should be addressed while ensuring appropriate treatment by the appropriate parties. We have serious concerns about the validity and reliability of self-report measures such as CAHPS for special needs populations with cognitive impairments, serious mental illness, behavioral problems and the like. We strongly urge the evaluation of self-report measures for selected populations and identification of more reliable alternatives.
Levels of Analysis and Potential Applications of Measures	WellCare Health Plans, Inc.	Elizabeth Goodman	There are a number of proposed measures that when applied to health plans, would need to be carefully weighted to assure that a plan's ability to impact them is taken into account (workforce capacity, fidelity to care plan, life enjoyment, etc.) Specifically, the proposed measure of daily activity function needs to be weighted to account for natural decline. Measures that are patient or member perception driven need to be weighted to account for depression, normal functional decline, cognitive impairments, and other issues out of health plan control. Examples are the CAHPS survey questions and the 3-item Care Transition Measure.
Measure Alignment Across Federal Programs	American Nurses Association	Maureen Dailey	The ANA supports measures alignment across federal programs informed by improved integrated, timely data integration (e.g., harnessing data warehouse data and meaningful use of electronic health records and other technology). Point of care targeted predictive risk modeling for high risk subpopulations, around avoidable complications and readmissions, will also better inform the quality measurement enterprise.
Measure Alignment Across Federal Programs	Association for Community Affiliated Plans	Mary Kennedy	We urge CMS to not make the duals measurement additive to all current measures especially those for D-SNPs. An approach that uses a framework that acknowledges underlying disparities and works to close those gaps would be welcome. We would like to see all initiatives for dual eligibles compared with a matched set of similar persons.
Measure Alignment Across Federal Programs	Federation of American Hospitals	Jayne Chambers	The Federation of American Hospitals agrees with the Committee's discussion of the need for alignment across set ting and across programs. Measures for the dual eligible population should be drawn from and harmonized with measures approved and used in other programs.
Measure Alignment Across Federal Programs	GlaxoSmithKline	Deborah Fritz	GSK supports alignment of measures for dual eligible across the Federal programs and recommends the definition of measure groups to allow appropriate flexibility across the various programs. It is also important to note that there should be consistency and alignment of measures across the various among dual eligible demonstration programs to ensure that the measures being employed at the state level do not conflict with those at the federal level. Because the state programs will likely be constructed differently, it is even more important that there are consistent, reliable, appropriate measures that can evaluate quality of care across these demonstration projects.

Comment Category	Commenter Organization	Commenter Name	Comment
Measure Alignment Across Federal Programs	National Kidney Foundation	Dolph Chianchiano	The Medicare ESRD Quality Incentive Program (QIP) is the federal government's first "pay for performance" value-based purchasing program, which includes process and reporting measures, and will ultimately encompass outcome measures. These QIP measures should be aligned across federal programs.
Measure Alignment Across Federal Programs	PhRMA	Jennifer Van Meter	PhRMA agrees that it is important to align measures for dual eligible across the Federal measurement programs. In order to accomplish that task, "families of measures" may have to be employed so that there is appropriate applicability within the various programs. It is also important to note that there should be consistency and alignment of measures across the various state dual eligible demonstration programs to ensure that the measures being employed at the state level do not conflict with those at the federal level. Because the state programs will likely be constructed differently, it is even more important that there are consistent, reliable, appropriate measures that can evaluate quality of care across these demonstration projects.
Measure Alignment Across Federal Programs	Renal Physicians Association	Robert Blaser	RPA believes it is critical that competing and conflicting measures be avoided to reduce the burden on physicians. Additionally, efforts to align physician and facility level measures should continue.
Measure Alignment Across Federal Programs	SNP Alliance (NHPG)	Valerie Wilbur	The SNP Alliance strongly supports measure alignment not only across federal programs, but between Federal and state programs, given duals' reliance on state programs. While all SNP reporting requirements are not identical, there are significant similarities and overlap across measures and various elements within these measures. This duplication creates unnecessary confusion, data burden and costs for plans - as well as data burden and costs for CMS and states - without adding value to quality, cost and care performance. A unified approach, without duplication or conflicts among the various reporting requirements, is critically needed. Measures and methods should be consistent, particularly where they are addressing the same clinical areas; e.g., a single QIP for Medicare and Medicaid and a single set of HEDIS or CAHPS data. The "end game" should be a core set of measures for duals. While we strongly support the NQF principle of parsimony, we also urge NQF to recognize that, because the dual population has many high-risk subsets with different needs and is not a homogeneous group, it also is important to ensure that the core set aligns with all population subgroups and, where appropriate, measures specific to subsets are also used; e.g., measures of importance to frail elderly such as drugs to be avoided by the elderly would not be appropriate for young disabled beneficiaries. NQF has acknowledged this in the report.

APPENDIX E:
MAP Measure Selection Criteria and Interpretive Guide

1. Measures within the program measure set are NQF endorsed or meet the requirements for expedited review

Measures within the program measure set are NQF endorsed, indicating that they have met the following criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. Measures within the program measure set that are not NQF endorsed but meet requirements for expedited review, including measures in widespread use and/or tested, may be recommended by MAP, contingent on subsequent endorsement. These measures will be submitted for expedited review.

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree

Measures within the program measure set are NQF endorsed or meet requirements for expedited review (including measures in widespread use and/or tested)

Additional implementation consideration: Individual endorsed measures may require additional discussion and may be excluded from the program measure set if there is evidence that implementing the measure would result in undesirable unintended consequences.

2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities

Demonstrated by measures addressing each of the National Quality Strategy priorities:

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

NQS priority is adequately addressed in the program measure set

Subcriterion 2.1 Safer care

Subcriterion 2.2 Effective care coordination

Subcriterion 2.3 Preventing and treating leading causes of mortality and morbidity

Subcriterion 2.4 Person- and family-centered care

Subcriterion 2.5 Supporting better health in communities

Subcriterion 2.6 Making care more affordable

3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)

Demonstrated by the program measure set addressing Medicare High-Impact Conditions; Child Health Conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s). (Refer to Table 2 for Medicare High-Impact Conditions and Child Health Conditions determined by the NQF Measure Prioritization Advisory Committee.)

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree:

Program measure set adequately addresses high-impact conditions relevant to the program.

4. Program measure set promotes alignment with specific program attributes, as well as alignment across programs

Demonstrated by a program measure set that is applicable to the intended care setting(s), level(s) of analysis, and population(s) relevant to the program.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 4.1 Program measure set is applicable to the program's intended care setting(s)

Subcriterion 4.2 Program measure set is applicable to the program's intended level(s) of analysis

Subcriterion 4.3 Program measure set is applicable to the program's population(s)

5. Program measure set includes an appropriate mix of measure types

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, and structural measures necessary for the specific program attributes.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 5.1 Outcome measures are adequately represented in the program measure set

Subcriterion 5.2 Process measures are adequately represented in the program measure set

Subcriterion 5.3 Experience of care measures are adequately represented in the program measure set (e.g., patient, family, caregiver)

Subcriterion 5.4 Cost/resource use/appropriateness measures are adequately represented in the program measure set

Subcriterion 5.5 Structural measures and measures of access are represented in the program measure set when appropriate

6. Program measure set enables measurement across the person-centered episode of care[1]

Demonstrated by assessment of the person's trajectory across providers, settings, and time.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 6.1 Measures within the program measure set are applicable across relevant providers

Subcriterion 6.2 Measures within the program measure set are applicable across relevant settings

Subcriterion 6.3 Program measure set adequately measures patient care across time

7. Program measure set includes considerations for healthcare disparities[2]

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, age disparities, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 7.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Subcriterion 7.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8. Program measure set promotes parsimony

Demonstrated by a program measure set that supports efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 8.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)

Subcriterion 8.2 Program measure set can be used across multiple programs or applications (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

TABLE 1: NATIONAL QUALITY STRATEGY PRIORITIES

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

TABLE 2: HIGH-IMPACT CONDITIONS

Medicare Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke/Transient Ischemic Attack
6. Alzheimer's Disease
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis/Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese (≥85th percentile BMI for age)
3. Risk of Developmental Delays or Behavioral Problems
4. Oral Health
5. Diabetes
6. Asthma
7. Depression
8. Behavior or Conduct Problems
9. Chronic Ear Infections (3 or more in the past year)
10. Autism, Asperger's, PDD, ASD
11. Developmental Delay (diag.)
12. Environmental Allergies (hay fever, respiratory or skin allergies)
13. Learning Disability
14. Anxiety Problems
15. ADD/ADHD
16. Vision Problems Not Corrected by Glasses
17. Bone, Joint, or Muscle Problems
18. Migraine Headaches
19. Food or Digestive Allergy
20. Hearing Problems
21. Stuttering, Stammering, or Other Speech Problems
22. Brain Injury or Concussion
23. Epilepsy or Seizure Disorder
24. Tourette Syndrome

MAP Measure Selection Criteria Interpretive Guide

Instructions for applying the measure selection criteria:

The measure selection criteria are designed to assist MAP Coordinating Committee and workgroup members in assessing measure sets used in payment and public reporting programs. The criteria have been developed with feedback from the MAP Coordinating Committee, workgroups, and public comment. The criteria are intended to facilitate a structured thought process that results in generating discussion. A rating scale of *Strongly Agree, Agree, Disagree, Strongly Disagree* is offered for each criterion or subcriterion. An open text box is included in the response tool to capture reflections on the rationale for ratings.

The eight criteria areas are designed to assist in determining whether a measure set is aligned with its intended use and whether the set best reflects "quality" health and healthcare. The term "measure set" can refer to a collection of measures—for a program, condition, procedure, topic, or population. For the purposes of MAP moving forward, we will qualify all uses of the term measure set to refer to either a "program measure set," a "core measure set" for a setting, or a "condition measure set." The following eight criteria apply to the evaluation of program measure sets; a subset of the criteria apply to condition measure sets.

FOR CRITERION 1—NQF ENDORSEMENT:

The optimal option is for all measures in the program measure set to be NQF endorsed or ready for NQF expedited review. The endorsement process evaluates individual measures against four main criteria:

1. **Importance to measure and report**—how well the measure addresses a specific national health goal/priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus.
2. **Scientific acceptability of the measurement properties**—evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.
3. **Usability**—the extent to which intended audiences (e.g., consumers, purchasers, providers, and policymakers) can understand the results of the measure and are likely to find the measure results useful for decisionmaking.
4. **Feasibility**—the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

To be recommended by MAP, a measure that is not NQF endorsed must meet the following requirements, so that it can be submitted for expedited review:

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use.
- whether the scope of the project/measure set is relatively narrow.
- time-sensitive legislative/regulatory mandate for the measure(s).

Measures that are NQF endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges and/or unintended negative consequences of measurement to individuals or populations may outweigh benefits associated

with the use of the performance measure. Additional consideration and discussion by the MAP workgroup or Coordinating Committee may be appropriate prior to selection. To raise concerns on particular measures, please make a note in the included text box under this criterion.

FOR CRITERION 2—PROGRAM MEASURE SET ADDRESSES THE NATIONAL QUALITY STRATEGY PRIORITIES

The program's set of measures is expected to adequately address each of the NQS priorities as described in criterion 2.1-2.6. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. This assessment should consider the current landscape of NQF-endorsed measures available for selection within each of the priority areas.

FOR CRITERION 3—PROGRAM MEASURE SET ADDRESSES HIGH-IMPACT CONDITIONS

When evaluating the program measure set, measures that adequately capture information on high-impact conditions should be included based on their relevance to the program's intended population. High-priority Medicare and Child Health Conditions have been determined by NQF's Measure Prioritization Advisory Committee and are included to provide guidance. For programs intended to address high-impact conditions for populations other than Medicare beneficiaries and children (e.g., adult non-Medicare and dual eligible beneficiaries), high-impact conditions can be demonstrated by their high prevalence, high disease burden, and high costs relevant to the program. Examples of other ongoing efforts may include research or literature on the adult Medicaid population or other common populations. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria.

FOR CRITERION 4—PROGRAM MEASURE SET PROMOTES ALIGNMENT WITH SPECIFIC PROGRAM ATTRIBUTES, AS WELL AS ALIGNMENT ACROSS PROGRAMS

The program measure sets should align with the attributes of the specific program for which they intend to be used. Background material on the program being evaluated and its intended purpose are provided to help with applying the criteria. This should assist with making discernments about the intended care setting(s), level(s) of analysis, and population(s). While the program measure set should address the unique aims of a given program, the overall goal is to harmonize measurement across programs and settings, and between the public and private sectors.

