NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership
MAP Coordinating Committee Web Meeting

July 18, 2014 | 12:00 pm - 2:00 pm ET

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Meeting Objectives:

- Finalize 2014 MAP Dual Eligible Beneficiaries Workgroup Report
- Finalize 2014 recommendations to HHS on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid
- Receive updates on MAP Kaizen process improvement activities

12:00 pm **Welcome and Review of Meeting Objectives**
George Isham, MAP Coordinating Committee Co-Chair
Beth McGlynn, MAP Coordinating Committee Co-Chair
Sarah Lash, Senior Director, NQF

12:10 pm **2014 Recommendations to HHS on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid**
Harold Pincus, MAP Medicaid Task Force Chair
Elizabeth Carey, Project Manager, NQF
Moderator: Beth McGlynn

- Themes from report: states' experience collecting and reporting the core set, MAP review of the core set, and strategic issues
- Recommendations: measures for phased addition, measures with conditional support for continued use, measures for removal, and addressing high-priority gaps

- MAP Coordinating Committee Discussion
    - Feedback on measures of medication management and readmission

1:00 pm **Opportunity for Public Comment**

1:10 pm **2014 MAP Dual Eligible Beneficiaries Workgroup Report**

Alice Lind, MAP Dual Eligible Beneficiaries Workgroup Chair
Megan Duevel Anderson, Project Manager, NQF
Moderator: George Isham

- Themes from report: strategy to maintain the family of measures, supporting improved beneficiary quality of life outcomes
- MAP Coordinating Committee Discussion
    - Review of public comments
    - Feedback on approach to gathering stakeholder experience with measure use
    - Potential future topics for workgroup consideration

1:40 pm **Opportunity for Public Comment**

1:45 pm **MAP Continuous Improvement – Updates**
Rob Saunders, Senior Director, NQF

1:55 pm **Summary and Next Steps**

2:00 pm **Adjourn**

Measure Applications Partnership

Coordinating Committee Web Meeting

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July 18, 2014

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- 2014 Recommendations to HHS on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid
- Opportunity for Public Comment
- 2014 MAP Dual Eligible Beneficiaries Workgroup Report
- Opportunity for Public Comment
- MAP Continuous Improvement – Updates
- Summary and Next Steps

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MAP Reports for HHS in 2014

Deliverables	Date Due to HHS
✓ MAP Pre-Rulemaking Input	February 1, 2014
✓ Families of Measures for Assessing Affordability, Population Health, and Person- and Family-Centered Care	July 1, 2014
2014 Report from the Dual Eligible Beneficiaries Workgroup	August 29, 2014
2014 Report on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid	August 29, 2014

2014 Recommendations to HHS on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid

Medicaid Task Force Membership

Workgroup Chair: Harold Pincus, MD

Organizational Members

American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
Humana, Inc.	George Andrews, MD, MBA, CPE
L.A. Care Health Plan	Jennifer Sayles, MD, MPH
March of Dimes	Cynthia Pellegrini
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Consumer Voice for Quality Long-Term Care	Lisa Tripp, JD
National Rural Health Association	Brock Slabach, MPH, FACHE

Medicaid Task Force Membership

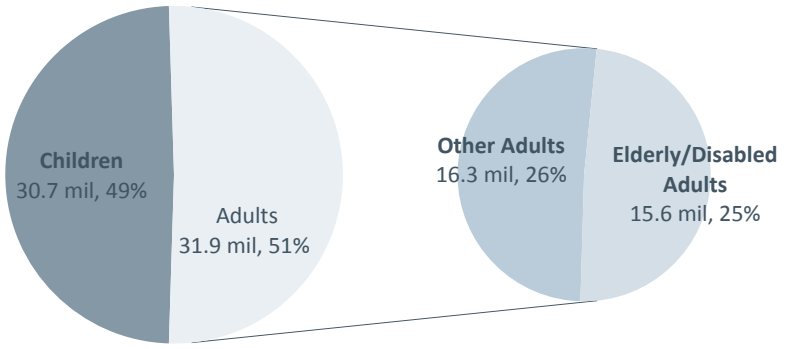
Subject Matter Experts

Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
Medicaid ACO	Ruth Perry, MD
Mental Health	Ann Marie Sullivan, MD
State Medicaid	Marc Leib, MD, JD

Federal Government Members

Centers for Medicare & Medicaid Services (CMS)	Marsha Smith, MD, PhD, FAAP

Medicaid Enrollees
(2009, in millions)



Since 1965, Medicaid has been the source of health coverage for low-income adults and children.

Kaiser Commission on Medicaid and the Uninsured. *Medicaid Primer: Key Information on the Nation's Health Coverage Program for Low-Income People*. March 2013.

Medicaid Adult Core Set

Background

- Requirement of the Affordable Care Act to identify a parsimonious core set of measures that is reflective of the diverse health care quality needs of adults in Medicaid
  - Initial core set identified through multistakeholder process, annual improvements to strengthen core set are required
  - *Voluntary* reporting began FFY 2013, with technical assistance program
- 2-year grant program began Dec 2012 to support Medicaid agencies in collecting and reporting the core set
  - 26 states required to report at least 15 measures in 2014
  - In the future, CMS will make information reported by the states publicly available

Medicaid Adult Core Set

CMS Goals

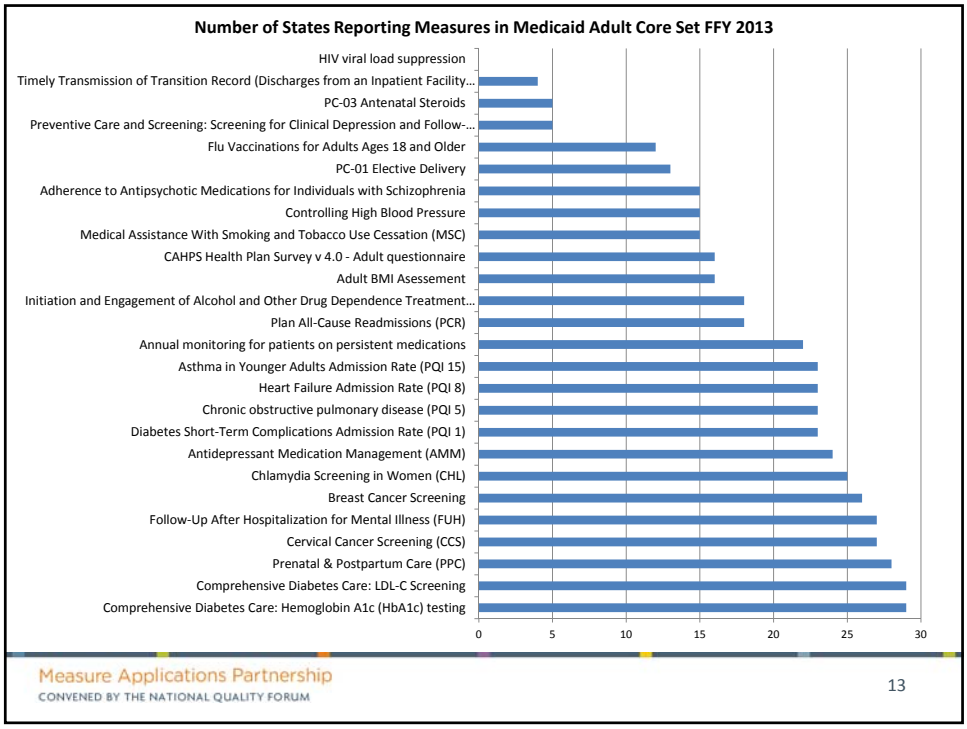
- Three-part goal for Core Set:
  1. Increase number of states reporting Core Set measures
  2. Increase number of measures reported by each state
  3. Increase number of states using Core Set measures to drive quality improvement
- Program is in its infancy
- As with any new reporting program, CMS has spent the past year working with states to understand the Core Set measures and to refine the reporting guidance provided
- Performance results of measures not yet available for MAP review

Medicaid Adult Core Set Properties: National Quality Strategy

National Quality Strategy and CMS Quality Strategy Priorities	Number of Measures in the Medicaid Adult Core Set (n = 26)
Patient Safety	7
Person- and Family-Centered Experience of Care	1
Effective Communication and Care Coordination	6
Prevention and Treatment of Chronic Disease	2
Healthy Living and Well-Being	8
Affordability	1

Medicaid Adult Core Set Properties: Conditions

Clinical Conditions in Current Medicaid Adult Core Set	Number of Measures (n = 26)
Preventive Screening and Care	6
Behavioral Health and Substance Use	5
Cardiovascular Disease and Diabetes	5
Care Coordination and Experience of Care	4
Maternal and Prenatal Health	3
Respiratory Care, COPD and Asthma	2
HIV/AIDS	1



States' Experiences: Reporting and Non-Reporting States

- 3 participating states and 2 non-participating states shared their perspectives with the MAP Medicaid Task Force
- Measure Selection Process
  - Preferred measures that they were already collecting
  - Preferred measures that had understandable specifications
  - In some cases, selected measures to strategically grow capacity or focus a quality improvement activity
  - Avoided measures with relatively high cost of reporting
- Use of Data
  - Found value in linking data sets (e.g., vital records) that could contribute to other state-wide quality improvement efforts

States' Experiences: Reporting and Non-Reporting States

- Perceived Benefits
  - States can test "clever ideas" for quality improvement
  - Data-driven Medicaid policy and interventions
  - New partnerships and data capabilities developed
- Barriers
  - Investment required for reporting each additional measure
  - Lack of benefits/payment for some services (e.g., treatment for SUD)
  - Bundled payments obscured data granularity needed for measure calculation
- Recommendations
  - Take steps to allow for valid comparisons between states
  - Measures should be aligned with other programs (e.g., Meaningful Use, HEDIS)

Strategic Issues

- Building state capacity for measurement and quality improvement
- Balancing sophisticated analysis with the need to encourage voluntary participation
- Alignment of measures across Adult and Children's Core Sets to provide an overall picture of quality within Medicaid
- Ultimate uses of measurement information for improvement, comparison, and public reporting

Task Force Recommendations

- MAP supports most measures in the Core Set
  - 22 of 26 measures supported for continued use in the program
- Measures with conditional support for continued use:
  - NQF# 2371 Annual Monitoring for Patients on Persistent Medications
  - NQF# 1768 Plan All Cause Readmission
  - NQF# 2372 Breast Cancer Screening
- Measures suggested for removal:
  - NQF# 0063 Comprehensive Diabetes Care: LDL-C Screening
    - » Removed from HEDIS 2015 because of changing lipid management guidelines

Measures for Phased Addition

Prioritized Additions to Fill Gaps

1. NQF# 0059 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
2. NQF# 1799 - Medication Management for People with Asthma
3. NQF# 0647 - Transition Record with Specified Elements Received by Discharged Patients

Remaining Gaps in Medicaid Adult Core Set

Long-term process to develop and add other measures

- While not inclusive of all gaps identified in the set, the Task Force recommended priorities for future action:
  - Maternal health
    - Use of progesterone to decrease early deliveries, contraception use, etc.
  - Behavioral health
    - Major driver of readmissions
  - Access to ambulatory services
    - Lack of access and care coordination contribute to overuse/inappropriate use of services
  - Beneficiary experience
    - Do CAHPS items reflect the issues important to adults with Medicaid?