- **Care settings include:** Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services—Ambulance, Home Health, Hospice, Hospital—Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.
- **Level of analysis includes:** Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System, and Population (Community, County/City, National, Regional, or States).
- **Target populations include:** Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

FOR CRITERION 5—PROGRAM MEASURE SET INCLUDES AN APPROPRIATE MIX OF MEASURE TYPES

The program measure set should be evaluated for an appropriate mix of measure types. The definition of "appropriate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. The evaluated measure types include:

1. **Outcome measures**—Clinical outcome measures reflect the actual results of care.[3] Patient-reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient-reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[4]
2. **Process measures**—Process denotes what is actually done in giving and receiving care.[5] NQF endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[6]
3. **Experience of care measures**—Defined as patients' perspective on their care.[7]
4. **Cost/resource use/appropriateness measures**

   a. Cost measures—Total cost of care.

   b. Resource use measures—Resource use measures are defined as broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).[8]

   c. Appropriateness measures—Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[9]
5. **Structure measures**—Reflect the conditions in which providers care for patients.[10] This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure.

Endnotes

1 National Quality Forum (NQF), *Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care*, Washington, DC: NQF; 2010.

2 NQF, *Healthcare Disparities Measurement*, Washington, DC: NQF; 2011.

3 NQF, 2011, *The Right Tools for the Job*. Available at www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx. Last accessed May 2012.

4 Consumer-Purchases Disclosure Project, 2011. Ten Criteria for Meaningful and Usable Measures of Performance.

5 Donabedian, A., The quality of care, *JAMA*, 1998;260:1743-1748.

6 NQF, 2011, Consensus development process. Available at www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx. Last accessed May 2012.

7 NQF, 2011, *The Right Tools for the Job*. Available at www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx. Last accessed May 2012.

8 NQF, 2009, National Voluntary Consensus Standards for Outpatient Imaging Efficiency. NQF, Washington, DC. Available at www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70048. Last accessed May 2012.

9 NQF, 2011, *The Right Tools for the Job*. Available at www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx. Last accessed May 2012.

10 Ibid.

APPENDIX F:
Guiding Principles

In considering how to achieve the desired vision, MAP established guiding principles for the approach to measurement. Measurement programs can be designed for many purposes, and at many levels of accountability and analysis. Individual measures are also generally designed for specific uses. Defining a purpose, goals, data platform, and levels of analysis for a measurement initiative are precursors to the selection and application of specific measures within a program. Individual measures must be chosen with the program goals and capabilities in mind. This concept of fit-for-purpose is so fundamental that MAP was limited in its ability to fully define federal and state-level measure sets for dual eligible beneficiaries. To do so, MAP would require detailed information about the aspects of the measurement programs that are still in the process of being established. Despite these constraints, MAP's Measure Selection Criteria (Appendix E), and the guiding principles below can assist in evaluating the appropriateness of potential measures to meet the goals of any initiative.

The guiding principles regarding measurement in the dual eligible beneficiary population fall into three general categories: desired effects of measurement, measurement design, and data platform principles.

Desired Effects of Measurement

Promoting Integrated Care. Measurement has the ability to drive clinical practice and provision of community supports toward desired models of integrated, collaborative, and coordinated care. Improving the health of dual eligible beneficiaries will require wide-scale cooperation, systematic communication, and shared accountability.

Ensuring Cultural Competence. The measurement approach also should promote culturally competent care that is responsive to dimensions of race, ethnicity, age, functional status, language, level of health literacy, environmental factors, and accessibility of the environment for people with different types of disability.

Health Equity/Reducing Disparities. Stratifying measures by such factors as race, ethnicity, or socio-economic status allows for identification of potential healthcare disparities and related opportunities to address them. Moreover, it is important to measure the experiences of dual eligible beneficiaries year-over-year and in contrast to Medicare-only and Medicaid-only beneficiaries in order to assess any differences in program access.

Measurement Design

Assessing Outcomes Relative to Goals. The measurement approach should evaluate person-level outcomes relative to goals that are defined in the process of developing a person- and family-centered plan of care. Such goals might include maintaining or improving function, longevity, palliative care, or a combination of factors. It also is vital to include outcome measures related to the individual's or family's assessment of the care and supports received.

Parsimony. To minimize the resources required to conduct performance measurement and reporting, a core measure set should be parsimonious. The set should include the smallest possible number of measures to achieve the intended purpose of the measurement program.

Cross-Cutting Measures. The heterogeneity of the dual eligible population complicates efforts to select a small number of measures that would accurately reflect their care experience. Thus, a parsimonious measure set should rely primarily on

cross-cutting measures and use condition-specific measures only to the extent they address critical issues for high-need subpopulations.

Inclusivity. The measurement strategy should span the continuum of care and include both Medicare and Medicaid services. It should include measures that are broadly applicable across age groups, disease groups, or other cohorts, as opposed to measures with narrowly defined denominator populations.

Avoiding Undesirable Consequences. The methodology should anticipate and mitigate potential undesirable consequences of measurement. This might include overuse or underuse of services as well as adverse selection. For example, the measurement approach could use strategies such as stratification or risk adjustment to account for the increased difficulty of caring for complex patients and to ensure that such individuals would have access to providers willing to treat them.

Data Platform Principles

Data Sharing. The measurement strategy should encourage dynamic data exchange and shared accountability. Interoperable health records that enable portability of information across providers can assist greatly in delivering timely, appropriate services that are aligned with a shared plan of care.

Using Data for Multiple Purposes. A robust data exchange platform also would assist providers in gathering information from the individual receiving care or his or her caregivers, and circulating feedback, as appropriate, to improve quality. Tracking data over time also enables longitudinal measurement and tracking "delta measures" of change in outcomes of interest.

Making the Best Use of Available Data. While our nation's health IT infrastructure develops, the measurement strategy must make the best use of all available data sources, including administrative claims, registries, and community-level information.

APPENDIX G:
Revised Core Set of Measures

Use NQF's Quality Positioning System (QPS) to review full specifications of the endorsed core measurses. www.qualityforum.org/QPS/QPSTool.aspx?p=672.

NQF Measure Number and Status	Measure Name	Measure Description	Potential Modifications/ Considerations	MAP High-Leverage Opportunities	NQS Priority	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0004 Endorsed (eMeasure specification available)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. 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. b. 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.	• Suggested to represent identification of dependence, initiation of treatment, and engagement in treatment as separate elements in a composite measure	Care Coordination, Mental Health and Substance Use	Effective Communication and Care Coordination, Health and Well-Being	Administrative Claims, Electronic Health Record, Paper Records	Process	Ambulatory Care, Hospital/ Acute Care Facility	Clinician, Health Plan, Integrated Delivery System, Clinician, Population	NCQA	Finalized for use in PQRS, Meaningful Use, Value Modifier, Medicaid Adult Core Measures
0022 Endorsed (eMeasure specification available)	Drugs to Be Avoided in the Elderly: a. Patients who receive at least one drug to be avoided, b. Patients who receive at least two different drugs to be avoided	Percentage of patients ages 65 years and older who received at least one drug to be avoided in the elderly in the measurement year. Percentage of patients 65 years of age and older who received at least two different drugs to be avoided in the elderly in the measurement year.		Care Coordination, Screening and Assessment	Effective Communication and Care Coordination, Patient Safety	Administrative Claims	Process	Ambulatory Care	Clinician	NCQA	Finalized for use in PQRS. Proposed for Stage 2 Meaningful Use
0028 Endorsed (eMeasure specification available)	Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period. Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.		Screening and Assessment, Mental Health and Substance Use	Prevention and Treatment of Leading Causes of Mortality, Health and Well-Being	Administrative Claims	Process	Ambulatory Care	Clinician	AMA-PCPI	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier
0097 Endorsed (eMeasure specification available)	Medication Reconciliation	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office 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.	• Suggested that the time window in which patient should see physician after discharge be condensed, potentially to 30 days or fewer	Care Coordination, Screening and Assessment	Effective Communication and Care Coordination, Patient Safety	Administrative Claims, Other Electronic Clinical Data, Paper Records	Process	Ambulatory Care	Clinician, Integrated Delivery System, Population	NCQA	Finalized for use in PQRS, Medicare Shared Savings Program, Value Modifier. Proposed for Stage 2 Meaningful Use
0101 Endorsed	Falls: Screening for Fall Risk	Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months.	• Suggested that the measure be expanded to include anyone at risk for a fall (e.g., individuals with mobility impairments), not just individuals older than 65 • Suggested that patients could report if they received counseling on falls rather than relying on claims data	Screening and Assessment	Patient Safety, Health and Well-Being	Administrative Claims	Process	Ambulatory Care, Home Health, Hospice, PAC/ LTC Facility	Clinician	NCQA	Finalized for use in PQRS, Medicare Shared Savings Program, Value Modifier. Proposed for Stage 2 Meaningful Use

NQF Measure Number and Status	Measure Name	Measure Description	Potential Modifications/ Considerations	MAP High-Leverage Opportunities	NQS Priority	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0208 Endorsed	Family Evaluation of Hospice Care	The survey measures family members' perception of the quality of hospice care for the entire enrollment period, regardless of length of service.		Quality of Life	Person- and Family-Centered Care	Patient Reported Survey	Composite	Hospice	Facility, Population	National Hospice and Palliative Care Org.	Under consideration for Hospice Quality Reporting (MAP Supported)
0209 Endorsed	Comfortable Dying	Percentage of patients who were uncomfortable because of pain on admission to hospice whose pain was brought under control within 48 hours.	• Give consideration to operationalizing this measure as pain assessment across settings; at a minimum could be applied more broadly to other types of palliative care • Comments suggested that advance care directives are equally important to ensure high-quality, patient-centered care	Quality of Life	Effective Communication and Care Coordination, Person- and Family-Centered Care	Patient Reported Survey	Outcome	Hospice	Facility, Population	National Hospice and Palliative Care Org.	Finalized for use in Hospice Quality Reporting
0228 Endorsed	3-Item Care Transition Measure (CTM-3)	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions.	• Broaden to additional settings beyond inpatient, such as ER and nursing facility discharges	Care Coordination	Effective Communication and Care Coordination, Person- and Family-Centered Care	Patient Reported Survey	Patient Engagement/ Experience	Hospital	Facility	University of Colorado Health Sciences Center	Proposed for Hospital Inpatient Reporting as part of HCAHPS
0260 Endorsed	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year.	• Emphasized for its consideration of quality of life, a rarity among available measures • Current survey is dialysis-specific and therefore inappropriate to use more broadly. Comments suggested that it remain unmodified. Rather, it should be used as a template for the development of a related measure of general health-related quality of life. • Construction of this concept as a process measure is not ideal.	Quality of Life	Person- and Family-Centered Care	Patient Reported Survey	Process	Dialysis Facility	Facility	RAND	MAP Supported for ESRD Quality Reporting
0418 Endorsed	Screening for Clinical Depression and Follow-up Plan	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented.		Screening and Assessment, Mental Health and Substance Use	Health and Well-Being	Administrative Claims	Process	Ambulatory Care, Hospital, PAC/ LTC Facility	Clinician	CMS/QIP	Finalized for use in PQRS, Medicare Shared Savings Program, Medicaid Adult Core. Proposed for Stage 2 Meaningful Use

NQF Measure Number and Status	Measure Name	Measure Description	Potential Modifications/ Considerations	MAP High-Leverage Opportunities	NQS Priority	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0421 Endorsed (eMeasure specification available)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented. Normal Parameters: Age 65 and older BMI≥23 and <30; Age 18–64 BMI≥18.5 and <25	• Noted as especially important in psychiatric patients, because individuals receiving certain medications are susceptible to increased BMI	Screening and Assessment	Health and Well-Being	Administrative Claims, Other Electronic Clinical Data	Process	Ambulatory Care	Clinician, Population	CMS/QIP	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier
0430 Endorsed	Change in Daily Activity Function as Measured by the AM-PAC	The Activity Measure for Post Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post acute care (PAC) patients. A Daily Activity domain has been identified, which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing.	• Emphasized for its consideration of functional status, a rarity among available measures • Broaden beyond post-acute care. • Measure has curative orientation. Include maintenance of functional status if this is all that can be realistically expected. If goal of care is to slow the rate of decline, this measure may not be appropriate. • Address floor effects observed when tool is applied to very frail/complex patients. • Incorporate community services in supporting post-acute recovery. • May present relatively larger data collection burden, brief surveys are preferred	Quality of Life	N/A	Electronic Health Record	Outcome	Ambulatory Care, Home Health, Hospital, PAC/ LTC Facility	Facility, Clinician	CREcare	None
0494 Endorsed	Medical Home System Survey	Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a. Improved access and communication b. Care management using evidence-based guidelines c. Patient tracking and registry functions d. Support for patient self-management e. Test and referral tracking f. Practice performance and improvement functions.	• Care management might be appropriately conducted by other parties besides primary care physician (e.g., family member, clinical specialist, PACE site). • A health home's approach to care management must consider both Medicaid and Medicare benefits. • Consider broader application in shared accountability models such as ACOs and health homes. • May be more important to measure whether duals have access to a usual source of primary care rather than the primary care providers' ability to meet these standards	Care Coordination, Structural	Effective Communication and Care Coordination, Person- and Family-Centered Care	Provider Survey, Patient Reported Survey, Other Electronic Clinical Data, Electronic Health Record, Paper Records	Structure	Ambulatory Care	Facility, Clinician	NCQA	None
0523 Endorsed	Pain Assessment Conducted	Percentage of patients who were assessed for pain, using a standardized pain assessment tool, at start/resumption of home health care.	• Suggested expansion beyond home health care • Outcome measure of pain management would be preferred	Quality of Life, Screening and Assessment	Effective Communication and Care Coordination	Other Electronic Clinical Data	Process	Home Health	Facility	CMS	Finalized for use in Home Health

NQF Measure Number and Status	Measure Name	Measure Description	Potential Modifications/ Considerations	MAP High-Leverage Opportunities	NQS Priority	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0557 Endorsed	HBIPS-6 Post Discharge Continuing Care Plan Created	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-7: Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge.	• This type of transition planning/communication is universally important. • Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox. • This measure is paired and should be used in conjunction with HBIPS-7: Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge.	Care Coordination, Mental Health and Substance Use	Effective Communication and Care Coordination	Administrative Claims, Paper Records, Other Electronic Clinical Data	Process	Hospital, Behavioral Health/ Psychiatric (Inpatient)	Facility	The Joint Commission	Proposed for Inpatient Psychiatric Facility Quality Reporting
0558 Endorsed	HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity.	• This type of transition planning/communication is universally important. • Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox. • Information should be transmitted to both nursing facility and primary care provider, if applicable. • This measure is paired and should be used in conjunction with HBIPS-6: Post Discharge Continuing Care Plan Created.	Care Coordination, Mental Health and Substance Use	Effective Communication and Care Coordination	Administrative Claims, Paper Records, Other Electronic Clinical Data	Process	Hospital, Behavioral Health/ Psychiatric (Inpatient)	Facility	The Joint Commission	Proposed for Inpatient Psychiatric Facility Quality Reporting
0576 Endorsed	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.	• Suggested expansion to incorporate substance use disorders/detox	Care Coordination, Mental Health and Substance Use	Effective Communication and Care Coordination	Administrative Claims, Electronic Health Record	Process	Ambulatory Care, Behavioral Health/ Psychiatric Outpatient, Inpatient	Health Plan, Integrated Delivery System, Clinician, Population	NCQA	Finalized for use in Medicaid Adult Core Measures, CHIPRA Core Measures
0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/ Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements.	• Do not limit to certain transition sites/settings.	Care Coordination	Effective Communication and Care Coordination	Paper Records, Electronic Health Record, Administrative Claims	Process	Hospital, PAC/ LTC Facility, Ambulatory Care	Facility, Integrated Delivery System	AMA-PCPI	None
0648 Endorsed	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	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 care within 24 hours of discharge.	• Do not limit to certain transition sites/settings.	Care Coordination	Effective Communication and Care Coordination	Administrative Claims, Paper Records, Electronic Health Record	Process	Hospital, PAC/ LTC Facility, Ambulatory Care	Facility, Integrated Delivery System	AMA-PCPI	Finalized for use in Medicaid Adult Core Measures

NQF Measure Number and Status	Measure Name	Measure Description	Potential Modifications/ Considerations	MAP High-Leverage Opportunities	NQS Priority	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0729 Endorsed	Optimal Diabetes Care	The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Patients ages 18–75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c<8.0, LDL<100, Blood Pressure<140/90, Tobacco non-user, and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component.	• While the all-or-none composite measure is considered to be the gold standard that reflects the best patient outcomes, the individual components may be measured as well. • Comments considered this measure to be resource-intensive because it requires review of medical charts; proposed that diabetes measures in the HEDIS set would be less burdensome to report • Stakeholders expressed concerns that the individual targets within the measure may be too aggressive, especially for individuals who are older and/or who have multiple chronic conditions.	Screening and Assessment	Effective Communication and Care Coordination, Prevention and Treatment of Leading Causes of Mortality	Paper Records, Other Electronic Clinical Data, Electronic Health Record	Outcome	Ambulatory Care	Integrated Delivery System, Clinician	MN Community Measurement	Components for this composite are finalized for use in Medicare Shared Savings and Value Modifier, Under consideration for PQRS (MAP Supported)
1768 Endorsed	Plan All-Cause Readmissions	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/Denominator) 5. Total Variance Note: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.		Care Coordination	Patient Safety, Effective Communication and Care Coordination	Administrative Claims	Outcome	Hospital, Behavioral Health/ Psychiatric (Inpatient)	Health Plan	NCQA	None
1789 Endorsed	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.		Care Coordination	Patient Safety, Effective Communication and Care Coordination	Administrative Claims	Outcome	Hospital	Facility	CMS, Yale	Proposed for Inpatient Quality Reporting

NQF Measure Number and Status	Measure Name	Measure Description	Potential Modifications/ Considerations	MAP High-Leverage Opportunities	NQS Priority	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
Multiple Endorsed: 0005, 0006, 0007, 0009, 0258, 0517	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys	Many versions of CAHPS patient experience surveys have been endorsed for use across the health system. Surveys are available for: Health Plan, Clinician & Group Practice, Experience of Care and Health Outcomes (ECHO) for Behavioral Health, Home Health Care, Hospital, In-Center Hemodialysis, Nursing Home. Supplemental Item Sets, topics including: People with Mobility Impairments, Cultural Competence, Health IT, Health Literacy, Patient-Centered Medical Home	• High prevalence of cognitive impairment and language barriers in dual eligible population will complicate reliable data collection. • Individual providers may not treat a large enough number of dual eligible beneficiaries to have sufficient sample size to calculate the measures. • Case mix and risk adjustment are considerations when comparing across health plans, providers, or other entities.	N/A	Person- and Family-Centered Care	Patient Reported Survey	Patient Engagement/ Experience	Ambulatory Care	Clinician, Facility, Health Plan, Integrated Delivery System, Population	AHRQ	Finalized for use in Medicare Shared Savings Program
Not Endorsed	SNP 6: Coordination of Medicare and Medicaid Coverage.	Intent: The organization helps members obtain services they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage. This is necessary because the two programs have different rules and benefit structures and can be confusing for both members and providers.	• Measure currently applies to Medicare Advantage Special Needs Plans only. Suggest expansion to other entities if possible	Structural	Effective Communication and Care Coordination	(not available)	Structure	(not available)	Health Plan	NCQA	None
Not Endorsed	Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment	A. Patients screened annually for alcohol misuse with the 3-item AUDIT-C with item-wise recording of item responses, total score and positive or negative result of the AUDIT-C in the medical record. B. Patients who screen for alcohol misuse with AUDIT-C who meet or exceed a threshold score who have brief alcohol counseling documented in the medical record within 14 days of the positive screening.	• Suggest use beyond just a single condition/setting	Screening and Assessment, Mental Health and Substance Use	Effective Communication and Care Coordination, Health and Well-Being	(not available)	Process	(not available)	(not available)	(not available)	None
Endorsement Removed	The Ability to Use Health Information Technology to Perform Care Management at the Point of Care	Documents the extent to which a provider uses a certified/ qualified electronic health record (EHR) system capable of enhancing care management at the point of care. To qualify, the facility must have implemented processes within its EHR for disease management that incorporate the principles of care management at the point of care, which include: a. The ability to identify specific patients by diagnosis or medication use b. The capacity to present alerts to the clinician for disease management, preventive services, and wellness c. The ability to provide support for standard care plans, practice guidelines, and protocol	• Could also capture this concept as a percentage of providers in a defined area or network achieving Meaningful Use incentives • Endorsement removed by request of the measure steward.	Care Coordination, Structural	N/A	Administrative Claims, Electronic Health Record	Structure	Ambulatory Care	Clinician	CMS	None

APPENDIX H:
Selected Potential Measures for Medicaid Home and Community-Based Services (HCBS)

MAP followed three national efforts related to long-term care quality to examine potential measures of quality in Home and Community-Based Services. NQF has not endorsed any measures of quality in HCBS to date, and MAP is not recommending this list for immediate implementation. Rather, the concepts described below were illustrative of the person-centered care MAP desires to promote and evaluate.

Framework: HCBS Scan (AHRQ, Thomson Reuters)

Domain	Sub-domain	Potential Measure	Source	Notes	High-Leverage Opportunities
Client Functioning	Change in daily activitiy function	Degree to which consumers experience an increased level of functioning	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disabilities populations	Quality of Life, Screening and Assessment
Client Functioning	Availability of support with everyday activities when needed	Unmet need in ADLs/IADLs (11 measures total)	Participant Experience Survey	Item present in all three versions (elderly/disabled, mental retardation/ developmental disabilities, and acquired brain injury); additional money management item in brain injury tool	Quality of Life, Structural
Client Functioning	Presence of friendships	Degree to which people express satisfaction with relationships	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disabilities populations	Quality of Life
Client Functioning	Presence of friendships	Satisfaction with close friends	Quality of Life Scale (modified by Burkhardt)	Developed and tested with populations with chronic illness	Quality of Life
Client Functioning	Maintenance of family relationships	Satisfaction with relationships with parents, siblings, and other relatives	Quality of Life Scale (Burkhardt version for chronic illness)	Developed and tested with populations with chronic illness	Quality of Life
Client Functioning	Community integration	Participants reporting unmet need for community involvement	Participant Experience Survey	Item supported by all three versions; additional community involvement measures related to specific activities such as shopping present in brain injury and mental retardation/ developmental disabilities versions	Quality of Life
Client Functioning	Receipt of recommended preventive healthcare services	Degree to which people with identified physical health problems obtain appropriate services and degree to which health status is maintained and improved	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disabilities populations	Screening and Assessment, Structural

Domain	Sub-domain	Potential Measure	Source	Notes	High-Leverage Opportunities
Client Experience	Respectful treatment by direct service providers	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	Commission on Accreditation of Rehabilitation Facilities	Developed and tested with multiple disability populations	Care Coordination
Client Experience	Opportunities to make choices about services	Degree of active consumer participation in decisions concerning their treatment	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disability populations	Care Coordination, Structural
Client Experience	Satisfaction with case management services	Case manager helpfulness	Participant Experience Survey	Item present in all three survey versions	Care Coordination
Client Experience	Client perception of quality of care	Degree to which consumers were satisfied with overall services	Commission on Accreditation of Rehabilitation Facilities	Developed and tested with multiple disability populations	Quality of Life
Client Experience	Client perception of quality of care	Service satisfaction scales: home worker; personal care; home-delivered meals	Service Adequacy and Satisfaction Instrument	Developed and tested with service recipients age 60 and older	Quality of Life
Program Performance	Access to case management services	Ability to identify case manager	Participant Experience Survey	Supported by all three survey versions	Care Coordination, Structural
Program Performance	Access to case management services	Ability to contact case manager	Participant Experience Survey	Supported by all three survey versions	Care Coordination, Structural

AHRQ: http://www.ahrq.gov/research/ltc/hcbsreport/

Framework: LTSS Scorecard (AARP, The Commonwealth Fund, The SCAN Foundation)

Domain	Sub-domain	Potential Measure	Source	Notes	High-Leverage Opportunities
Choice of Setting and Provider	N/A	Tools and programs to facilitate consumer choice (composite indicator, scale 0-4)	AARP conducted a state survey to collect information about states' single entry point systems and various functions that facilitate consumer choice. Data from State LTSS Scorecard Survey (AARP PPI, Scorecard 2010)	States were scored from 0 (no use of tool or program) to 1 (full use of tool or program) in each of four categories: 1. Presumptive eligibility (scoring: 1 point) 2. Uniform assessment (scoring: proportion of Medicaid and state-funded programs that use a uniform assessment tool, with multiple HCBS waivers counting as two programs regardless of the number of waivers) 3. Money Follows the Person and other nursing facility transition programs (scoring: 1/3 point if a program exists, 1/3 point if statewide, 1/3 point if it pays for one-time costs to establish community residence) 4. Options counseling (scoring: whether offered to individuals using each of five types of payment source)	Quality of Life, Structural
Quality of Life and Quality of Care	N/A	Percent of adults age 18+ with disabilities in the community usually or always getting needed support	Data from 2009 BRFSS (NCCDPHP, BRFSS 2009)	Percent of adults limited in any way in any activities because of physical, mental, or emotional problems who usually or always received needed social and emotional support	Structural
Quality of Life and Quality of Care	N/A	Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life	Data from 2009 BRFSS (NCCDPHP, BRFSS 2009)	Percent of adults limited in any way in any activities because of physical, mental, or emotional problems who were satisfied or very satisfied with their life	Quality of Life, Structural
Support for Family Caregivers	N/A	Percent of caregivers usually or always getting needed support	Institute analysis of 2009 BRFSS (NCCDPHP, BRFSS 2009)	Percent of adults who provided regular care or assistance to a friend or family member during the past month and who usually or always received needed social and emotional support	Structural