MAP Coordinating Committee Discussion

Further Guidance on Measures with Conditional Support – 1 of 2

- Core Set currently contains Annual Monitoring for Patients on Persistent Medications (#2371, formerly #0021)
  - The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.
- Following an update, the measure has been recommended by the NQF Safety Steering Committee for endorsement (after losing it in the past)
  - During last year's review, the measure was not endorsed and MAP recommended it be considered for replacement. Task Force also thought its scope was relatively limited.
  - **Now that the measure is likely to regain endorsement, is there a compelling reason to substitute a different medication measure?**

Further Guidance on Measures with Conditional Support – 2 of 2

CMS Considering an Alternative Readmission Measure

- Core Set currently contains Plan All-Cause Readmissions (#1768)
- Stakeholders have suggested that Hospital-Wide All-Cause Unplanned Readmission (#1789) may be a superior measure because it aligns with facility-level programs.
- The two measures differ in their design due to the purposes for which they were intended to be used
- MAP conditionally supports the continued use of #1768 to maintain stability in the measure set, but urges CMS to consider issues related to fit-for-purpose

CMS' Strategic Considerations for Fit-For-Purpose

Would the Coordinating Committee suggest any additions?

- CMS must establish the primary intended use for the measurement information because different "use cases" lead to different conclusions.
  - Is alignment with health plan information or hospital information preferred?
  - Will health plan information or hospital information be more actionable for State Medicaid agencies? For CMS?
  - Does one method of data collection offer a significant advantage over the other?
  - What additional investments in testing are required?

Opportunity for Public Comment

2014 MAP Dual Eligible Beneficiaries Workgroup Report

Dual Eligible Beneficiaries Workgroup Membership

Workgroup Chair: Alice Lind, MPH, BSN

Organizational Members

America's Essential Hospitals	Steven Counsell, MD
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	Gwendolen Buhr, MD, MHS, MEd, CMD
Center for Medicare Advocacy	Alfred Chiplin Jr., Esq, JD, MDiv
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE
L.A. Care Health Plan	Representative to be determined
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

Dual Eligible Beneficiaries Workgroup Membership

Subject Matter Experts

Substance Abuse	Mady Chalk, MSW, PhD
Disability	Anne Cohen, MPH
Emergency Medical Services	James Dunford, MD
Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Medicaid ACO	Ruth Perry, MD
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

Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Jamie Kendall
Substance Abuse and Mental Health Services Administration	Lisa Patton, PhD
Veterans Health Administration	Daniel Kivlahan, PhD

Current Report Builds on Previous Work

Themes in 2014 Report on Quality for Dual Eligible Beneficiaries

- Maintaining the family of measures
- Supporting improved quality of life outcomes
  - Strategies and available tools to drive quality improvement
  - Activities to address high-priority measure gaps
- Approach to gathering stakeholder experience
  - Understanding alignment and impact of measures
  - Developing feedback mechanisms
- Potential future topics for Workgroup consideration

What is a family of measures?

The family of measures functions differently than the Medicaid Adult Core and other defined program sets

- Families of measures:
  - Provide a tool that stakeholders can use to identify the most relevant measures for their particular measurement needs,
  - Promote alignment by highlighting the most important measurement categories, and
  - Can be applied by other measurement initiatives.
- Consider the family of measures like a menu or "pick list"
- MAP uses families of measures to guide its pre-rulemaking recommendations on measures for specific federal programs

Properties of the Family of Measures

- The Family of Measures for Dual Eligible Beneficiaries contains 58 total measures and a list of prioritized gap areas.
- The majority of the measures in the family are currently in use across HHS programs.
  - 43 of the measures are finalized in at least one HHS program
  - 32 are finalized in more than one program
  - 14 measures in the family have been included in the CMS core for the Financial Alignment Initiative
- MAP periodically revisits the Family of Measures for Dual Eligible Beneficiaries to ensure that it reflects the best available measures.

Maintaining the Family of Measures

Incremental changes to the family: 2 deletions, 2 additions

- Since MAP's last review of the family of measures, two measures within it have had their endorsement removed and were retired:
  - # 0486 Adoption of Medication E-Prescribing
  - # 0573 HIV Screening Members at High Risk of HIV
- New measures also became available or were needed to substitute for retired measures:
  - # 2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB)
  - # 2079 HIV Medical Visit Frequency

High-Priority Measure Gaps

The same gap areas for measurement persist…

- Goal-directed, person-centered care planning and implementation
- Shared decisionmaking
- Systems to coordinate acute care, long-term services and supports, and nonmedical community resources
- Beneficiary sense of control/autonomy/self-determination
- Psychosocial needs
- Community integration/inclusion and participation
- Optimal functioning (e.g., improving when possible, maintaining, managing decline)

Strategies to Support Improved Quality of Life Outcomes for Dual Beneficiaries

Models and Practices

- **Person- and Family-Centered Care Planning** considers the consumer first in any healthcare conversation and decision.
- **Team-Based Care** is necessary to address complex medical and social needs to support consumers' quality of life outcomes.
- **Shared Accountability** includes the individual and his or her family/caregivers, health professionals, provider systems, health plans, community and human services, and state and federal governments in joint responsibility.
- **Shared Decisionmaking** is particularly important for preference-sensitive healthcare choices.

Strategies to Support Improved Quality of Life Outcomes for Dual Beneficiaries

Indicators and Surveys

- CMS Continuity Assessment Record and Evaluation (CARE) Tool
- Uniform Data System for Medical Rehabilitation (UDSMR) Functional Independence Measure (FIM)® instrument
- National Core Indicators Surveys (NCI)
  - NCI Intellectual/Developmental Disabilities Survey
  - NCI Aging and Disability Survey

Approach to Gathering Stakeholder Feedback

- MAP is seeking more direct information on the experience of using measures to inform future decisionmaking.
- The report provided a potential approach for how this feedback from stakeholders could be gathered.
- Sought public comment on the aims and methods of the analysis.
  - Alignment
  - Impact
- Coordinating Committee feedback also needed.

Approach to Gathering Stakeholder Feedback

Measure Alignment

- Alignment is achieved when sets of measures function well across settings or programs to produce meaningful information without creating extra burden for those responsible for the measurement.
- Use of the same measures across programs can reduce conflicting or redundant requirements.
- MAP has identified as an important characteristic of measure sets and recognizes poorly aligned program requirements as a source of frustration for stakeholders.

Approach to Gathering Stakeholder Feedback

Measure Impact

- The concept of fit-for-purpose complements alignment. Measure designs and specifications should match the goals, target population, care setting, and other features of the program in which they are used.
- A healthcare system that maintains a balance of a small number of well-aligned measures that have strong fit-for-purpose will avoid placing unintended measurement burden on participants.
- Quality improvement efforts can be concentrated on a select few priority areas and have greater impact

Approach to Gathering Stakeholder Feedback

Building Feedback Mechanisms

- Creating more structured feedback mechanisms is a way to collect and share insights about measurement successes and opportunities for revision.
- MAP has suggested the types of information that should be collected from entities using measures for the purpose of this analysis. Potential topics of interest include the identification of:
  - Measures that are widely used, to promote further alignment, contribute to a significant positive impact on healthcare quality,
  - Measures not functioning as intended, to convey desired modifications to measures' stewards;
  - Measures that are a poor fit for a program's goals, to potentially reduce burden by recommending their use be discontinued.

MAP Coordinating Committee Discussion

Themes from Public Comment

General Comments	• Supported a parsimonious and harmonized family of measures to reduce data collection fatigue; • Expressed uncertainties relating to the use of surveys to capture experiences of care due to concerns about data integrity in some cases and recommended that MAP focus measurement efforts on direct outcomes measures; • Discussed the need for risk adjustment of measures for high risk beneficiaries to ensure better alignment of measures across various populations.
Updates to Family of Measures and Gaps	• Emphasized the importance of person-centered care planning through a more comprehensive approach (e.g., skill set, experience surveys, gaps research on social determinants of health) • Supported MAP's list of gap areas and provided recommendations for additional measurement gaps to be explored;
Strategies to Support Quality of Life Outcomes	• Supported the four domains of quality of life measurement and recommended further exploration of the HCBS rule that can lead to further measurement areas.
Approach to Constructing a Stakeholder Feedback Loop	• Recommended conducting informational interviews with stakeholders to ensure accurate representation of their voices and identify possible quality areas for measurement.

Coordinating Committee Discussion Points

- Is a specific response to any of the public comments needed?
- Does the CC approve of the following potential research questions for the "feedback loops" effort or have other comments?
  - Are measures used in programs fulfilling their intended purpose of producing improved quality?
  - Is alignment among certain programs of particular interest?
  - From what types of stakeholders should MAP gather feedback about measure use?
  - Do stakeholders beyond MAP have information needs that could be satisfied by this analysis?

Potential Future Topics: Coordinating Committee preferences?