Scorecard: www.longtermscorecard.org

Framework: National Balancing Indicators (Abt Associates, IMPAQ International)

Domain	Sub-domain	Potential Measure	Source	Notes	High-Leverage Opportunities
Sustainability	N/A	Proportion of Medicaid HCBS Spending of the Total Medicaid LTC Spending	NBIC using Thomson Reuters	The proportion of Medicaid HCBS spending of the total Medicaid long-term care spending	Structural
Self-determination/ Person-centeredness	N/A	Availability of Self-Direction Options	NBIC using CMS Medicaid Waiver Database, and State Self-Assessment	Does the State have one or more Medicaid waivers that offer participant-directed services? If yes, what is the employer status of participant? • Employer authority –Yes/No; Co-employer option, common law employer option • Budget authority –Yes/No; participant exercises decision-making authority and management responsibility; participant afforded flexibility to shift funds; participant authorizes purchase of approved waiver goods and services	Quality of Life, Structural
Community Integration and Inclusion	N/A	Waiver Waitlist	NBIC using CMS Medicaid Waiver Database, and State Self-Assessment	There is a process for tracking people who are unable to gain access to services (e.g., waiting list management and protocols).	Structural
Prevention	N/A	Proportion of People with Disabilities Reporting Recent Preventive Health Care Visits (Individual-level)	NBIC calculations using the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS) data	The proportion of individuals with disabilities who report having had a preventive healthcare visit within the past year	Screening/ Assessment
Coordination and Transparency	N/A	Proportion of People Reporting That Service Coordinators Help Them Get What They Need (Individual-level)	NBIC using National Core Indicators (NCI) Data	The proportion of people reporting that service coordinators help them get what they need	Care Coordination, Structural
Coordination and Transparency	N/A	Coordination Between HCBS and Institutional Services	State Self-Assessment	Coordinated Policymaking: The State coordinates budgetary, programmatic, and oversight responsibility for institutional and home- and community-based services	Care Coordination

NBIC: http://nationalbalancingindicators.com/

APPENDIX I:
Analytic Support for the Measure Applications Partnership*

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* Appendix I is a report dated March 29, 2012, prepared for the National Quality Forum. It was prepared by L&M Policy Research, LLC, under subcontract to Avalere Health, LLC Attn: Lisa Green, 1743 Connecticut, Ave., Suite 200, Washington, DC 20009; phone: (240) 476-6663; email: LGreen@LMpolicyresearch.com

Executive Summary

When the U.S. Congress passed the Patient Protection and Affordable Care Act (ACA) in March 2010, it established the Federal Coordinated Health Care Office (FCHCO) to more effectively integrate benefits under Medicare and Medicaid and improve federal and state coordination for the nation's 9.2 million dual-eligible beneficiaries (duals) (Clemans-Cope and Waidmann, 2011). Such legislation emphasized the need to provide better coordinated and, in turn, higher quality care to a subpopulation of notoriously underserved and chronically ill individuals. In general, duals are among the most vulnerable beneficiaries: most face multiple and severe chronic conditions that require complex and intense care. And because they receive both Medicare and Medicaid coverage, they must navigate two separate health care programs, often yielding fragmented, inefficient, and costly care. Although duals account for just 18 percent of Medicaid and 20 percent of Medicare enrollment, they represent 46 percent of Medicaid and 28 percent of Medicare program spending (Kasper, Watts & Lyons, 2010). Much of this phenomenon can be attributed to the average health status of duals – three in five dual eligibles have multiple chronic conditions, and two-fifths of those with multiple physical or physical and mental conditions were hospitalized in the previous year – coupled with the lack of coordination between the Medicare and Medicaid programs (Kasper, Watts & Lyons, 2010).

The literature clearly documents the population-level spending trends and poor health status of the dually eligible population, but in conjunction with the new mandates of the ACA related to coordination of care for duals, there is a need for additional research around measure development that will enable tracking of quality care for duals. As part of its larger contract with Avalere Health, LLC (Avalere), the National Quality Forum (NQF) has subcontracted L&M Policy Research, LLC (L&M), to focus on Task 3 of the project, Analytic Support for the Measure Applications Partnership (MAP). In particular, this task focuses on identifying quality issues for duals and related measures across all settings of care, organized around the five high-leverage domains defined by the MAP to guide measure development:

- Quality of life
- Care Coordination
- Screening and assessment
- Mental health and substance use
- Structural measures

The research team undertook an environmental scan that included nine discussions with experts, a focused literature scan that built upon the MAP activities and interaction/feedback from the MAP workgroup itself. The goal of this scan was to winnow a broad set of potential measures (and possible gaps) into a prioritized subset of measures that address the five high-leverage domains and informs the broader MAP goals of drafting a core measure set.

The key gaps in existing quality measures the team reviewed and discussed with interviewees are the lack of cross-setting, cross-organization applicability and the general clinical orientation of the measures. Interviewees across the board emphasized that ongoing, person-centered care that focuses resources on those most in need is the paramount goal. More specifically, interviewees said, a duals-focused measure set should capture: 1.) the extent that "high-touch" person-centered care planning and management occurs when needed and 2.) the extent to which the processes and structures in place support this as an on-going activity.

Using person-centered health and well-being as the focal point of duals-specific measures, interviewees generally expressed the importance of seven key areas vital to creating a robust set of measures for duals:

- **Consumer-based assessment of goal-oriented planning and care delivery** – Patient/caregiver/family perception of extent to which care plan (if needed) and care delivered reflect goals and desires of the individual and/or care plan[1]
- **Management and monitoring of specific conditions and disabilities** – Provider and patient active awareness of and engagement with signs and symptoms related to conditions (and clusters of them) to achieve individual's care plan goals
- **Medication management/reconciliation across settings** – Shared management of medications among provider and patient/caregiver focusing on goals of care plan to optimize appropriate use of medication and minimize negative drug interactions
- **Transition management** – Interactions that occur within and across settings among providers with patients and their families to ensure individuals receive comprehensive and streamlined care without duplication
- **Integration and coordination of community social supports and health delivery** – Ability to identify need for and ultimately integrate community social supports into care plan based on individual/caregiver needs
- **Utilization benchmarking** – Ability to gauge the extent of service use among duals and their subpopulations across settings
- **Process improvement across settings** – Ensure quality improvement programs are in place within and across settings and organizations that serve duals and their subpopulations
- Ultimately, to deliver high-quality care, the literature and interviewed stakeholders noted having an integrated delivery system as the key. To gauge the success of that system, measures must examine the extent to which processes occur across settings, at appropriate times, and in meaningful ways. This approach to measure development requires an evolution beyond the existing array of single-setting, single-condition measures. In doing so, measure developers could consider:
- Identify key components of "system-ness" that are critical to capture in a measure set
- Limit the number of measures so those responsible for focusing on improving quality have particular areas of focus
- Develop clear and specific criteria so that each measure gauges "apples to apples"
- Identify the particular sub-population each measure applies to
- Account for the data source of each measure because pulling and merging data from different agencies can be difficult if not impossible
- Apply consistent requirements across programs that account for meaningful use requirements, as stipulated in the Health Information Technology for Economic and Clinical Health Act (HITECH), to minimize duplication

Introduction

When the U.S. Congress passed the Patient Protection and Affordable Care Act (ACA) in March 2010, it established the Federal Coordinated Health Care Office (FCHCO) to more effectively integrate benefits under Medicare and Medicaid and improve federal and state coordination for the nation's 9.2 million dual-eligible beneficiaries (duals) (Clemans-Cope and Waidmann, 2011). Such legislation emphasized the need to provide better coordinated and, in turn, higher quality care to a subpopulation of notoriously underserved and chronically ill individuals. In general, duals are among the most vulnerable beneficiaries: Most

1 Multiple interviewees emphasized the importance of not "over-medicalizing" this assessment process for duals, given their many non-medical priorities.

face multiple and severe chronic conditions that require complex and intense care. And because they receive both Medicare and Medicaid coverage, they must navigate two separate health care programs, often yielding fragmented, inefficient, and costly care. Although duals account for just 18 percent of Medicaid and 20 percent of Medicare enrollment, they represent 46 percent of Medicaid and 28 percent of Medicare program spending (Kasper, Watts & Lyons, 2010). Much of this phenomenon can be attributed to the average health status of duals – three in five dual eligibles have multiple chronic conditions, and two-fifths of those with multiple physical or physical and mental conditions were hospitalized in the previous year – coupled with the lack of coordination between the Medicare and Medicaid programs (Kasper, Watts & Lyons, 2010).

The literature clearly documents the population-level spending trends and poor health status of the dually eligible population, but in conjunction with the new mandates of the ACA related to coordination of care for duals, there is a need for additional research around measure development that will enable tracking of quality care for duals. As part of its larger contract with Avalere Health, LLC (Avalere), the National Quality Forum (NQF) has subcontracted L&M Policy Research, LLC (L&M), to focus on Task 3 of the project, Analytic Support for the Measure Applications Partnership (MAP). Specifically, this task focuses on identifying quality issues for duals and related measures, and measure gaps, across all settings of care. The following five high-leverage domains defined by the MAP served as the overarching framework for this research task: quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures.

Methods

The research team undertook an environmental scan that included nine discussions with experts, a focused literature scan that built upon the MAP activities and interaction/feedback from the MAP workgroup itself. The goal of this scan was to winnow a broad set of potential measures (and possible gaps) into a prioritized subset of measures that address the five high-leverage domains and informs the broader MAP goals of drafting a core measure set. Figure 1 below includes a depiction of the major research activities associated with this task, followed by a description of each.

FIGURE 1. TASK 3 RESEARCH APPROACH

Literature review

To ground this task in an evidence base, we reviewed the NQF-supplied literature and began culling additional sources to improve our understanding of the relevant information published around quality metrics concerning duals. This literature review addressed a wide range of topics the team refined based on feedback from informant interviews and under consultation with NQF. Given the considerable amount of work the Duals Workgroup had already accomplished and the preceding research conducted under Task 2, the intent of this literature review was to build upon this body of work, not duplicate it.

As a first step, we reviewed the Duals Workgroup products and Avalere's Task 2. These sources included the current database of NQF-endorsed standards and the following:

- MAP Duals Workgroup Measure Table
- MAP Duals Interim Report
- MAP Clinician Coordination Strategy Report
- MAP Safety Coordination Strategy Report
- National Priorities Partnership Input to HHS on the National Quality Strategy

As a second step, L&M created a list of terms and/or relevant combinations of terms and inclusion/exclusion criteria (e.g., publication years, etc.) for use in the search of the extant literature. Search terms mapped to the described aims of the task, and the team systematically tried to address the key research aims through the literature review.

These terms included:

- Quality of life
- Care coordination
- Screening and assessment
- Mental health and substance use
- Structural measures
- Duals, Medi-Medi, Dual eligible
- Spend down
- Disability
- Functional status
- Frail elderly
- Vulnerable population
- Coordination of Medicare/Medicaid
- Fragmentation of care
- Coverage gaps
- Quality of care
- Quality measures
- Quality benchmarks
- Outcomes measures
- Disparities
- Self-directed care

Because the subject of duals is so broad and there is a multiplicity of terms that could have been used during this search to find relevant material, we created a tracking worksheet that included the combination of terms used and the number of relevant sources found in each database (see Attachment 3). We refined our search terms throughout the process based on the combination of terms that proved most successful. Using the criteria described above, L&M conducted searches using a combination of databases as well as targeted searches of articles published by relevant organizations and journals as well as the databases/search engines Academic Search Premier, PubMed, and Google Scholar.

To inform the measure development process, the team focused on literature associated with the best practices and challenges related to caring for the population of beneficiaries dually eligible for Medicare and Medicaid. There is sparse literature focusing on the intersection of measures development and caring for the dually eligible: The MAP workgroup reflects an innovative shift in thinking — the need for measures that specifically cater to the needs of this population. For background associated with the development of measures, the research team relied on NQF's reports as well as findings from the MAP workgroup, informant interviews, and the AHRQ Clearinghouse, which provided an additional source of specific measures beyond those initially provided by NQF. For an additional understanding of the most important facets of care delivered to the dually eligible individual, the research team relied on the literature search, its previous research experience around duals, and discussions with key informants.