General Topic Areas	Specific Components Suggested by Workgroup Members
Conceptual work to revisit high-leverage opportunities and explore person-centered wellness	• Visioning a future state for quality measurement • Conceptual models of system change and individual behavior change • Discussion of research priorities with PCORI • Shift to a wellness-directed model over a disease-focused model using IOM model of living well with chronic illness and social/behavioral domains • Identification of interim measures to use in nonmedical domains • Levels of beneficiary capacity to engage in shared decisionmaking and choice
Additional topics on measure development and application	• How to engage private sector and provider organizations in measure development, review, and endorsement processes to enhance adoption, participation, and buy-in • Linking public/private data, involving other disciplines, and using "big data" analytics to accelerate measure development • Creating structural measures to evaluate the degree of integration of Medicare/Medicaid benefits and services • Identifying a core data set for the FAD that honors person-centered values
Other factors related to quality of care and outcomes	• Primary care/behavioral health integration models • Employment outcomes for dual eligible beneficiaries • Implications of measurement activities on the workforce • Potential for risk adjustment of measures within the Dual Eligible Beneficiaries Family of Measures

MAP Continuous Improvement – Updates

Opportunities for Improvement

- Responding to Coordinating Committee feedback, staff have been working through a Kaizen improvement process.
- Surveyed MAP members on key considerations.
- Changes to highlight today:
  - Streamlining deliverables with measure input and guidance on programs and policy
  - Simplifying meeting materials for committee deliberations
  - Extending public comment windows and making comments available for MAP discussions

Opportunity for Public Comment

Next Steps

- **Through July 30:** Public comment on draft report on Adult Medicaid Core Set
- **July 29:** Dual Eligible Beneficiaries Workgroup teleconference to consider public comments and Coordinating Committee feedback
- **August 29:** MAP's reports on Adult Medicaid Core Set and Dual Eligible Beneficiaries due to HHS

Adjourn

Appendix Material (if needed)

0097 – Medication Reconciliation

NQF Endorsed
Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0097

Description:	Percentage of patients aged 18 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days of discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist who had reconciliation of the discharge medications with the current medication list in the outpatient medical record documented. This measure is reported as two rates stratified by age group: 18-64 and 65+.
Exclusions:	N/A
Data Source:	Administrative claims, Electronic Clinical Data
Level of Analysis:	Clinician: Individual, Population: National
Care Setting:	Ambulatory Care: Clinician Office/Clinic, Home Health
Alignment:	Medicare Shared Savings Program, PQRS

0419 – Documentation of Current Medications in the Medical Record

NQF Endorsed – Steward: Centers for Medicare & Medicaid Services

QPS Link: http://www.qualityforum.org/qps/0419

Description:	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration
Exclusions:	For Members on Anticonvulsants: (optional) Members who had an inpatient (acute or nonacute) claim/encounter during the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data: Registry
Level of Analysis:	Clinician: Individual, Population: National
Care Setting:	Clinician Office/Clinic, Outpatient Behavioral Health/Psychiatric Facility, Dialysis Facility, Home Health, Other, Inpatient Rehabilitation Facility, Nursing, Home/Skilled Nursing Facility
Alignment:	Meaningful Use Stage 2 – Eligible Professionals, PQRS

0541 – Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

NQF Endorsed – Steward: Pharmacy Quality Alliance

QPS Link: http://www.qualityforum.org/qps/0541

Description:	The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Beta-Blockers (BB), Renin Angiotensin System (RAS) Antagonists, Calcium-Channel Blockers (CCB), Diabetes Medications, Statins.
Exclusions:	Exclusion criteria for the PDC category of Diabetes medications: Patients who have one or more prescriptions for insulin in the measurement period.
Data Source:	Electronic Clinical Data: Pharmacy
Level of Analysis:	Clinician: Group/Practice, Team, Health Plan
Care Setting:	Ambulatory Care: Clinician Office/Clinic, Pharmacy
Alignment:	Meaningful Use Stage 2 – Eligible Professionals, PQRS

NATIONAL QUALITY FORUM

Measure Applications Partnership: 2014 Report from the Dual Eligible Beneficiaries Workgroup

DRAFT REPORT FOR COMMENT

June 13, 2014

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I task order 11.

Table of Contents

Introduction

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF). MAP provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs (Appendix A). MAP has also been charged with providing input on the use of performance measures to assess and improve the quality of care delivered to individuals who are enrolled in both Medicare and Medicaid.

The Medicare-Medicaid dual eligible population is a unique and heterogeneous group generally characterized as 'vulnerable' or 'high-risk' because most dual eligible individuals are affected by complex clinical conditions in addition to social disadvantages including poverty. Keeping the specific needs of this population in mind, MAP convenes a broad range of stakeholders to discuss strategies to improve health outcomes in this population. The MAP Dual Eligible Beneficiaries Workgroup is a 29-member, multistakeholder group which serves as one of five advisory workgroups to the MAP Coordinating Committee (Appendix B). The workgroups are responsible for advising the Coordinating Committee on the use of measures to encourage performance improvement based on the MAP Measure Selection Criteria (MSC) and other inputs (Appendix C). The Coordinating Committee issues all final MAP recommendations.

This is MAP's fifth report related to quality measurement in the dual eligible beneficiary population. It builds on prior work and also looks ahead to additional topics that warrant further consideration. The first section of this report describes updates to MAP's Family of Measures for Dual Eligible Beneficiaries, including progress on measure alignment and remaining measure gaps. The report goes on to highlight promising activities related to performance measure development in topic areas relevant to dual eligible beneficiaries and strategies the workgroup considered to support improved quality of life outcomes. Finally, the report outlines a basic rationale for engaging stakeholders using measures in learning more about their experience to inform MAP's future decisionmaking.

Current Family of Measures for Dual Eligible Beneficiaries

A "family of measures" is a set of related measures that best address an important quality issue and span the continuum of care. A family of measures looks purposefully across care settings, within specific content areas, and through varying levels of analysis to assess important quality issues and identify measurement gaps. To date, MAP has identified families of measures for seven topics related to the aims and priorities of the National Quality Strategy (NQS).[1,2] Measure families for population health, affordable care, and person- and family-centered care are currently being finalized.[3]

MAP previously considered hundreds of measures for possible inclusion in the Family of Measures for Dual Eligible Beneficiaries and published the first iteration of the family in 2013. The Family of Measures for Dual Eligible Beneficiaries currently consists of 57 NQF-endorsed measures and one measure that is no longer endorsed, including 38 process measures, 10 outcome measures, five composite measures, four patient engagement/experience measures, and one efficiency measure (Appendix D). Measures are applicable across a variety of clinical conditions, care settings, and levels of analysis.

Updates to the Family of Measures

MAP will periodically revisit the Family of Measures for Dual Eligible Beneficiaries to ensure that it reflects the best available measures. This section discusses the first purposeful revision of the family since it was first released.

Measures are occasionally removed from the NQF-endorsed portfolio at the request of their stewards. This can take place for a variety of reasons. Since MAP's last review of the family of measures, two measures within it have had their endorsement removed.

NQF #0486 Adoption of Medication E-Prescribing is a structural measure previously included in CMS' E-Prescribing Incentive Program. CMS withdrew the measure because there is no longer a federal program need for it. NQF #0573 HIV Screening Members at High Risk of HIV had endorsement removed because the steward opted out of the NQF endorsement maintenance process. With this context in mind, MAP considered whether the non-endorsed measures should be retired from the family of measures. Ultimately, there was consensus to retire the two measures from the family of measures because the stewards would not be making any updates to them going forward.

In situations where a measure is retired from the family of measures, MAP will determine if there is a suitable alternative measure that covers a similar topic. In the case of the structural measure of electronic prescribing, no alternative was available. Rates of e-prescribing have increased dramatically since the measure was first introduced, with one report estimating that 73 percent of office-based physicians have adopted e-prescribing.[4,5] MAP also considered alternatives to the measure about the frequency of medical visits for individuals with HIV, described below.

Alternative Measures Related to HIV/AIDS Care

When MAP initially selected measures for the family, members expressed the importance of screening all dual eligible beneficiaries for a variety of sexually transmitted infections (STIs). Specifically, adults with disabilities experience disparities in STI screening rates due to factors such as inaccessible exam equipment and provider bias.[6] A broadly inclusive measure related to STI screening was not available for inclusion in the family, but MAP initially selected NQF #0573 HIV Screening Members at High Risk of HIV as the best available at the time.

While the ideal STI screening measure is still not available, MAP chose to replace the retired measure with another related to care for individuals with HIV/AIDS. This condition is disproportionately represented among dual eligible beneficiaries and some Medicare Advantage Special Needs Plans specifically enroll beneficiaries with HIV/AIDS. MAP considered five possible alternative measures that had been pre-selected by the HHS Measure Policy Council for alignment across federal programs:

- NQF #0405: HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis
- NQF #0409: HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis
- NQF #2079: HIV Medical Visit Frequency

- NQF #2082: Viral Load Suppression
- NQF #2083: Prescription of HIV Antiretroviral Therapy

MAP reiterated its preference for a broad, upstream screening measure and expressed support for ongoing measure development activities by the Centers for Disease Control and Prevention (CDC) to provide a measure of universal HIV screening based on new guidelines. Until this measure or others are available, MAP decided to include measure #2079 HIV Medical Visit Frequency in the family of measures because of its emphasis on continuity of care.

Addition of Newly Endorsed Measures

MAP will continue to monitor the NQF portfolio of measures for new additions that could be included in the family. Three measures have gained NQF endorsement since the last iteration. MAP briefly considered NQF #1529 Beta Blocker at Discharge for ICD Implant Patients with Left Ventricular Systolic Dysfunction and NQF #2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18). Both measures were quickly found to be too narrow and would not address any gap areas within the family of measures. Neither measure was recommended for addition to the family.

MAP also reviewed NQF #2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB). This measure addresses the NQS aim of affordable care, a topic that is also a gap area within the family of measures. The measure captures the total cost of care related to a hospital admission, including three days prior to and 30 days after discharge. The methodology is very inclusive and captures services such as mental health treatment and discharges to skilled nursing facilities. Further, if the beneficiary is readmitted to the hospital within the 30-day window, measured costs will continue to accumulate until 30 days following the subsequent discharge. When the measure was reviewed for endorsement, the Steering Committee encouraged the developer to allow for stratification by dual eligible beneficiary status and other markers of socioeconomic status to enable more understanding of potential disparities. Ultimately, MAP decided to include NQF #2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB) in the family of measures.

Use of the Family of Measures to Promote Cross-Program Alignment

MAP promotes alignment, or use of the same or related measures, as a critical strategy for accelerating improvement in priority areas, reducing duplicative data collection, and enhancing comparability and transparency of healthcare information. Lack of alignment can be observed throughout the health system, but entities providing services and supports to dual eligible beneficiaries experience it acutely when the Medicare and Medicaid programs are not consistent with each other. MAP intends families of measures to be useful tools around which to create alignment of measures. Appendix E quantifies the use of measures within the Family of Measures for Dual Eligible Beneficiaries across numerous federal quality measurement programs. Of the 58 measures in the family, at least 41 measures are currently used in federal measurement programs.

MAP also endeavors to drive alignment in measure use across state and private-sector programs. Most notably, states are participating in partnership with HHS and health plans to launch and run

demonstrations to better align care for dual eligible beneficiaries. To date, several states have each published a memorandum of understanding that describes a demonstration model, including quality measures to be used. HHS and states have looked to MAP to guide their selection of measures, as indicated by convergence on the use of a small number of key measures within the family that suits the purposes of the demonstrations. Currently, 14 measures in the family have been included in the CMS core for the Financial Alignment Initiative – Capitated Demonstrations and 6 measures in the family have been included in the CMS core for the Financial Alignment Initiative – Managed Fee-for-Service Demonstrations. MAP will continue to monitor the use of measures in the demonstrations.