Measures inventory, review, and prioritization

The team began the task by reviewing a compendium of more than 150 NQF-endorsed measures that each fell into at least one of the five high-leverage domains the MAP workgroup had previously identified as of particular importance to duals: quality of life, care coordination, screening and assessment, mental health and substance

use, and structural measures. To create a working set of measures manageable enough to review with stakeholders in one to one-and-a-half hour discussions, while still meaningfully representing the scope of available measures, the research team developed a five-step filtering process. The project team selected measures that fell into the areas of care delivery deemed most relevant to duals (i.e., discharges and follow-ups, transitions, medication management/reconciliation, end-of-life planning, etc.), as guided by the literature and previous relevant research conducted by the team. Within each of those groups, the team identified measures that best represented coordinated and comprehensive care. For example, the team selected a measure that included identification of a condition, documentation, management, and follow-up rather than one that just measured the frequency for which providers screened for a condition.

Key informant interviews

Following review of the initial measure cull with NQF, the team solicited the expertise of key informants to further explore the existing, as well as ideal or potential, measures. In doing so, the team presented each interviewee with a table of the measures identified through the filtering process and used a protocol with open-ended questions (see Attachment 1). Discussions solicited the informant's insights about the areas most relevant to capture when measuring the quality of care delivered to duals, as well as the strengths and weaknesses of the currently available measures. As directed and specified by NQF, the project team conducted nine interactions with key informants representing a range of perspectives during December 2011 and January 2012. Table 1 below lists interviewees, their organizations, and the perspective they offered. The team spoke with a range of interviewees representing different backgrounds so as to acquire a more robust picture of current gaps and barriers in measurement as well as areas that should be emphasized when targeting with duals.

TABLE 1: EXPERT DISCUSSIONS

Organization	Individuals	Perspective
Health Management Associates	Jack Meyer	Access issues for special needs populations
State of Minnesota	Pam Parker, Jeff Schiff, Scott Leitz	State concerns
Senior Whole Health/ Special Needs Plan (SNP)	John Charde, M.D.	Medical director, SNP, NY
National Program for All-Include Care for the Elderly (PACE) Association	Adam Burrows, M.D., Maureen Amos	Medical director and VP of quality and performance
National Committee for Quality Assurance (NCQA)	Sarah Scholle, Jennifer French	Measurement expertise
State of North Carolina	Denise Levis and team	State concerns
Centers for Medicare & Medicaid Services (CMS)	Cheryl Powell and team.	Federal policy priorities
Kaiser Family Foundation	MaryBeth Musumeci, Barbara Lyons	Data expertise
National Academy for State Health Policy (NASHP)	Neva Kaye, Diane Justice	State health policy expertise

Findings

This section presents a literature summary the team utilized to frame the environmental scan, followed by integrated findings from the scan, identifying the major gaps in the currently available measures as well as the areas key informants most frequently cited as intrinsic to gauging the nature of care delivered to duals.

Literature summary

Duals have been at the forefront of the push within the last decade to reduce disparities in care through an increased emphasis on quality improvement approaches (Weinick and Hasnain-Wynia, 2011). In December 2010, the Center for Medicare & Medicaid Innovation (CMMI) and the FCHCO together released a Request for Proposals

(RFP) for "State Demonstrations to Integrate Care for Dual Eligible Individuals," which ultimately seeks to test a variety of payment system and delivery models that integrate care for duals (Families USA, 2011). The release of this RFP—in addition to the ACA's creation of the FCHCO office itself—signifies an increased nationwide understanding that the opportunity to integrate cross-setting care and funding streams offer great potential in terms of improving the quality and cost of care delivered to this particularly vulnerable population (Bella and Palmer, 2009).

Currently, there are only a few models that represent the kind of cross-setting care integration these demonstrations seek to encourage: special needs plans (SNPs), The Program of All- Inclusive Care for the Elderly (PACE), and Medicaid managed care (MMC) (Bella and Palmer, 2009). SNPs are specialized Medicare Advantage (MA) plans that operate off of capitated premiums to provide Medicare-covered services; they covered just one million enrollees nationwide in 2009. PACE serves only an estimated 20,000 people nationwide, integrating Medicare and Medicaid services through capitated payments through each program (Fontenot and Stubblefield, 2011). Because the program is limited to people who need a nursing home level of care, it serves only a small number of duals (Jacobson, Neuman, Damico, and Lyons, 2010). MMC models vary widely but generally include fee-for-service (FFS) arrangements in conjunction with additional capitated payments to further coordinate care (Fontenot and Stubblefield, 2011).

Although integrated Medicare-Medicaid programs serve a small minority of duals, the literature clearly documents a number of elements needed for integration to be successful. According to the Center for Health Care Strategies (CHCS), these elements include:

- Comprehensive assessment to determine needs, including screening for cognitive impairment/dementia;
- Personalized (person-centered) plan of care, including a flexible range of benefits;
- Multidisciplinary care teams that put the individual beneficiary at the center;
- Involvement of the family caregiver, including an assessment of his or her needs and competency;
- Comprehensive provider networks, including a strong primary care base;
- Strong home- and community-based service options, including personal care services;
- Adequate consumer protections, including an ombudsman;
- Robust data-sharing and communications system; and
- Aligned financial incentives (Gore, Lind, & Somers, 2010).

Studies by Komisar and Feder (2011) and Thorpe (2011) suggest a similar list of elements as well as the importance of their simultaneous presence. In 2010, a study published by Burwell and

Saucier that reviewed the practices of four care management plans for duals noted that all possessed several elements that served as a framework for providing care: supportive services, primary care, medical management, behavioral health management, and member services.

In reality, however, providing quality care through these means is, at the very least, challenging. The traditional barriers to providing quality care for duals still hold true: Across the continuum, providers face fragmentation of financing and care, a lack of integration between medical services and social supports, and a need for more effective measures to gauge the quality of care being delivered (Brookings, 2010). A 2009 CHCS policy brief noted that the challenges associated with integration with SNPs as well as alternative integrated care models included:

- *Administrative/operational challenges*—integration of benefits is difficult due to the lack of alignment between Medicare and Medicaid
- *Financial misalignment*—savings achieved through Medicare are not felt on the Medicaid side and vice versa

- *Low enrollment*—SNPs do not draw large numbers of beneficiaries
- *Forging state-SNP relationships*—there are few contracts established between states and SNPs
- *Developing and bringing model SNPs to scale*—most SNPs do not have experience as Medicare insurers (typically born out of provider-sponsored organizations)

Among the four care management plans Burwell and Saucier (2010) studied, all faced challenges related to overlapping roles, non-comprehensive HIT, and administrative duplication.

As states begin to develop models of care that more consistently cater to the needs of dually eligible populations, overcoming some of these classic challenges, the available measures must reflect the specific needs of this vulnerable population. According to a 2010 report released by the Brookings Institution, performance measures should begin to target the distinct needs and goals of chronically ill patients through "patient- and family-focused" measures, which specifically stress continuity of relationships between patients and providers. The report also noted that while outcome measures provide information crucial to assessing quality, they are oftentimes problematic when it comes to sample sizes, variations in inputs, and risk adjustment. As a first step in developing measures specifically targeting the chronically ill, the focus should be on structure and process measures. Regardless of the approach, the message is clear: the development of an altered approach to measures so they target the needs of this particular population should coincide with the development of innovative integrated care delivery systems themselves.

Potential measures or measure concepts

In general, the notable gaps in the existing measures are the lack of cross-setting, cross-organization applicability and the general clinical orientation of the measures. While certain measures gauge key components of health care delivery, to truly measure the extent of person- centered care delivered to duals, they must be expanded to cover more than one patient condition or multiple settings, including behavioral health as well as non-medical social supports. Furthermore, this population is not homogenous—at the very least there are three distinct groups (frail elderly, younger adults with disabilities, and individuals with behavioral health issues)—and some measures must be considered differently from one strata to the next. The ultimate compendium of core measures would ideally reflect this heterogeneity. For example, the goal of a frail elderly individual may not be to avoid falls but, rather, to achieve the best quality of life possible, therein staying mobile and possibly enduring falls. To the extent possible, it is important to incorporate the individual's goals, level of functionality, and level of cognition, which vary significantly depending on the individual's personal circumstances.

Interviewees across the board emphasized that, when caring for this highly vulnerable population with complex needs, ongoing person-centered care that focuses resources on those most in need is the paramount goal. And when creating a compendium of measures best suited to gauge the quality of care delivered to duals, the compendium must be structured with this in mind. More specifically, interviewees said, it must measure: 1.) the extent that "high-touch" person-centered care planning and management occurs when needed and 2.) the extent to which the processes and structures in place support this as an ongoing activity. Using person-centered health and well-being as the focal point of measures relevant to duals, interviewees generally expressed the importance of seven key measures areas vital to creating a robust set of measures for duals:

- **Consumer-based assessment of goal-oriented planning and care delivery—**Patient/caregiver/family perception of extent to which care plan (if needed) and care delivered reflect goals and desires of the individual and/or care plan[2]
- **Management and monitoring of specific conditions and disabilities—**Provider and

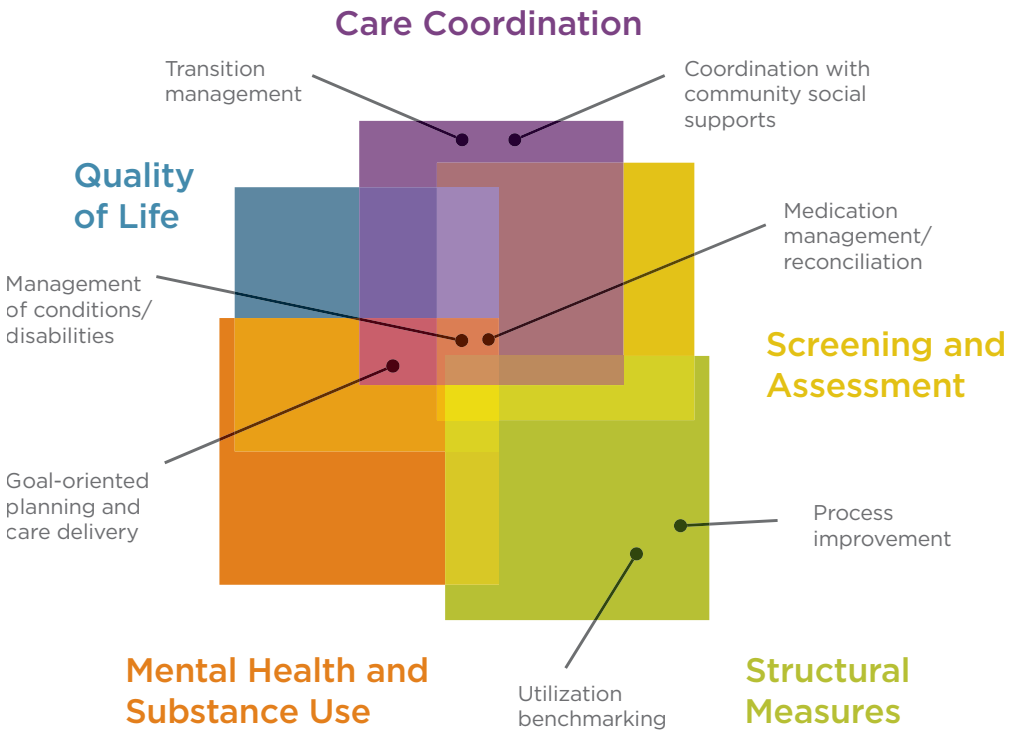
2 Multiple interviewees emphasized the importance of not "over-medicalizing" this assessment process for duals, given their many non-medical priorities.

patient active awareness of and engagement with signs and symptoms related to conditions (and clusters of them) to achieve individual's care plan goals

- **Medication management/reconciliation across settings—**Shared management of medications among provider and patient/caregiver focusing on goals of care plan to optimize appropriate use of medication and minimize negative drug interactions
- **Transition management—**Interactions that occur within and across settings among providers with patients and their families to ensure individuals receive comprehensive and streamlined care without duplication
- **Integration and coordination of community social supports and health delivery—**Ability to identify need for and ultimately integrate community social supports into care plan based on individual/caregiver needs
- **Utilization benchmarking—**Ability to gauge the extent of service use among duals and their subpopulations across settings
- **Process improvement across settings—**Ensure quality improvement programs are in place within and across settings and organizations that serve duals and their subpopulations

It is important to note that while not all of these focus areas speak directly to quality, the interviewees emphasized the importance of considering some indirect indicators of the status of services delivered to duals to highlight the importance of focusing on the improvement of service delivery across the continuum for this vulnerable population. Taken together, such areas represent a more robust and interconnected picture of the desired delivery system that will encourage "system-ness" with a team of primary service providers continuously recognizing and focusing on individuals' goals. Still, all seven areas fit within the five-high leverage areas the MAP developed as a framework to assess measures of particular importance to duals, as shown in Figure 2 below.

FIGURE 2. RELATIONSHIPS ACROSS FIVE HIGH-LEVERAGE AREAS AND KEY MEASURE AREAS



To capture all aspects of care delivery, it is important to recognize the focus of measures by dividing them into national-, state-, and provider-level areas. This approach can help clarify which entity is responsible for capturing and monitoring particular aspects of care delivery. Interviewees emphasized that a specific measure captured at the state level could look drastically different from a measure captured at the regional level or even the county or provider level, each telling a different story about the nature of care delivery.

To get a sense of how the existing measures (NQF-endorsed and others from the AHRQ Clearinghouse) fit into the measure areas informants highlighted, the research team created the table in Attachment 2. For each of the seven measure areas, the team chose a combination of measures most reflective of findings from discussions with key informants and pointed out their limitations for future application, therein suggesting areas that require further evolution in quality measurement. Although the team included non-NQF-endorsed measures in the table, it, first, reviewed and used NQF measures pulled from the initial filtering process. Second, it pulled additional measures as needed to round out the picture of currently available measures that fit within each of the seven measure areas.

Attachment 2 does not represent an exhaustive list of measures that must be applied to duals. Rather, it enumerates examples of selected existing measures related to the seven areas interviewees identified as key to gauging the extent of person-centered care delivery as well as the limitations and gaps that currently exist. Measures related to a specific condition/disability are meant to illustrate the limits of a single-condition measure and are not meant to suggest that one condition is more important to monitor than another. For this exercise, the research team chose measures reflective of the conversations with interviewees, which included a focus on mental health conditions, substance use issues, and diabetes.

CONSUMER-BASED ASSESSMENT OF GOAL-ORIENTED PLANNING AND CARE DELIVERY

Of the seven areas interviewees identified as intrinsic to capturing the quality of care delivered to duals, consumer-based assessment of goal-oriented planning and care delivery was emphasized most prominently. Key informants noted that to truly capture this area, measures must include the presence (or absence) of care plans that focus on the goals of the consumers and/or their families. This aspect of consumer involvement is central to gauging whether quality care is being delivered because oftentimes the goals of the individual are not necessarily the same as those of the clinician—and it is imperative that the individual play a central role in care-related decisions. “When we sit down to develop participant-centered plan with goals, we think of what’s important with this person’s life — and it’s not necessarily medical at all,” one informant said. “It may have to do with establishing meaning in life, and we don’t have much to assess.”

Although interviewees uniformly agreed that care planning should ideally play a central role in duals’ experience in the health care system, they also noted that it is challenging to develop meaningful measures that capture more than merely a “yes” or a “no” but, rather, the complexity of components that truly make a care plan useful to the individual. One interviewee noted that when he reviews care plans, he looks for multidimensional assessment across a number of domains—medical, social, functional, and nutritional—that identify patient goals and include an interdisciplinary team. Still, because not all dually eligible beneficiaries are in need of a care plan, measures that are developed to capture this area of care delivery must be flexible in their application.

The currently available measures related to this aspect of care delivery are for the most part limited to Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey measures as well as other sporadically applied consumer and quality-of-life surveys. Attachment 2 shows

a subset of measures that generally fit under the umbrella of this measure area. Still, they all have limitations, either as a result of their application in only a single setting, their lack of consumer input, or their application to a limited population.

MANAGEMENT AND MONITORING OF SPECIFIC CONDITIONS AND DISABILITIES

When discussing this measure area, interviewees noted that there currently exist a broad array of measures that fit under this umbrella category, but for the most part they are single-setting, single-condition measures, that do not truly capture the needs of the dually eligible population. As a majority of duals have multiple chronic conditions, it is important to capture the type of care provided to manage and monitor those conditions together across settings. For example, one interviewee noted that his studies have shown that diabetes and cardiovascular disease tend to present together and are also oftentimes accompanied by depression, making them logical to combine into one larger composite measure. "I think the conversation points to the fact that the science of disease-related quality measurement is not caught up with the complex dual population," one interviewee said. "We can measure entities that are measureable—A1C control, etc.—but that constellation of care is probably not as important as other things we should measure. I think it's a difficult area." Approaching disease-related measures in this way—by grouping conditions and monitoring them across settings—promotes a more "whole-person" approach to care that moves beyond viewing single conditions in a vacuum.

MEDICATION MANAGEMENT/RECONCILIATION ACROSS SETTINGS

Interviewees considered this measure area to be "one of the lowest hanging fruits for this population." It is crucial to capture documentation and continued management of medications across settings, which includes communication among multiple providers and continued awareness and engagement of patients/caregivers. Measures must extend well beyond walls of hospitals and primary care physician offices, especially given the number of specialists with whom duals typically interact, interviewees said. As Attachment 2 shows, there are currently a number of measures that target medication management/reconciliation upon discharge from an acute care setting. While this scenario is clearly important to capture, interviewees emphasized that the measures need to go beyond that—to account for the movement of duals through multiple different settings, not just upon discharge from the hospital. "We simplify medication management a bit too much," one interviewee said. "Hospitals might be doing a good job, but a lot of times they don't know what drugs the patients are on when they come in, then the patients leave with new drugs. It's a much more complex problems we're getting at right now." Of course, the type of measures that can be developed are dependent on the type of data collected: In many cases it is impossible for a provider to know if his or her patient filled a prescription and whether or not the patient takes that medication as directed. Still, the currently available measures can be built upon to focus not just on medication reconciliation within 30 days of discharge (see measure 0554 in Attachment 2) to include follow-up and management across multiple settings of care.

TRANSITION MANAGEMENT

While there is a plethora of measures associated with transition measurement, many of which focus on key areas such as communication among providers, they are still limited in their scope. Like the currently available measures for medication management/reconciliation, transition measures focus on the acute care setting—from an inpatient facility to the home (see measures 0646, 0647, 0648 in Attachment 2), or an emergency department (ED) to an ambulatory setting (measure 0649), or even from one acute care setting to another (measures 0291 through 0297).

Because duals frequently receive care in other settings, such as nursing homes, the limited nature of these measures does not capture

the full spectrum of care and the number of equally important transitions that require the same type of management and communication that occurs upon discharge from an acute care setting. According to one informant: "The quality measurement approach tends to work within a setting. That ignores critical handoffs that happens between settings."

INTEGRATION AND COORDINATION OF COMMUNITY SOCIAL SUPPORTS AND HEALTH DELIVERY

Due to the profile of the dually eligible population—poor, elderly, disabled—the integration and coordination of community social supports and health delivery is integral to their receiving quality care. Naturally, though, it may be the most difficult area to measure. As Attachment 2 shows, there is a paucity of measures that fit into this category, and those that do are generally limited to measures that assess the use of checklists that numerate patient needs for social supports. As this gap in the measures suggests, the development of such measures is problematic because the supports that are particularly important to duals are frequently not covered benefits, and is difficult to determine who should be held accountable.

Ideally, however, a measure set for duals would incorporate such integral elements as: transportation services to and from appointments, safe and clean low-income housing, translation services for non-English speakers, and employment counseling/training. Oftentimes these elements prove larger barriers to quality care than any of the other areas previously discussed. For example, without transportation, duals may be unable to get to their physician appointments, making the management and monitoring of their chronic conditions virtually impossible. Even if an individual has the means to arrive at an appointment, if he or she does not speak English, it may be difficult or impossible to understand a prognosis and how best to manage it.

In the case of some covered benefits, such as home- and community-based services (HCBS) waivers, there is also often little integration. Providers frequently do not alert their patients to the availability of HCBS services because they do not know they exist. When providers are aware of the HCBS system, they may still encounter difficulty in knowing which of their patients receive those services and supports, and how to coordinate them with medical care. In general, this area of the delivery system represents a major gap in measurement for duals: "The measures out there don't capture what's important in lives of individual families we serve. The gaps far dwarf what's actually available to measure quality for this population," one informant said.

UTILIZATION BENCHMARKING

The concept of utilization benchmarking is not traditionally discussed within the context of quality measurement because utilization is not a direct indicator of quality. Still, interviewees emphasized the importance in developing state and national benchmarks that promote a more robust picture of the status of service delivery to duals. Utilization trending at each level would ideally offer a profile of patterns that states, regions, and providers could use when comparing their own care delivery against national and state norms for important areas of service use beyond merely spending per beneficiary (Medicare and Medicaid), hospital days, and length of stay. Interviewees suggested that other high-leverage areas are also important to capture, such as: readmissions, ED visits, number of primary care physician (PCP) and specialty visits, number of specialists per beneficiary, condition-specific costs, etc. Interviewees said that tracking utilization trends for duals in particular is crucial to understanding the system entry and exit points for duals and gauging utilization trends against established norms so as to target outlier areas for improvement.

PROCESS IMPROVEMENT ACROSS SETTINGS

Structural measures of capacity for process improvement are also important. Similar to utilization benchmarking, these types of measures are indirect indicators of actual quality of care.

Because this measure area generally occurs at the organizational level to inform internal process improvement, it is challenging to measure these types of structures on a widespread basis. But without process improvement, there is no guarantee that any of the direct quality measures will see improvement over time. This measure area would ideally incorporate multiple provider settings and human service settings/organizations and gauge the extent to which they identify and solve problems within and across the continuum of care. As Attachment 2 shows, measures are trending toward process improvement—to gauge the intricacies of a person-centered medical home structure or the entrenchment of health information technology (HIT)—but there is still work remaining, particularly in determining the appropriate entity to be measured.

Practical issues

When discussing the ideal delivery system areas that should be captured to appropriately gauge the quality of care delivered to duals, interviewees mentioned three areas of practical hurdles that must be accounted for when developing new measures: population, data, and adoption. In terms of population concerns, interviewees emphasized that the current approach to viewing all duals as a single population is inaccurate. There are three distinct populations: frail elderly, younger adults with disabilities, and individuals with behavioral health needs. Because the populations differ drastically in their needs and health statuses, they should not be measured together and in the same way.

In terms of data hurdles, interviewees expressed a number of oft-repeated concerns: 1) the separate Medicare and Medicaid datasets make it nearly impossible to track duals in the data, 2) states have difficulty getting Part D claims in a timely fashion from CMS, which makes medication management challenging, 3) states have difficulty accessing substance abuse data without patient consent, and 4) electronic medical records (EHRs) vary in their state of development and ability to capture advanced data.

Interviewees also expressed concern around the methods associated with adopting new measures targeting duals. Because the population of duals is diverse in its care needs, many measures may suffer from their small sample size, as few duals will meet the criteria for inclusion. Interviewees also warned that because Medicaid programs differ from state to state, the profile of duals receiving certain services may differ across state lines, which will make it difficult to compare "apples to apples." "I would have a checklist for [measure developers] that would ask questions for these measures—is it something that everyone can gather? Is the definition accepted equally? If no on either, I'd drop the measure," one interviewee said. "This is something they are holding people accountable for. There are a minority of measures we can do."

Recommendations

Ultimately, to deliver high-quality care, the literature and interviewed stakeholders noted having an integrated delivery system as the key. To gauge the success of that system, measures must examine the extent to which processes occur across settings, at appropriate times, and in meaningful ways. This approach to measure development requires an evolution beyond the existing array of single-setting, single-condition measures. In doing so, measure developers could consider:

- Identifying key components of "system-ness" that are critical to capture in a measure set
- Limiting the number of measures so those responsible for focusing on improving quality have particular areas of focus
- Developing clear and specific criteria so that each measure gauges "apples to apples"
- Identifying the particular sub-population each measure applies toAccount for the data source of each measure because pulling and merging data from different agencies can be difficult if not impossible

- Applying consistent requirements across programs that account for meaningful use, as stipulated in the Health Information Technology for Economic and Clinical Health Act (HITECH), requirements to minimize duplication

Ideally, rather than backing into a measure set by incorporating a number of individual, "off the shelf" measures, the process of developing a measure set would begin with the availability and use of primary care providers within some form of a "medical home" and span outward. From there, the measure set could subsequently include screening and evaluation to determine those most in need of a care plan, the use of a care plan for those individuals, and, ultimately, improved outcomes in relation to the individuals' goals as identified through assessment and screening and outlined in the care plan when needed. Of course, these measures would ideally cover all settings and the full continuum of care provided to duals. This approach would recognize the importance of duals having an identified primary service provider who is acknowledged as their lead advisor and team member, helping them achieve their individual goals—in essence, ensuring that each dual (or ideally all beneficiaries) has a "primary home." Additionally, the approach would even go beyond a "medical home" since the team would take into account more than just medical needs — the focal point of this primary service provider would be the first proxy for quality care.