Refining High-Priority Measure Gaps

MAP has identified high-priority gaps in available performance measures throughout its work and will continue to do so. Measure gaps are an important component of each family of measures because they indicate measurement needs not met by existing measures. MAP determines the priority measure gaps through deliberations that consider available measures to address high-leverage opportunities and program and population needs. MAP continued to emphasize that new and improved measures are needed to evaluate:

- Goal-directed, person-centered care planning and implementation
- Shared decisionmaking
- Systems to coordinate acute care, long-term services and supports, and nonmedical community resources
- Beneficiary sense of control/autonomy/self-determination
- Psychosocial needs
- Community integration/inclusion and participation
- Optimal functioning (e.g., improving when possible, maintaining, managing decline)

Current measures fail to capture the complex and dynamic array of conditions that are at play in a chronically ill person's life over time. Resources must be devoted to research activities to explore new methodologies for measurement of complex topics, especially nonclinical processes and person-centered outcomes. As described in the following section, MAP welcomed discussion of ongoing measure development activities related to assessment, care planning, and setting person-centered goals.

MAP members also suggested that the measurement field should do more to address the social issues that affect health outcomes in vulnerable populations, including individuals with a history of incarceration and veterans of military service. MAP will continue to discuss strategies for filling gaps with organizations that fund and perform measure development to facilitate progress. As part of a separate project, NQF will be issuing a series of reports in summer 2014 on priority measure development needs in areas of high interest to MAP, including: care coordination, person-centered care and outcomes, and Alzheimer's disease and related dementias.

Measure Development Progress to Address High-Priority Gaps

Performance measure development is complex, painstaking work that can take years from start to finish. Accuracy is paramount when measures are used to publicly report information about quality or influence payments. MAP continues to monitor changes in measurement science and the availability of new measures. While progress on addressing MAP's measure gap priorities has taken time, there are now clear indications that measure developers and their funding partners have received and responded to that guidance. MAP members were encouraged to see the influence of their upstream input and can continue to offer their perspectives on planned and ongoing measure development efforts.

NCQA Measures In Development

The National Committee for Quality Assurance (NCQA) is an accrediting organization that develops performance measures. Similar to NQF, NCQA works to evaluate the quality of health services in pursuit of the three-part aim of the NQS. NCQA is developing new performance measures in two topic areas of high interest to MAP: assessment and care planning as well as goal assessment and achievement. Their methods to evaluate person-centered care for dual eligible beneficiaries stem from a white paper that described their model for evaluating quality.[7] The model employs a focus on the consumer and family/caregiver perspective and coordination of a care team across settings.

NCQA develops and uses structure, process, and outcome measures throughout its standards for accreditation. The organization recognizes the relative and progressive difficulty of collecting data, demonstrating improvement, and holding providers accountable for high-quality care across these measure types. They are actively working to determine which structures are needed to underpin evidence-based processes, which in turn contribute to achieving desired outcomes. Further complexity presents itself when deciding how to quantify and measure these structures, processes, and outcomes. NCQA is continuing to develop measures that monitor progress in achieving optimal outcomes of care without misplacing accountability that might lead to unintended consequences (e.g., providers avoiding complex cases).

In collaboration with CMS and Mathematica Policy Research, NCQA is developing six measures for Managed Long Term Services and Supports (MLTSS) programs. These measures include:

- **Assessment Composite**: The percentage of newly enrolled MLTSS beneficiaries who have documentation of an in-home assessment with the following components within 90 days of enrollment
    - Physical functioning and disability, medical conditions, mental and behavioral health, needs and risks, social support, preferences and use of services
    - Documentation of involvement of family member, caregiver, guardian, or power of attorney in assessment (with beneficiary consent)
- **Care Plan Composite**: The percentage of newly enrolled MLTSS beneficiaries who have documentation of a care plan developed face-to-face within 30 days of completed assessment
    - Documentation of beneficiary needs in core domains
    - Documentation of beneficiary goals of care and identified barriers to meeting goals.

    - Documentation of service plan and providers of services addressing needs including frequency and duration of service.
    - Beneficiary signature or that of their guardian or power of attorney (POA)
    - Signature of family member or caregiver (if applicable and with beneficiary consent)
- **Shared Care Plan**: The percentage of MLTSS beneficiaries with a care plan for whom all or part of the care plan was transmitted to key long-term services and supports providers and the primary care provider within 30 days of development or update.
- **Assessment Update**
- **Care Plan Update**
- **Reassessment and Care Plan Update After Discharge**

To inform testing of these six new measures for MLTSS, NCQA sought MAP's feedback to ensure they target a goal-directed and person-centered care planning process. A shared, longitudinal plan of care that is regularly updated by all members of the care team (including the beneficiary/family) is essential to improve care coordination. Discussions revealed tensions and differences of opinion as to whether the measures are sufficiently consumer-oriented. MAP recognizes the ideal process of developing a shared plan of care to require an "authentic" interpersonal dialogue between a beneficiary, his/her family, and his/her team of medical and non-medical service providers. The purpose of this dialogue is to understand the beneficiary's ultimate goals and to create a set of services that will best support those goals. The dialogue is very likely to extend over a series of interactions and deepen over time. The care team must focus on the personal needs of an individual beneficiary and that person's vision of how they would like to live their life.

MAP members asserted that the critical, yet often intangible, aspects of these interactions (such as respect and openness) are at odds with the methods available to create objective measures of quality. Genuine person-centeredness is not compatible with measures' building blocks of standardized data. At the same time, MAP has strongly recommended that measures need to capture the beneficiary perspective. This tension must continue to be explored. It might be preferable to directly question the people involved in the care-planning process to gauge their experience, but this would be burdensome and subjective.

During preparatory case studies, NCQA found wide variation in practices for documenting and monitoring progress related to goals, one of the most basic aspects of a person-centered plan of care. The concept of creating patient-reported outcome measures (PROMs) related to goal attainment received positive responses from NCQA focus group participants. Consumers noted that they would be a "good way to communicate with my doctor." More groundwork must be provided to support standard practices for goal-directed care and associated measurements, but current activities show promise.

MAP members recommended the care plan include beneficiary-identified goals that capture the voice and preferences of that person. Although far from ideal, requirements that care planning activities take place in person and that agreement with the care plan must documented with a consumer's signature are still significant improvements over the current state of practice. MAP encouraged all types of

providers to be innovative in their approaches to engaging beneficiaries and their family members and caregivers. For example, the group suggested that technology solutions like video chat platforms could enable long-distance family members to be part of goal setting and care planning processes.

In addition to balancing standardized vs. customized approaches to care planning, stakeholders must be aware of related issues of assigning accountability for meeting goals. Healthcare providers may be comfortable taking partial responsibility for clinical outcomes, but they largely are unable to address social needs that can be equally or more important to beneficiaries. MAP encouraged more deliberate thinking about accountability challenges raised by the use of a common care plan. As part of this consideration, MAP members have advocated for the ownership and locus of control of the care plan to remain with the individual beneficiary. Importantly, the consumer should be in control of identifying the other people with whom portions of the care plan should be shared.

Strategies to Support Improved Quality of Life Outcomes

Quality of life has been identified since the start of MAP's work as a high-leverage opportunity for improvement through measurement. Adults with lower levels of income/education and chronic disease or disability report higher numbers of unhealthy days.[8] Quality of life outcomes are of particular importance for dual eligible beneficiaries because a large portion of them are affected by permanent or chronic health conditions that are not expected to improve. Significant numbers of dual eligible beneficiaries are also close to end-of-life. It is critical that all individuals, especially those in poor or declining health, receive the supports and services necessary to live with dignity, to have their pain and symptoms controlled, and to maximize their functional status.

MAP has previously explored tools to assess quality of life and discussed a variety of definitions, frameworks for measurement, and survey tools the 2014 Interim Report. In later discussions, MAP continued to emphasize that quality of life measures should reflect a broad view of health and well-being. Four domains were commonly used across organizing frameworks in quality of life measurement: physical health, mental and psychological health, social relationships, and environment.

MAP encourages innovation and exploration of strategies to improve and assess quality of life. Summarized broadly, these include: maintaining a consumer focus, utilizing team-based care models, shared accountability for outcomes, and shared decisionmaking. Because measurement is a tool to understand and drive improvement of quality of life outcomes, MAP reviewed and offers reflections on some of the currently available surveys, indicators, and measures.

Models and Practices

Person- and Family-Centered Care

The first strategy recommended to support improved quality of life outcomes is to maintain focus of all care and supportive services on the needs of the individual consumer through person- and family-centered care. Person- and family-centered care can be defined as:

> *Person- and family-centered care is an approach to the planning and delivery of care across settings and time that is centered around collaborative partnerships among individuals, their defined family, and providers of care. It supports health and well-being by being consistent with, respectful of, and responsive to an individual's preferences, needs, and values.*[9]

The individual receiving services must be at the center of all quality of life discussions. Healthcare providers and organizations need to continue to approach consumers as equals and engage them in decisionmaking. MAP encourages all parties involved in providing healthcare or supportive services to consider the consumer first in any healthcare conversation and decision.

MAP members recommended continuation of work underway at NQF and elsewhere to address this high-priority measurement issue. Promising activities that could support future measure development include investments being made through the Person-Centered Outcomes Research Institute (PCORI) to expand the evidence base. Additionally, the Institute of Medicine's *Living Well with Chronic Illness* report could provide a theoretical basis for the discussion of person-centered wellness and related measurement opportunities.[10] The high levels of activity around person- and family-centered care amplify the sense of importance and urgency communicated by MAP. Ongoing coordination is recommended to prevent duplication of effort and realize potential advances in healthcare quality and measurement.

Other NQF Projects Related to Person- and Family-Centered Care

Consensus Development Project to review newly-submitted measures for endorsement and measures due for endorsement maintenance

MAP Family of Measures to identify aligned measures, including available measures and measure gaps that span programs, care settings, and levels of analysis.

Team-Based Care

To address complex medical and social needs, team-based approaches to delivering care and supports are essential to supporting the consumers' quality of life outcomes. A definition of team-based healthcare has been proposed by participants drawn from the Best Practices Innovation Collaborative of the Institute of Medicine Roundtable:

> *The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient and equitable.*[11]

When multiple healthcare and supportive service providers are tending to the needs of consumers and families, information and interpersonal interactions grow increasingly complex. Without purposeful identification of the team of providers, supports and services systems are more prone to inefficiencies

and errors. MAP recognized the immediate need for high-functioning teams and continued to stress that the individual receiving care should be the primary team member. However, the "formula" for effective team-based healthcare is not yet known and will vary based on the needs of the individual and availability of staff and resources.[12] Teams can be fluid as consumers' needs change over time. In addition, they are not intended to be exclusive to healthcare providers, but could include case managers, community-based service providers, allied health professionals, and direct care workers. Team-based care also supports other strategies to improve quality of life, including shared decisionmaking and shared accountability.

Shared Accountability

Care for the dual eligible beneficiary population is complex in nature because of factors such as the fragmented benefits structure and the diverse health and social needs of beneficiaries. Many individuals and disciplines contribute to supporting this population and their roles vary with the needs of individual beneficiaries. Because quality of life outcomes are all-encompassing and cumulative in nature, all stakeholders have an influence on them. However, MAP recognized that there are meaningful differences between influence and responsibility or accountability for quality of life.

While it is not possible to assign overall responsibility to any entity, some portion it might be attributed to health plans, providers, or others that have ability to change an element that could improve or diminish a beneficiary's quality of life. Those who share partial accountability for beneficiaries' quality of life include the individual and his or her family/caregivers, health professionals, provider systems, health plans, community and human services, and state and federal governments. The determination of who is accountable for what tends to be driven by the scope of contracting and payment for specific services. Stakeholders do not feel responsible for outcomes outside of their direct control, but when everyone adheres to this attitude it creates a vacuum of accountability for overall quality of life outcomes.

MAP discussed barriers to adoption of shared accountability in the health and human services systems. At a basic level, the presence of both Medicare and Medicaid benefits for dual eligible beneficiaries has split responsibility and payment for different types of health and long-term care services. Fragmentation and diffusion of responsibility extends from there, exemplified by strict rules for how health plans can use funds for the benefit of their enrollees. For example, an individual may be identified as at risk for malnutrition because they have not had proper dental care. Dental care may not be available to them through their combined benefits or affordable out of pocket. MAP supports efforts to pool resources for the benefit of the consumer, such as Money Follows the Person, PACE, and the Financial Alignment Demonstrations.

Shared Decisionmaking

Shared decisionmaking (SDM) is an approach to making healthcare choices that is designed to respect personal autonomy and give equal weight to the expertise of the consumer about his or her own life and the expertise of the care team on clinical matters.[13] SDM is particularly important for preference-sensitive conditions or health care choices. Dual eligible beneficiaries, their families, and/or caregivers have the right to be fully informed of available care options, including the potential harms and benefits,

and to make their own choices with the support and input they need from providers to establish an appropriate care plan.

MAP asserted the importance of several contributing factors to successful shared decisionmaking. These included consumer engagement, team-based care, and access to care supported by appropriate payment. Consumers, particularly high-need individuals, should be engaged in a dialogue with any provider involved in their care, supported in expressing their preferences, and respected as the expert on their health care needs and medical history. Team-based care, as discussed above, is particularly important in SDM for dual beneficiaries because they often experience more complex care systems. Furthermore, consumers need easy access to digestible information to inform their decisions. Healthcare and service providers need to be allowed time to engage and educate consumers and partner with them to weigh risks and benefits. MAP suggested that providers need to be trained and compensated for providing these navigation services, as they are more time-intensive than a standard office visit.

MAP called for more research and testing of SDM methods. In particular, there is a need to confirm the association between SDM and quality of life outcomes to support development of performance measures on that topic. Other recommended areas of study include the relationship of SDM processes to health and functional status outcomes, providers' ability to empower consumers, and the usefulness of these methods within diverse populations of all types (e.g., individuals with certain conditions, racial/ethnic minority groups). With sufficient evidence in place, performance measures of the SDM processes and outcomes could be developed in coordination.

Indicators and Surveys

CARE Tool

A major ongoing assessment standardization initiative at the federal level is CMS' development of the Continuity Assessment Record and Evaluation (CARE) tool item set. The intent of the CARE item set is to create uniformity of information across acute and post-acute care settings to support and focus on the person and understand the impact of providers and models of care. CARE is intended to contain "best in class" items as determined by the best science for measuring concepts common in the three assessment instruments mandated for Medicare post-acute settings: OASIS, MDS, and IRF-PAI.[14] MAP was very supportive of the efforts to develop a central repository of elements because it will improve standardization and interoperability.

Assessment data from the CARE tool is designed to be standardized, reusable, and informative because it is drawn from a common language and set of data. Data collected is intended to evaluate improvement or maintenance of cognitive and physiological functional outcomes. It can assess quality across post-acute care settings, including inpatient rehabilitation facilities, skilled nursing facilities, long-term care hospitals, and home health agencies. CMS has developed and is planning to submit for endorsement several measures based on CARE data. Four would apply to inpatient rehabilitation, two to long-term-care hospitals, and four to skilled nursing facilities. CMS plans to evaluate a subset of the CARE items for potential expansion for use in community based long-term supports and services (CB-

LTSS). Similarly, other CARE components are being evaluated for use in a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey across all CB-LTSS settings. MAP has previously discussed the importance and value of CAHPS surveys to gain insight into consumers' perspectives across CB-LTSS and reiterates its support for the field testing of the CB-LTSS CAPHS tool.

UDSMR FIM®

The Uniform Data System for Medical Rehabilitation developed and maintains the Functional Independence Measure (FIM)® instrument, an 18-item tool to assess patient functional status, quality outcomes in rehabilitation facilities, and the level and cost of assistance needed by an individual to carry out usual activities of daily living (ADLs). The instrument may have particular utility for dual beneficiaries who transition between settings and benefit systems because it has been validated across acute care and long term care settings, can be administered by any provider, and is applicable across payer populations. The FIM is currently in use in the CMS Inpatient Rehabilitation Facility Prospective Payment System and in program evaluation models for accreditation purposes. MAP would looks forward to reviewing results of endorsement of performance measures based on the FIM and could consider further opportunities for alignment.

National Core Indicators Surveys

As discussed in the 2012 Final Report, the National Core Indicators (NCI) present an opportunity for the development of gap filling measures. NCI is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI).[15] The NCI is a nationally recognized set of performance and outcome indicators for developmental disabilities service systems.

National Core Indicators: Intellectual/Developmental Disabilities Survey

Launched in 1997, 39 States and the District of Columbia currently use the NCI survey to collect data and evaluate the outcomes of state-funded services for individuals with intellectual/developmental disabilities. The components of the indicators address some of MAP's priorities for person-centered care, such as evaluating experiences of beneficiaries globally across multiple supports and services, allowances for proxy responders for persons who have difficulty communicating, experiences of family members and caregivers, and use of qualitative and quantitative data (Table 1). The results are calculated at the state level of analysis. States use the results for quality assurance and improvement, CMS waiver reporting requirements, comparisons against other states, and public accountability of programs.

Table 1: NCI Evaluation of State-Funded Services

Key Components	Data Collection	Domains
• Individuals' characteristics • Locations where people live • Preferred activities for engagement • Experience across the supports and services received • Context of their life (e.g. friends, community involvement, safety, etc.) • Health, health care, and well-being	• Random samples of in-person interviews of consumers • Three types of family surveys collected via mail o Adult Family Survey o Family Guardian Survey o Children Family Survey	• Individual outcomes • Family outcomes • Health, welfare, and system outcomes

Data collected through the NCI survey is collected, submitted, and owned by individual states. The NCI administrators support states to ensure validity of administrative data and inter-rater reliability within each state system and to detect changes over time. They also support states in key uses of the indicators such as identifying outcomes for at-risk populations, examining potential disparities in services, and conducting comparisons across states. MAP has suggested similar applications for quality data on dual eligible beneficiaries. MAP identified that the data already collected from states ID/DD systems could have many potential uses because it is de-identified and accessible to researchers.

National Core Indicators: Aging and Disability Survey

In response to stakeholder feedback, HSRI, NASDDDS, and the National Association of States United for Aging and Disabilities (NASUAD) are working to translate the NCI survey from an intellectual/developmental disabilities focus to also include older adults and individuals with physical disabilities. The expansion has produced the National Core Indicators Aging and Disability survey (NCI-AD). The goals of this survey are for participating state aging and disabilities agencies to collect data to measure the performance and outcomes of their aging and disability services. The NCI-AD provides an opportunity to assess the impact of LTSS on the aging and physically disabled populations to inform states' policy and regulations, drive improvement, and make comparisons between states possible. MAP supported expansion of the survey to the additional populations but cautioned that individuals with mental health and substance use disorders should not be excluded.

The NCI-AD was developed from an extensive databank of potential indicators, steering committee review, and focus groups. Currently in a pilot testing phase, the data analysis, risk-adjustment methodology, and reporting methodology is planned to be completed in early 2015. Regular data collection for the NCI-AD is scheduled to begin in summer of 2015 with 12 participating states.

A majority of the NCI-AD indicators and questions are aligned with the original NCI for individuals with intellectual/developmental disabilities. One significant early finding of this effort is that the quality of

life outcomes valued by individuals are largely the same despite the diversity of health and social challenges each person may experience. MAP has come to the same conclusion during its deliberations and the NCI-AD expansion work reinforces this thinking. MAP looks forward to implementation of the survey and additional opportunities to learn from the use of quantitative and qualitative data to assess quality of life.

Future Collaboration on Addressing Measure Gaps

MAP members voiced their appreciation for the hard work underway to develop strategies and solutions to improve the quality of care for dual eligible beneficiaries and other high-need adults. MAP encourages stakeholders to continue developing gap-filling measures and implementation strategies to drive improvement in outcomes. In particular, efforts to embed person-centeredness in the healthcare system should be redoubled.

It is essential to capture the voices of consumers across all types of care and support systems. This has been lacking in quality measurement to date. MAP has reviewed many different surveys and tools that are contributing to a better understanding of the beneficiary experience. However, the existence of multiple surveys, particularly the many variations of CAHPS, could pose a significant response burden on the beneficiaries if they receive more than one. CAHPS surveys are expensive to administer and response rates are typically mediocre. MAP has previously stated its concern about the format of these mailed instruments not being appropriate to vulnerable individuals for a variety of reasons. As part of measure development, other methods of capturing consumers' input should be explored.

MAP acknowledges that developing and testing measures is a complex and time-consuming activity. Developers are invited to contact NQF for support with the process of submitting measures for potential endorsement as consensus standards. This collaboration will be especially necessary to translate surveys and tools, which are not endorsed by NQF, to the format of performance measures. NQF encourages upstream dialogue to strengthen measures and increase their chances of gaining endorsement.