On the medical side, this would signal an ideal shift to a broader perspective on quality, one that focuses on routine check-ups, management, monitoring, and prevention, which, in turn, avoids frequent cycling in and out of the ED, a pattern that oftentimes impacts duals in greater numbers than other populations. Interviewees recognized that this desired outcome is not currently supported by current health system design or, in some instances, mandated benefits. Nonetheless, an evolving and more sophisticated measure set would view the use of this primary care giving team in the context of the system as a whole, gauging its frequency of use and availability related to other care settings.

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Attachment 1: Discussion Guide

Introduction

Thank you for speaking with us today. I work for L&M Policy Research, a health policy research firm in Washington, D.C. My research team is working with Avalere Health on behalf of the National Quality Forum (NQF) to provide analytic support for NQF's Measure Applications Partnership (MAP).

As you read in your invitation for this call, NQF convenes MAP to provide multi-stakeholder input to the Department of Health and Human Services (HHS) on the selection of performance measures for use in Federal programs. L&M is assisting the MAP in identifying measures of particular importance to Medicare-Medicaid dual-eligible beneficiaries (duals). L&M is tasked with helping NQF review and vet the MAP's initial list of current measures which are potentially appropriate for use in assessing the quality of care delivered to dual eligible beneficiaries.

Today we would like to hear your perspective on measures that may especially pertain to this population group. Additionally, we will ask for your feedback on the list of potential measures. The measures are grouped by five categories that MAP has identified as "high-leverage" in framing quality and the care experience for the duals population. We sent you this list in advance of our call—and for the purposes of this conversation, it will be helpful if you have the list in front of you and can refer back to it, since we will be discussing specific measures. *[Confirm they have it in front of them or help them retrieve it from an email before proceeding with the interview. The interviewee will have the list accessible in the event that the e-mail needs to be sent again.]* Essentially, we are seeking your insight into the top measures identified by the MAP Duals Workgroup as well as your perspective on the gaps in measures available.

We are soliciting input from a range of individuals and appreciate your perspective on these issues. Your honest opinions and comments will be extremely helpful. The information you share today will not be linked to you or your agency/office in any identifiable way in our report. Instead, your comments will summarized in combination with other interviewees by subject matter, without attribution, to provide NQF perspective on the measures under review.

Before we begin, do you have any questions?

General Background

I'd like to start by asking you a few questions about your background and your current role within [insert name of organization].

1. What is your current position and what are your responsibilities? Can you tell me about your experience, particularly as it relates to dual eligible beneficiaries or related issues in healthcare quality?

As I mentioned, the purpose of today's discussion is to discuss a series of quality measures identified by an NQF work group on duals. We are interested in your thoughts on which measures would be most effective given your experience in or with…*(tailor what you say here to the individual interviewee's description of their relevant experience).*

Measure Prioritization

2. The five domains identified by NQF as high-priority for the dual eligible population include:

- Quality of life
- Care coordination
- Screening and assessment
- Mental health and substance use
- Structural measures

Which of these domains seem particularly important to measure? Why? Are any major domains missing? *[Prior to reviewing any measures]*

3. For domain X *[go through all five domains if you have time, starting with the most important*

domain] what issues would you consider the most important indicators of quality? Put another way, what are the most important aspects of the care experience for duals and their caregivers/ families? Can you provide examples?

4. When considering the group of measures under domain X *(refer to the list developed by taking the best combination of the duals work group and L&M's filtering exercise sent to them in advance of the call),* do any measures seem particularly good or bad to use in assessing the quality of care provided to dual eligible beneficiaries?

Measure Implementation

5. For each of the measures in domain X, what barriers to use do you foresee? For example, is it feasible for providers, health plans, state agencies, and other stakeholders to use the suggested measures?

   a. Would data be readily available, or be retrievable without undue burden? *[Probe: availability of electronic information, reporting requirements, etc.]*

   b. Do you have any concerns related to the potential use of the measures on the list?

   [Probe: high risk of unintended consequences]

   c. Would any of the measures need to be modified before they could be used widely for the purpose of assessing the quality of care for dual eligible beneficiaries?

Gaps in Measures for Duals

6. Considering the list as a whole, do you believe there are important conditions or quality issues for which measures are missing? Do you know of specific measures that are available which could be added to the list to fill those gaps?

7. Do you have any insights related to how measures could be more rapidly developed in order to fill pressing gaps?

For example, we would like to ensure that measures are available at multiple levels of analysis and that there is a mix of process, outcome, structure, patient experience, and resource use measures.

Closing

Finally, do you have any closing comments or questions for us?

We appreciate your taking the time to speak with us and discuss your perspectives. If you have further thoughts or questions after this interview, feel free to contact me or Sarah Lash at NQF. Thank you.

Attachment 2: Delivery System Areas and Related Measures

Measure area: Consumer-based assessment of goal-oriented planning in care delivery

Measures	Sample gaps, barriers, & challenges
****0557-0558 NQF Endorsed:** Patients discharged from a hospital- based inpatient psychiatric setting with a continuing care plan created/ provided to the next level of care clinician or entity.	• Does not include patient perspective in creation of care plan; does not take into account that not all discharged patients may not need care plan • Only gauges whether or not care plan exists – not what it is composed of and to what extent it is referenced
****CAHPS NQF Endorsed** (NQMC:000849, ECHO® Survey 3.0 Adult Questionnaire): Behavioral health care patients' experiences: percentage of adult patients who reported whether someone talked to them about including family or friends in their counseling or treatment.	• Does not include Medicare (only commercial and Medicaid members) and only includes those in an MCO or MBHO • Not available at the provider level
****CAHPS NQF Endorsed** (NQMC:000843, ECHO® Survey 3.0 Adult Questionnaire): Behavioral health care patients' experiences: percentage of adult patients who rated how much improvement they perceived in themselves.	• Includes behavioral health patients – large group of duals. But denominator only includes those in an MCO or MBHO • Patients' perceived improvement – but does not necessarily imply existence of care plan that outlines goals
****CAHPS NQF Endorsed** (NQMC:006293, CAHPS® Health Plan Survey 4.0H, Adult Questionnaire): Health plan members' experiences: percentage of adult health plan members who reported whether a doctor or other health provider included them in shared decision making	• Only includes those in MCO – limited population • Not available at the provider level or for specific settings
****CAHPS NQF Endorsed** (NQMC:004536, CAHPS® Health Plan Survey 4.0, Adult Questionnaire): Health plan members' satisfaction with care: adult health plan members' overall ratings of their health care.	• Purely based on 1 to 10 rating of general care received. Lacking in specific areas of care (i.e. individualized care planning) that would really indicate the nature of satisfaction with care • Only includes those in MCO – limited population • Not available at the provider level or for specific settings
PSS-HIV (NQMC:002046): HIV ambulatory care satisfaction: percentage of HIV positive adolescent and adult patients who reported how often their case manager went over their service plan and updated it with them every 3 months.	• Limited to one setting (ambulatory) for one patient population (HIV) • Worthwhile to couple measure with measure gauging contents and "meaningfulness" of service plan
PSS-HIV (NQMC:002046): HIV ambulatory care satisfaction: percentage of HIV positive adolescent and adult patients who reported how often they wanted to be more involved in making decisions about their service plan and goals.	• Limited to one setting (ambulatory) for one patient population (HIV)

Measures	Sample gaps, barriers, & challenges
PSS-HIV (NQMC:002077): HIV ambulatory care satisfaction: percentage of HIV positive adult patients who reported whether their substance use counselors helped them to achieve their substance use treatment plan goals.	• Concept of measure is important – but is limited to one patient population in one setting. • Measure could be coupled with existence of "meaningful" care plan that is includes goals of individual
Non-U.S., Ministry of Health, Spain (NQMC:004978, AHRQ Clearinghouse) End-of-life care: percentage of healthcare professionals who affirm that in their unit or area enquiries are always made about terminal patients' preferences regarding life-support procedures and treatment.	• Limited to one provider's perspective – process measure as opposed to experience measure. But concept of including documentation of inquiries around end-of-life preferences in individualized care plan is important • Measure limited to "terminal patients" – in ideal world, would extend beyond that population to include advanced care planning • Non-U.S. measure
Non-U.S., British Medical Association (NQMC:005100, AHRQ Clearinghouse): Mental health: the percentage of patients on the mental health register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate.	• Sentiment of measure is important (existence of care plan agreed upon by individual/family/caregiver) • U.S. has no mental health register. Emphasizes importance of first having a designated patient population in need of care plan before developing a measure gauging extent of care plans' existence • Does not include patient perspective • Only measures the existence of care plan – not its component parts or the extent to which it is followed • Non-U.S. measure

COMMENTS

- Ideally, a measure set for this area would gauge consumer satisfaction with cross-setting care and/or of the care plan (if needed) to meet quality of life and quality of service needs
- To have measures that include goal planning documented in care plan, one must first identify population in need of care plan.
- Such measures run the risk of providers simply checking off the box rather than developing meaningful care plans. Important to have consumer perspective to reflect extent to which individual feels care needs are being met.
- Importance of including "goal-oriented planning" because personal desires/goals may be different from what physician deems "clinically correct" or "appropriate." Such goals and priorities may be driven by healthy literacy of patient, circumstances of patient/family/caregiver, patient's age and medical and home conditions
- *"When we sit down to develop participant-centered plan with goals, we think of what's important with this person's life – and it's not necessarily medical at all. It may have to do with establishing meaning in life – and we don't have much to assess."*
- *"There are ways I look at care plans to see they are multidimensional … The broad domains are medical, social, functional, and nutritional."*
- *"I'm looking to see that it's member-centered, it identifies patient goals, and then I want to see some reflection of interdisciplinary medication, problem solving – contributions from multiple disciplines… And the participant signs off on it. That's the real work of interdisciplinary care."*

Measure area: Management and monitoring of specific conditions and disabilities

Measures	Sample gaps, barriers, & challenges
0105 NQF Endorsed: Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner during the 84-day (12-week) Acute Treatment Phase. b. Percentage of patients who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day Acute Treatment Phase. c. Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days.	• Single-condition process measure – no sense of whether course of treatment was correct for individual patient or whether patient adhered to treatment plan; no sense of patient improvement as result of treatment
****0418 NQF Endorsed:** Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented	• Limited to single condition – useful to screen for depression and other conditions that often present with it, particularly for duals
0544 NQF Endorsed: Assess the use of and the adherence of antipsychotics among members with schizophrenia during the measurement year	• Limited – better to base on care plan (if it exists) and adherence to all medications taken based on goals of plan
0111 NQF Endorsed: Percentage of patients with bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide	• No sense of follow-up across settings, communication with other providers and development of plan with patient moving forward
0112 NQF Endorsed: Percentage of patients treated for bipolar disorder with evidence of level-of-function evaluation at the time of the initial assessment and again within 12 weeks of initiating treatment	• Limited to the evaluation – does not include goals of patient related to function
0110 NQF Endorsed: Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use	• No sense of follow-up across settings, communication with other providers and development of plan with patient moving forward
0077 NQF Endorsed: Percentage of patient visits for those patients aged 18 years and older with a diagnosis of heart failure with quantitative results of an evaluation of both current level of activity and clinical symptoms documented	• Single-condition measure with no sense of follow-up or long-term management
0076 NQF Endorsed: Percentage of adult patients ages 18 to 75 who have ischemic vascular disease with optimally managed modifiable risk factors (LDL, blood pressure, tobacco-free status, daily aspirin use).	• Single-condition measure with only one standard for "optimally managed" – no sense that patients vary in needs and goals
****CAHPS NQF Endorsed** (NQMC:000850, ECHO® Survey 3.0) Behavioral health care patients' experiences: percentage of adult patients who reported whether they were given enough information to manage their condition.	• Does not account for whether the information given to them was in line with care goals

COMMENTS

- Ideally, a measure set for this area would consist of a tailored compendium of measures (composites when feasible) that focus on person-centered care planning (when needed)
- The compendium would not only include single-conditions/diseases but also composites that couple screening of multiple conditions or condition clusters – that often present themselves together – at once.
- Measures will also ideally integrate management and monitoring of physical, behavioral and social risk factors and conditions
- For duals, particularly important conditions and risk factors to assess/measure include but are not limited to:
  - COPD
  - Cardiovascular disease
  - Diabetes
  - Depression and other serious mental illnesses
  - Substance use disorders
  - Intellectual/developmental disabilities or conditions
  - Multiple chronic conditions/polymedicine
- *"Take cardiovascular disease and diabetes. I'm finding that in the poor people with Medicaid, there's a huge cross-over between diabetes and cardiovascular disease – and those two and depression. So it would be nice if we were measuring whether people who have diabetes and cardiovascular disease are evaluated for depression."*