Approach to Gathering Stakeholder Experience with Measure Use

Together with its partners and members, NQF is seeks ways to transform healthcare and health outcomes through performance measurement. Measurement has the potential to drive healthcare system change when used to identify opportunities for improvement and subsequent gains in performance. MAP is seeking more direct information on the experience of using measures to inform future decisionmaking. The Dual Eligible Beneficiaries Workgroup provided guidance on how this feedback from stakeholders could be gathered. The workgroup recommended that future efforts to gather implementation experience should focus on two features: alignment and impact of measures.

Measure Alignment

Alignment is achieved when sets of measures function well across settings or programs to produce meaningful information without creating extra work for those responsible for the measurement. Use of the same measures across programs can reduce conflicting or redundant requirements. MAP has

identified alignment as an important characteristic of measure sets in the MAP Measure Selection Criteria; sub-criterion 7.2 states, "Program measure set places strong emphasis on measures that can be used across multiple programs or applications."

MAP has increasingly recognized poorly aligned program requirements as a source of frustration for stakeholders. Specifically, healthcare systems, payers, and providers can find participation in measurement programs burdensome when they are compelled to invest resources in reporting requirements that are duplicative, conflicting, or especially labor-intensive. Providers and health plans that offer services to dual eligible beneficiaries are particularly affected by fragmented program requirements. While the extent of this problem varies by provider or health plan type, it is common for Medicare, Medicaid, multiple private payers, and other local programs to each dictate separate requirements. Poor alignment scatters scarce resources away from true quality improvement priorities.

MAP recommends that the first research question to be explored through stakeholder feedback loops is "To what extent are program measure requirements aligned with one another?" A more concrete understanding of this issue can illuminate any opportunities for MAP to recommend that different measures be used in programs to improve alignment. MAP already emphasizes the importance of using the same measures in multiple programs when making its annual pre-rulemaking recommendations on the use of measures in Federal programs.

To date, MAP's pre-rulemaking efforts focused on aligning programs related to the care and supports accessed by dual eligible beneficiaries have been guided by the Family of Measures for Dual Eligible Beneficiaries. As described previously, the family of measures is a group of the best available measures to address the unique needs of the dual eligible beneficiary population. The family functions like a menu stakeholders can consult to select subsets of measures that best suit the needs of particular programs. If more stakeholder groups and programs join MAP in selecting measures from within families, alignment will be improved. While progress has been made on aligning key Federal programs (Appendix E), much remains to be learned about the effect of other public and private programs on alignment.

Measure Impact

The concept of fit-for-purpose complements alignment. Measure designs and specifications should match the goals, target population, care setting, and other features of the program in which they are used. Sometimes development of a new, innovative measure is a better solution than using an existing measure beyond the scope of its original design. A healthcare system that maintains a balance of a small number of well-aligned measures that have strong fit-for-purpose will avoid placing unintended measurement burden on participants. Further, quality improvement efforts can be concentrated on a select few priority areas and have greater impact. This leads to MAP's second recommendation that stakeholder feedback loops also seek to answer the question, "Are measures used in programs fulfilling their intended purpose of producing improved quality?"

MAP seeks to provide input on the potential impact of quality measures that MAP recommends for future use in federal programs. MAP has been collaborating with HHS to refine an approach for these assessments based on the data and resources available. More sophisticated analysis and assessment of potential measure impact presents an opportunity for MAP to provide better guidance to HHS on the

selection of measures having the highest potential to achieve programmatic goals, and ultimately improve health outcomes. This type of prospective analysis will be very challenging; working with stakeholders to understand their measure use experience retrospectively may shed light on features of measures that correlate with improved results. Alternatively, MAP may glean important contextual information related to promising program structures, implementation approaches, incentives, or other broad features of measurement programs.

Building Feedback Mechanisms

Creating more structured feedback mechanisms for gathering information from stakeholders using measures is a way to collect and share insights about measurement successes and opportunities for revision. Such an exchange of information between NQF and groups directly involved in using measures promotes ongoing learning and improvement across the entire healthcare system. MAP has suggested the types of information that should be collected from entities using measures for the purpose of this analysis. Potential topics of interest include the identification of:

- Measures that are widely used, to promote further alignment
- Measures that have contributed to a significant positive impact on healthcare quality, to explore encouraging broader use
- Measures not functioning as intended, to convey desired modifications to measures' stewards
- Measures that are a poor fit for a program's goals, to potentially reduce burden by recommending their use be discontinued

Some information on alignment of measures is already available and MAP plans to build from this base when creating and strengthening feedback loops. NQF currently invites feedback on the usage experience of measures through the Quality Positioning System and commenting opportunities on measures undergoing endorsement review. The NQF Community Tool to Align Measures also provides a snapshot of measure alignment. This tool, developed in collaboration with the 16 Aligning Forces for Quality (AF4Q) communities, illustrates measure use across programs and identifies measures for possible alignment or expansion. In addition, the Buying Value Project research on Alignment of Existing Measure Sets conducted an analysis of hundreds of measure sets across the states. The analysis sought answers to several questions, including: to what extent are measures used and which are the most frequently shared measures? The Buying Value Project has begun development of technical assistance resources on constructing measure sets that NQF will review and utilize when possible.

MAP considered the information needed to support its decisionmaking process about the use of measures and is interested in hearing from other stakeholders on the following questions.

- Is alignment among certain programs of particular interest?
- From what types of stakeholders should MAP gather feedback about measure use?
- What additional data on measure use could help to refine the family of measures?
- Do stakeholders beyond MAP have information needs that could be satisfied by this analysis?

Path Forward

In this report, MAP provides its latest guidance to HHS on the use of performance measures to improve care for dual eligible beneficiaries. For the first time since its official publication, MAP has provided an update to the Family of Measures for Dual Eligible Beneficiaries. This report also updated findings on measure alignment across programs and persistent measure gaps. MAP joined with other measurement stakeholders to advise the field on several performance measure development and application issues that relate to care for dual eligible beneficiaries. Building on findings from its last report, MAP explored strategies to support improved quality of life outcomes for the population. Lastly, MAP is soliciting feedback on the outlined an approach to engaging stakeholders using measures to inform MAP's future decisionmaking.

MAP looks forward to future opportunities to explore healthcare quality and performance measurement issues germane to dual eligible beneficiaries. As reflected in this report, NQF will continue to facilitate the connection between the endorsement and application of healthcare performance measures. Specifically, MAP will monitor connections to development of other families of measures and the forthcoming report from the MAP Medicaid Task Force. The Dual Eligible Beneficiaries Workgroup, in consultation with the MAP Coordinating Committee, will be choosing from among the topics listed in Table 2 for its next iteration of work.

Table 2: Potential Topics for Future Consideration by MAP

General Topic Areas	Specific Components Suggested by MAP Members
Conceptual work to revisit high-leverage opportunities and explore person-centered wellness	• Visioning a future state for quality measurement • Conceptual models of system change and individual behavior change • Discussion of research priorities with PCORI • Shift to a wellness-directed model over a disease-focused model using IOM model of living well with chronic illness and social/behavioral domains • Identification of interim measures to use in non-medical domains • Levels of beneficiary capacity to engage in shared decisionmaking and choice
Additional topics on measure development and application	• How to engage private sector and provider organizations in measure development, review, and endorsement processes to enhance adoption, participation, and buy-in • Linking public/private data, involving other disciplines, and using "big data" analytics to accelerate measure development • Creating structural measures to evaluate the degree of integration of Medicare/Medicaid benefits and services • Identifying a core data set for the FAD that honors person-centered values
Other factors related to quality of care and	• Primary care/behavioral health integration models

outcomes	• Employment outcomes for dual eligible beneficiaries • Implications of measurement activities on the workforce • Potential for risk adjustment of measures within the Dual Eligible Beneficiaries Family of Measures

NQF and MAP welcome commenters' input on the future direction of measurement for dual eligible beneficiaries and how MAP's multi-stakeholder process can continue to add value to ongoing quality improvement efforts.

Appendix A: MAP Background

Purpose

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, and other programs. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[16]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures that 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 progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable. Accordingly, MAP informs the selection of performance measures to achieve the goal of **improvement, transparency, and value for all**.

MAP's objectives are to:

1. **Improve outcomes in high-leverage areas for patients and their families**. MAP encourages the use of the best available measures that are high-impact, relevant, and actionable. MAP has adopted a person-centered approach to measure selection, promoting broader use of patient-reported outcomes, experience, and shared decisionmaking.
2. **Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy based on value**. MAP promotes the use of measures that are aligned across programs and between public and private sectors to provide a comprehensive picture of quality for all parts of the healthcare system.
3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden**. MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

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 and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology 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 enterprise that includes:

Setting priorities and goals. The work of the Measure Applications Partnership is predicated on the National Quality Strategy and its three aims of better care, affordable care, and healthy people/healthy communities. The NQS aims and six priorities provide a guiding framework for the work of the MAP, in addition to helping align it with other quality efforts.

Developing and testing measures. Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies).

Endorsing measures. 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.

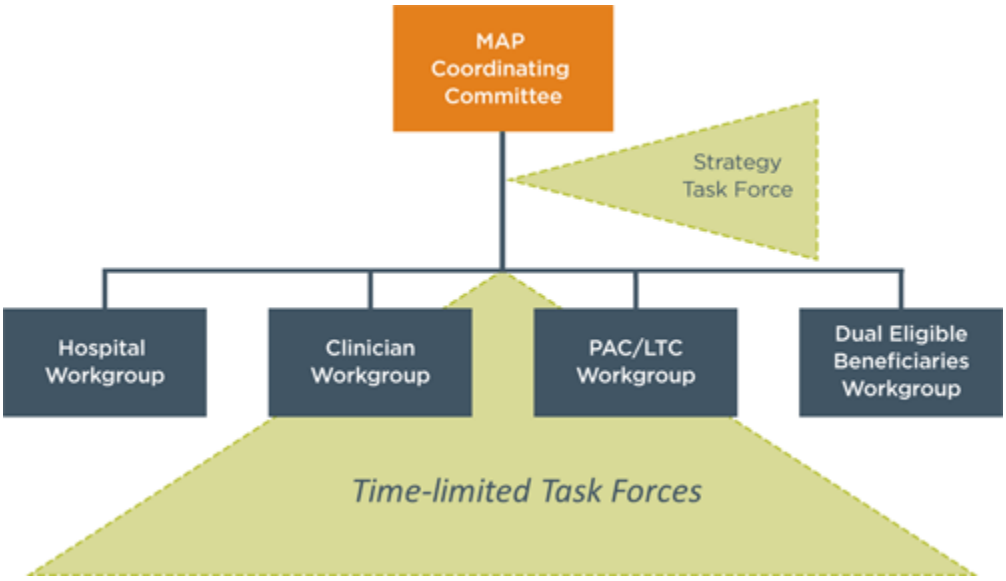
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.

Impact and Evaluation. Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate if measures are having their intended impact and are driving improvement, transparency, and value. Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements. MAP seeks to engage in bidirectional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

Structure

MAP operates through a two-tiered structure (see Figure A1). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with developing "families of measures"—related measures that cross settings and populations—and a multiyear strategic plan provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

Figure A1. MAP Structure



All MAP activities are conducted in an open and transparent manner. The appointment process includes 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.

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see MAP 2014 Pre-Rulemaking Report).

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall to inform MAP's pre-rulemaking input. To date MAP has issued a series of reports that:

- Developed the **MAP Strategic Plan** to establish MAP's goal and objectives. This process identified strategies and tactics that will enhance MAP's input.
- Identified **Families of Measures**—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities—to facilitate coordination of measurement efforts.
- Provided input on **program considerations and specific measures** for federal programs that are not included in MAP's annual pre-rulemaking review, including the Medicaid Adult Core Set and the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces.
- Developed **Coordination Strategies** intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives.

Appendix B: Rosters for the MAP Dual Eligible Beneficiaries Workgroup and MAP Coordinating Committee

CHAIR (VOTING)
Alice Lind, MPH, BSN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
America's Essential Hospitals	Steven Counsell, MD
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	Gwendolen Buhr, MD, MHS, MEd, CMD
Center for Medicare Advocacy	Alfred J. Chiplin, JD, MDiv
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE
L.A. Care Health Plan	Representative to be determined
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Substance Abuse	Mady Chalk, MSW, PhD
Disability	Anne Cohen, MPH
Emergency Medical Services	James Dunford, MD
Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Medicaid ACO	Ruth Perry, MD
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 Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Jamie Kendall, MPP

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Substance Abuse and Mental Health Services Administration	Lisa Patton, PhD
Veterans Health Administration	Daniel Kivlahan, PhD

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

Roster for the MAP Coordinating Committee

CO-CHAIRS (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	Gerry 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	Lisa McGiffert
Federation of American Hospitals	Chip Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Shari Davidson
National Partnership for Women and Families	Alison Shippy
Pacific Business Group on Health	William Kramer, MBA

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher Dezii, RN, MBA,CPHQ

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
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 (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Health Resources and Services Administration (HRSA)	John E. Snyder, MD, MS, MPH (FACP)
Office of Personnel Management/FEHBP (OPM)	Edward Lennard, PharmD, MBA
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD, FACP

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

NQF Staff

Megan Duevel Anderson	Project Manager
Laura Ibragimova	Project Analyst
Sarah Lash	Senior Director
Alexandra Ogungbemi	Administrative Assistant

Appendix C: MAP Measure Selection Criteria

The Measure Selection Criteria (MSC) are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Although competing priorities often need to be weighed against one another, the MSC can be used as a reference when evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set.

Criteria

1. NQF-endorsed® measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.

Sub-criterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need

Sub-criterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs

Sub-criterion 1.3 Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

2. Program measure set adequately addresses each of the National Quality Strategy's three aims

Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:

Sub-criterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

Sub-criterion 2.2 Healthy people/healthy communities, demonstrated by prevention and well-being

Sub-criterion 2.3 Affordable care

3. Program measure set is responsive to specific program goals and requirements

Demonstrated by a program measure set that is "fit for purpose" for the particular program.

Sub-criterion 3.1 Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)

Sub-criterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Sub-criterion 3.3 Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

Sub-criterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program

Sub-criterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

4. 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, composite, and structural measures necessary for the specific program

Sub-criterion 4.1 In general, preference should be given to measure types that address specific program needs

Sub-criterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

Sub-criterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

5. Program measure set enables measurement of person- and family-centered care and services

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

Sub-criterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

Sub-criterion 5.2 Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives

Sub-criterion 5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

6. Program measure set includes considerations for healthcare disparities and cultural competency

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, sexual orientation, age, 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).

Sub-criterion 6.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Sub-criterion 6.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

7. Program measure set promotes parsimony and alignment

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Sub-criterion 7.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

Sub-criterion 7.2 Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

Appendix D: Current Family of Measures for Dual Eligible Beneficiaries

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0004 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Measure Steward: NCQA **Starter Set Measure**	Process	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.	Health Plan; Integrated Delivery System; Population: County or City, National, Regional	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use- EP; PQRS; Medicaid Health Home State Duals Demonstrations: CA, IL, MA, OH, VA, WA Private Programs: HEDIS
0005 Endorsed CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys) Measure Steward: NCQA	Patient Engagement /Experience	Adult Primary Care Survey: 37 core and 64 supplemental question survey of adult outpatient primary care patients. Pediatric Care Survey: 36 core and 16 supplemental question survey of outpatient pediatric care patients. Specialist Care Survey: 37 core and 20 supplemental question survey of adult outpatients specialist care patients. Level of analysis for each of the 3 surveys: group practices, sites of care, and/or individual clinicians	Health Plan; Integrated Delivery System	
0006 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) Measure Steward: NCQA	Process	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. -Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. -Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Health Plan; Integrated Delivery System	

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0007 Not Endorsed NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H) Measure Steward: NCQA **Starter Set Measure**	Composite	This supplemental set of items was developed jointly by NCQA and the AHRQ-sponsored CAHPS Consortium and is intended for use with the CAHPS 4.0 Health Plan survey. Some items are intended for Commercial health plan members only and are not included here. This measure provides information on the experiences of Medicaid health plan members with the organization. Results summarize member experiences through composites and question summary rates. In addition to the 4 core composites from the CAHPS 4.0 Health Plan survey and two composites for commercial populations only, the HEDIS supplemental set includes one composite score and two item-specific summary rates. 1. Shared Decision Making Composite 1. Health Promotion and Education item 2. Coordination of Care item	Clinician: Group/ Practice, Health Plan, Individual; Integrated Delivery System; Population: National, Regional, State	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part D Plan Rating; State Duals Demonstration: VA Private Programs: HEDIS
0008 Endorsed Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) Measure Steward: AHRQ **Starter Set Measure**	Composite	52 questions including patient demographic information. The survey measures patient experiences with behavioral health care (mental health and substance abuse treatment) and the organization that provides or manages the treatment and health outcomes. Level of analysis: health plan- HMO, PPO, Medicare, Medicaid, commercial	Health Plan	State Duals Demonstrations: CA, IL, MA, OH

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0018 Endorsed Controlling High Blood Pressure Measure Steward: NCQA **Starter Set Measure**	Outcome	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	Health Plan; Integrated Delivery System	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Part C Plan Rating; Medicare Shared Savings Program; PQRS; HRSA; Medicaid Health Home, Special Needs Plan State Duals Demonstrations:: CA, IL, MA, OH, VA Private Programs: eValue8; at least 1 Beacon community; HEDIS; Wellpoint; Buying Value core ambulatory measure
0022 Endorsed Use of High Risk Medications in the Elderly Measure Steward: NCQA **Starter Set Measure**	Process	a: Percentage of Medicare members 66 years of age and older who received at least one high-risk medication. b: Percentage of Medicare members 66 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	Health Plan; Integrated Delivery System	Federal and State Programs: Meaningful Use-EP; Medicare Part D Plan Rating; Physician Feedback; PQRS; Value-Based Payment Modifier Program; Special Needs Plan State Duals Demonstration: MA Private Programs: HEDIS; Buying Value core ambulatory measure

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation Measure Steward: NCQA	Process	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.	Health Plan	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS Private Programs: HEDIS; Wellpoint
0028 Endorsed Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention Measure Steward: AMA-PCPI **Starter Set Measure**	Process	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user	Clinician: Group/ Practice, Individual, Team	Federal and State Programs: Meaningful Use-EP; Medicare Shared Savings Program; PQRS State Duals Demonstration: MA Private Programs: eValue8 At least 1 Beacon community; Buying Value core ambulatory measure

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0032 Endorsed Cervical Cancer Screening Measure Steward: NCQA	Process	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	Clinician: Group/ Practice, Individual; Health Plan	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; PQRS; HRSA State Duals Demonstrations: IL, MA Private Programs: HEDIS; Wellpoint; Aetna; AmeriHealth Mercy Family of Companies; Cigna; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure
0034 Endorsed Colorectal Cancer Screening Measure Steward: NCQA	Process	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.	Clinician: Group/ Practice, Individual, Team; Health Plan	Federal and State Programs: Meaningful Use-EP; Medicare Part C Plan Rating; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: eValue8; at least 1 Beacon community; HEDIS ; Wellpoint; Aetna; Community Health Alliance; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0043 Endorsed Pneumonia vaccination status for older adults Measure Steward: NCQA	Process	Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination	Population: County or City; Facility; Health Plan; Integrated Delivery System; Clinician: Group/ Practice, Individual, Team	Federal and State Programs: Meaningful Use-EP, Medicare Part C Plan Rating, Medicare Shared Savings Program, Physician Feedback, PQRS Private Programs: At least 1 Beacon community; HEDIS; Wellpoint; Buying Value core ambulatory measure
0097 Endorsed Medication Reconciliation Measure Steward: NCQA	Process	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.	Population: County or City; Clinician: Group/ Practice, Individual; Integrated Delivery System	Federal and State Programs: Medicare Shared Savings Program; Physician Feedback; PQRS State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: Buying Value core ambulatory measure
0101 Endorsed Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls Measure Steward: NCQA **Starter Set Measure**	Process	This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates: A) Screening for Future 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 B) Multifactorial Risk Assessment for Falls: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months C) Plan of Care to Prevent Future Falls: Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	Clinician: Group/ Practice, Individual, Team	State Duals Demonstrations: WA

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0105 Endorsed Antidepressant Medication Management (AMM) Measure Steward: NCQA	Process	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	Clinician: Group/ Practice, Individual; Health Plan; Integrated Delivery System; Population: National, Regional, State	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Part C Plan Rating; Physician Feedback; PQRS; Value-Based Payment; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: HEDIS; Cigna; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure
0111 Endorsed Bipolar Disorder: Appraisal for risk of suicide Measure Steward: Center for Quality Assessment and Improvement in Mental Health	Process	Percentage of patients with bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide.	Clinician: Group/ Practice, Individual	
0166 Endorsed HCAHPS Measure Steward: CMS	Patient Engagement /Experience	27-items survey instrument with 7 domain-level composites including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information.	Facility	
0176 Endorsed Improvement in management of oral medications Measure Steward: CMS	Outcome	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.	Facility	Federal and State Programs: Home Health Quality Reporting