Measure area: Medication management/reconciliation across settings

Measures	Sample gaps, barriers, & challenges
0554 NQF Endorsed: Percentage of discharges from January 1 to December 1 of the measurement year for patients 65 years of age and older for whom medications were reconciled on or within 30 days of discharge.	• Limited to single act of "reconciliation" – no sense of whether patients have a plan for managing or understanding of how to manage medications; no sense of provider follow-up in management
0419 NQF Endorsed: Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over- the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verified with the patient or authorized representative documented by the provider.	• No sense of whether patient actually takes the medications and whether that list is communicated to all relevant providers
0553 NQF Endorsed: Percentage of adults 65 years and older who had a medication review	• Does not cross settings/providers or measure the extent to which medications are actually managed following review – no sense of follow-up beyond initial review
0520 NQF Endorsed: Percent of patients or caregivers who were instructed during their episode of home health care on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems	• No patient perspective – important to gauge whether patient actually understood instructions so as to manage own medications
****CAHPS NQF Endorsed** (NQMC:002460, CAHPS Hospital Survey (HCAHPS)): Hospital inpatients' experiences: percentage of adult inpatients who reported how often the hospital staff communicated well about medications.	• Limited to experience in hospital setting
NCQA (NQMC:002922) Geriatrics: percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.	• No sense of whether medication list was explained to and understood by patient and whether there was follow- up to make sure patient was managing medications. Documentation does not signal adherence to medication list

COMMENTS

- Ideally, a measure set for this area would focus on management of medications across providers and settings so as to ensure appropriate use of medications and avoid duplications/unnecessary side effects
- It is important to capture documentation and continued management of medications across settings, which includes communication among multiple providers and continued awareness and engagement of patients/caregivers. Measures must extend well beyond walls of hospitals and primary care physician offices, especially given the number of specialists with whom duals typically interact.
- "*We simplify medication management a bit too much. Hospitals might be doing a good job, but a lot of times they don't know what drugs patients are on when they come in, then the patients leave with new drugs. It's a much more complex problem we're getting at right now.*"

Measure area: Transition management

Measures	Sample gaps, barriers, & challenges
0646-0647 NQF Endorsed:** Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a reconciled medication list/transition record at the time of discharge including, at a minimum, medications in the specified categories	• Limited to measuring transition from acute care setting but stops there. • Missing component of reinforcement – either a visit to home to make sure management of medications is occurring properly or, at least, reinforcement through communication with PCP
****0648 NQF Endorsed:** 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 care within 24 hours of discharge	• Important in that it measures level of communication among providers and follow-up but only focuses on movement from inpatient facility
0649 NQF Endorsed: Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements	• Limited to transition from hospital setting; no sense of whether follow-up regularly occurs (despite existence of transition record) • Still, important measure for duals because many enter system through ED
0291-0297 NQF Endorsed: Percentage of patients transferred to another acute hospitals whose medical record documentation indicated that administrative information/ vital signs/ medication information/ patient information/ physician information/ nursing information/ procedures and tests was communicated to the receiving hospital within 60 minutes of departure.	• Does not include Medicare (only commercial and Medicaid members)
0291-0297 NQF Endorsed: Percentage of patients transferred to another acute hospitals whose medical record documentation indicated that administrative information/ vital signs/ medication information/ patient information/ physician information/ nursing information/ procedures and tests was communicated to the receiving hospital within 60 minutes of departure.	• Only focuses on transfer of information in acute care setting
****CAHPS NQF Endorsed** (NQMC:006296, CAHPS® Health Plan Survey 4.0H, Adult Questionnaire): Health plan members' experiences: percentage of adult health plan members who reported how often their personal doctor seemed informed and up-to-date about care they got from other doctors or other health providers.	• Limited to those in MCO (might mean a limited group of physicians as well as patient population)

COMMENTS

- Ideally, a measure for this area would track a patient's transition within and across multiple settings, throughout the full continuum of care - noting communication among providers, services agencies, and patients/families/ caregivers; documentation of conditions; and follow-up
- Transition management tends to stop when patient is discharged from hospital and not extend to other settings. Measures for this area must encourage and capture whether communication and documentation occur among multiple providers in various settings.

Measure area: Integration and coordination of community social supports and health delivery

Measures	Sample gaps, barriers, & challenges
Non-U.S., British Medical Association (NQMC:003014) Management: the practice has a protocol for the identification of [caregivers] and a mechanism for the referral of [caregivers] for social services assessment.	• Only applies to one practice at a time – no sense of larger community presence and integration of community social supports Non-U.S. measure
PSS-HIV (NQMC:002031): HIV ambulatory care satisfaction: percentage of HIV positive adolescent and adult patients who reported whether their providers or case managers asked them how they were feeling emotionally and made a referral to a mental health provider, counselor, or support group if needed.	• Limited to HIV patients in ambulatory setting and only includes a couple specific types of supports; additionally, no sense that the patient actually accessed the service or that there was follow-up

COMMENTS

- Ideally, a measure set for this area would gauge the extent of community and social supports available and the ease with which an individual can access those services
- Examples include availability of and connections with:
  - Transportation services to and from appointments
  - Safe and clean low-income housing
  - Translation services for non- English speakers
  - Employment counseling/training

Measure area: Utilization benchmarking

Measures	Sample gaps, barriers, & challenges
****0329 NQF Endorsed:** Overall inpatient 30-day hospital readmission rate	• Need state and national benchmarks for this to be useful and translate into actionable process improvements
0330 NQF Endorsed: Hospital- specific, risk-standardized, 30-day all-cause readmission rates for Medicare fee-for-service patients discharged from the hospital with a principal diagnosis of heart failure (HF).	• Need state and national benchmarks for this to be useful and translate into actionable process improvements
NCQA HEDIS (NQMC:006257): Ambulatory care: summary of utilization of ambulatory care in the following categories: outpatient visits and emergency department visits.	• Only includes outpatient and ED visits • Medicaid, Medicare, commercial managed care
NCQA HEDIS (NQMC:006258, AHRQ Clearinghouse): Inpatient utilization--general hospital/acute care: summary of utilization of acute inpatient care and services in the following categories: total inpatient, medicine, surgery, and maternity.	• Only includes managed care plans and not duals who may have no medical home

COMMENTS

- Ideally, a measure set for this area would track overall utilization trends and those for subpopulations across all settings and develop comprehensive set of national benchmarks for states, regions, and providers
- Utilization trending at each level would offer a profile of patterns which states and providers could use in comparing their own care delivery for important areas of service use beyond overall spending per beneficiary (Medicare and Medicaid) hospital days and length of stay but also focusing on high leverage areas such as: readmissions, ED visits, number of PCP and specialty visits, number of specialists per beneficiary, condition-specific costs, etc.
- *"There's a huge unmet need for meaningful measures...In an effort like this I'd be more inclined to get coordination around the ultimate outcomes – institutionalization, end- of -life care costs, cost utilization measures. I think I feel more passionate about needing that for benchmarking rather than micro- managing process measures within a program."*

Measure area: Process improvement across settings

Measures	Sample gaps, barriers, & challenges
****0490 NQF Endorsed:** Documents the extent to which a provider uses a certified/qualified electronic health record (EHR) system capable of enhancing care management at the point of care. To qualify, the facility must have implemented processes within their EHR for disease management that incorporate the principles of care management at the point of care which include: (a.) The ability to identify specific patients by diagnosis or medication use (b.) The capacity to present alerts to the clinician for disease management, preventive services and wellness (c.) The ability to provide support for standard care plans, practice guidelines, and protocol	• Process improvement measures generally need to be pinpointed by and tailored to individual organizations/ settings • Must determine which types of organizations are required to undertake certain processes and determine which types of processes are most important for which kinds of organizations
****0494 NQF Endorsed:** Percentage of practices functioning as a patient- centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: (a.) Improved access and communication (b.) Care management using evidence-based guidelines (c.) Patient tracking and registry functions (d.) Support for patient self-management (e.) Test and referral tracking (f.) Practice performance and improvement functions	• *"Measuring the number of practices in there that have a medical home is not the way to go. People are not equally distributed among all practices. There are some other proxies. Some things around identifying usual sources of care – softer areas – might get at the patient perspective."* • *"Yes, this is what the medical home should do, but the question is how do you check it?"*

COMMENTS

- Ideally, a measure set for this area would incorporate multiple provider settings and human service settings/organizations to ultimately address population health
- Measures in this set represent areas where there is room for innovation and improvement in and among individual settings
- Challenging measure area because process improvement is oftentimes identified by a single organization or even within a single hospital or social service department. Represents importance of identifying and solving problems across, among, and within a setting, but needs to be encouraged across the full continuum of duals care delivery.

**MAP core measure for dual eligible beneficiaries

Attachment 3: Literature Tracking Sheet

Database	Term used	Other filters	Hits	Pulled
Academic Search Premier	Quality measures +duals		11	0
Academic Search Premier	Measures + duals + quality of care		3	0
Academic Search Premier	Quality benchmarks + duals		0	0
Academic Search Premier	Benchmarks + duals +quality		19	0
Academic Search Premier	Benchmarks + dual eligible +quality		0	0
Academic Search Premier	Measuring +dual eligibles		1	0
Academic Search Premier	Quality of care + dual eligibles		1	0
Academic Search Premier	Quality of care + vulnerable populations		15	0
Academic Search Premier	Quality of care + disparities + measures		65	5
Academic Search Premier	Coverage gaps + disparities + measures		0	0
Academic Search Premier	Quality of care + disparities + benchmarks		3	0
Google Scholar	Quality measures + duals	since 2002	127	1
Google Scholar	Quality of care + duals + benchmarks	since 2002	35	1
Google Scholar	Measuring + dual eligibles	since 2002	312	0
Google Scholar	Best practices + dual eligibles	since 2002	202	1
PubMed	Dual eligibles + measures		4	0
PubMed	Dual eligibles + best practices		0	0
PubMed	Dual eligibles + quality		0	0
PubMed	Benchmarks + duals		0	0
PubMed	Quality measures + duals		0	0
PubMed	Quality of care + measures + disparities	Full text	129	1
PubMed	Dual eligible		46	0
MedPAC	Dual eligible		Culled site	0
NCQA	Dual eligible		124	1
Robert Wood Johnson Foundation	Dual eligible		8	0
The Commonwealth Fund	Dual eligible		133	0
Kaiser Family Foundation	Dual eligible		Culled site	0
New England Journal of Medicine	Dual eligible		111	1
CHCS	Dual eligible		28	4
Mathematica Policy Research	Dual eligible		35	0
Health Affairs	Dual eligible + quality measures		352	2
SCAN Foundation	Dual eligible		Culled site	0
AHRQ	(culled the measures)		N/A	N/A

APPENDIX J:
Measure Endorsement and Maintenance

NQF offers three primary opportunities for communication with measure developers to improve the applicability of measures to the dual eligible population. These opportunities include new calls for measures, measure maintenance reviews, and annual measure updates.

NQF uses its formal **Consensus Development Process** (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry. NQF's measure endorsement activities are standardized in a regular cycle of topic-based measure evaluation. NQF follows a **three-year schedule** that outlines the review and endorsement of measures in 22 topic areas such as cardiology, behavioral health, and functional status. As the need arises, the topic areas may be revised to account for measures that may require a new or more appropriate topic area.

As an endorsing body, NQF is committed to ensuring the performance measures it endorses continue to meet the rigorous NQF **measure evaluation criteria**. Every three years, endorsed measures are re-evaluated against these criteria and are reviewed alongside newly submitted (but not yet endorsed) measures. This head-to-head comparison of new and previously endorsed measures fosters harmonization and helps ensure NQF is endorsing the best available measures.

Prior to the scheduled three-year maintenance review, stewards of endorsed measures provide NQF with any modifications to the measure specifications, current evidence supporting the measure, data supporting use of the measure, testing results, and other relevant information. NQF also solicits stakeholder input on implementation and use of the measure, changes in evidence, scientific soundness, and feasibility.

In the two years when an endorsed measure is not being re-evaluated for continued endorsement, measure stewards will submit a status report of the measure specifications to NQF. This report will either reaffirm that the measure specifications remain the same as those at the time of endorsement or last update, or outline any changes or updates made to the endorsed measure. An ad hoc review will be conducted if the changes materially affect the measure's original concept or logic.

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