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0201 Endorsed Pressure ulcer prevalence (hospital acquired) Measure Steward: The Joint Commission	Outcome	The total number of patients that have hospital-acquired (nosocomial) category/ stage II or greater pressure ulcers on the day of the prevalence measurement episode.	Facility; Clinician: Team	Private Programs: National Database of Nursing Quality Indicators (NDNQI); Alternative Quality Contract Wellpoint
0202 Endorsed Falls with injury Measure Steward: American Nurses Association	Outcome	All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as Injury falls per 1000 Patient Days. (Total number of injury falls / Patient days) X 1000 Measure focus is safety. Target population is adult acute care inpatient and adult rehabilitation patients.	Clinician: Team	
0228 Endorsed 3-Item Care Transition Measure (CTM-3) Measure Steward: University of Colorado Health Sciences Center **Starter Set Measure**	Composite	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions.	Facility	Federal and State Programs: Hospital Inpatient Quality Reporting State Duals Demonstration: MA
0326 Endorsed Advance Care Plan Measure Steward: NCQA	Process	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Clinician: Group/ Practice, Individual	Federal and State Programs: Physician Feedback; PQRS; Special Needs Plan

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0418 Endorsed Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan Measure Steward: CMS **Starter Set Measure**	Process	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Clinician: Group/ Practice, Team, Individual; Population: National, Regional, State, County or City, Community	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use-EP; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA; Medicaid Health Home State Duals Demonstrations: CA, IL, MA, OH, VA, WA Private Programs: Bridges to Excellence
0419 Endorsed Documentation of Current Medications in the Medical Record Measure Steward: CMS **Starter Set Measure**	Process	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/ her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, vitamin/ mineral/ dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2012 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.	Clinician: Individual; Population: National	Federal and State Programs: Meaningful Use-EP; Physician Feedback; PQRS
0420 Endorsed Pain Assessment and Follow-Up Measure Steward: CMS	Process	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Clinician: Individual	Federal and State Programs: Physician Feedback; PQRS

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0421 Endorsed Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Measure Steward: CMS **Starter Set Measure**	Process	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 within the past six months or during the current visit Normal Parameters: Age 65 years and older BMI > = to 23 and <30 Age 18 – 64 years BMI > = to 18.5 and <25	Clinician: Group/ Practice, Individual; Population: National, Regional, State, County or City	Federal and State Programs: Meaningful Use-EP; Medicare Shared Savings Program; Physician Feedback; PQRS; HRSA State Duals Demonstration: MA Private Programs: At least 1 Beacon community; Wellpoint; Buying Value core ambulatory measure
0553 Endorsed Care for Older Adults – Medication Review Measure Steward: NCQA	Process	Percentage of adults 66 years and older who had a medication review; a review of all a member's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Clinician: Group/ Practice, Individual; Health Plan; Integrated Delivery System; Population: National, Regional, State	Federal and State Programs: Medicare Part C Plan Rating Private Programs: HEDIS; IHA
0554 Endorsed Medication Reconciliation Post-Discharge Measure Steward: NCQA	Process	The percentage of discharges from January 1– December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.	Health Plan; Integrated Delivery System; Population: National, Regional, County or City	Federal and State Programs: Special Needs Plan State Duals Demonstration: CA Private Programs: HEDIS
0557 Submitted HBIPS-6 Post discharge continuing care plan created Measure Steward: The Joint Commission	Process	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post discharge continuing care plan created. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-7 (Post Discharge Continuing Care Plan Transmitted).	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0558 Endorsed HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge Measure Steward: The Joint Commission	Process	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). Note: this is a paired measure with HBIPS-6: Post discharge continuing care plan created.	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting
0576 Endorsed Follow-Up After Hospitalization for Mental Illness Measure Steward: NCQA **Starter Set Measure**	Process	This measure assesses the 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. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	Clinician: Team; Health Plan; Integrated Delivery System; Population: National, Regional, State, County or City	Federal and State Programs: Children's Health Insurance Program Reauthorization Act Quality Reporting; Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Physician Feedback; PQRS; Medicaid Health Home, Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA, WA Private Programs: Wellpoint; HEDIS; Buying Value core ambulatory measure
0640 Endorsed HBIPS-2 Hours of physical restraint use Measure Steward: The Joint Commission	Process	The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint per 1000 psychiatric inpatient hours, 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).	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0641 Endorsed HBIPS-3 Hours of seclusion use Measure Steward: The Joint Commission	Process	The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion per 1000 psychiatric inpatient hours, 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).	Facility	Federal and State Programs: Inpatient Psychiatric Facility Quality Reporting
0646 Endorsed Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	Facility; Integrated Delivery System	Private Programs: ABIM MOC; Highmark
0647 Endorsed Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation 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	Facility; Integrated Delivery System	State Duals Demonstrations: CA, MA Private Programs: ABIM MOC; Highmark
0648 Endorsed Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI	Process	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation 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	Facility; Integrated Delivery System	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults State Duals Demonstrations: MA, WA Private Programs: ABIM MOC; Highmark; Buying Value core ambulatory measure

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0649 Endorsed Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/ Self Care] or Home Health Care) Measure Steward: AMA-PCPI	Process	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	Facility, Integrated Delivery System	Private Programs: ABIM MOC; Highmark
0674 Endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) Measure Steward: CMS	Outcome	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percent of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the last year (12-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	Facility; Population: National	Federal and State Programs: Nursing Home Quality Initiative and Nursing Home Compare
0682 Endorsed Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay) Measure Steward: CMS	Process	The measure reports the percentage of short stay nursing home residents or IRF or LTCH patients who were assessed and appropriately given the pneumococcal vaccine during the 12-month reporting period. This measure is based on data from Minimum Data Set (MDS) 3.0 assessments of nursing home residents, the Inpatient Rehabilitation Facilities Patient Assessment Instrument (IRF-PAI) for IRF patients, and the Long Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set for long-term care hospital patients, using items that have been harmonized across the three assessment instruments. Short-stay nursing home residents are those residents who are discharged within the first 100 days of their nursing home stay.	Facility; Population: National	Federal and State Programs: Nursing Home Quality Initiative and Nursing Home Compare

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0692 Endorsed Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument Measure Steward: AHRQ	Outcome	The CAHPS® Nursing Home Survey: Long-Stay Resident Instrument is an in-person survey instrument to gather information on the experience of long stay (greater than 100 days) residents currently in nursing homes. The Centers for Medicare & Medicaid Services requested development of this survey, and can be used in conjunction with the CAHPS Nursing Home Survey: Family Member Instrument and Discharged Resident Instrument. The survey instrument provides nursing home level scores on 5 topics valued by residents: (1) Environment; (2) Care; (3) Communication & Respect; (4) Autonomy and (5) Activities. In addition, the survey provides nursing home level scores on 3 global items.	Facility	State Duals Demonstration: VA Private Programs: Health Quality Council of Alberta, Canada
0709 Endorsed Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year. Measure Steward: Bridges to Excellence	Outcome	Percent of adult population aged 18 – 65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, were followed for one-year, and had one or more potentially avoidable complications (PACs). A Potentially Avoidable Complication is any event that negatively impacts the patient and is potentially controllable by the physicians and hospitals that manage and co-manage the patient. Generally, any hospitalization related to the patient's core chronic condition or any co-morbidity is considered a potentially avoidable complication, unless that hospitalization is considered to be a typical service for a patient with that condition. Additional PACs that can occur during the calendar year include those related to emergency room visits, as well as other professional or ancillary services tied to a potentially avoidable complication.	Clinician: Group/ Practice; Health Plan; Population: National, Regional, County or City, State	Private Programs: Prometheus

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0710 Endorsed Depression Remission at Twelve Months Measure Steward: MN Community Measurement	Outcome	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/ - 30 days) are also included in the denominator.	Facility, Clinician: Group/ Practice	Federal and State Programs: Meaningful Use-EP; PQRS Private Programs: MN Community Measurement
0712 Endorsed Depression Utilization of the PHQ-9 Tool Measure Steward: MN Community Measurement	Process	Adult patients age 18 and older with the diagnosis of major depression or dysthymia (ICD-9 296.2x, 296.3x or 300.4) who have a PHQ-9 tool administered at least once during the four month measurement period. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This process measure is related to the outcome measures of "Depression Remission at Six Months" and "Depression Remission at Twelve Months". This measure was selected by stakeholders for public reporting to promote the implementation of processes within the provider's office to insure that the patient is being assessed on a routine basis with a standardized tool that supports the outcome measures for depression. Currently, only about 20% of the patients eligible for the denominator of remission at 6 or 12 months actually have a follow-up PHQ-9 score for calculating remission (PHQ-9 score < 5).	Facility; Clinician: Group/ Practice	Federal and State Programs: Meaningful Use-EP; PQRS Private Programs: MN Community Measurement

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
0729 Endorsed Optimal Diabetes Care Measure Steward: MN Community Measurement	Composite	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.	Clinician: Group/ Practice; Integrated Delivery System	Federal and State Programs: Medicare Shared Savings Program; PQRS Private Programs: At least 1 Beacon community
1626 Endorsed Patients Admitted to ICU who Have Care Preferences Documented Measure Steward: The RAND Corporation	Process	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	Facility; Health Plan; Integrated Delivery System	
1659 Endorsed Influenza Immunization Measure Steward: CMS	Process	Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.	Facility; Population: National, Regional, State	Federal and State Programs: Hospital Inpatient Quality Reporting

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
1768 Endorsed Plan All-Cause Readmissions Measure Steward: NCQA **Starter Set Measure**	Outcome	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.	Health Plan	Federal and State Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Medicare Part C Plan Rating; Special Needs Plan State Duals Demonstrations: CA, IL, MA, OH, VA Private Programs: Wellpoint; HEDIS; IHA; AHIP survey - Measures used by a Majority of Health Plans; Buying Value core ambulatory measure
1789 Endorsed Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) Measure Steward: CMS	Outcome	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.	Facility	Federal and State Programs: Hospital Inpatient Quality Reporting

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
1902 Endorsed Clinicians/ Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy Measure Steward: AHRQ	Outcome	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician & Group Survey. The item set includes the following domains: Communication with Provider (Doctor), Disease Self-Management, Communication about Medicines, Communication about Test Results, and Communication about Forms. Samples for the survey are drawn from adults who have had at least one provider's visit within the past year. Measures can be calculated at the individual clinician level, or at the group (e.g., practice, clinic) level. We have included in this submission items from the core Clinician/ Group CAHPS instrument that are required for these supplemental items to be fielded (e.g., screeners, stratifies). Two composites can be calculated from the item set: 1) Communication to improve health literacy (5 items), and 2) Communication about medicines (3 items)	Clinician: Group/ Practice, Individual	Private Programs: Highmark; Buying Value core ambulatory measure
1909 Endorsed Medical Home System Survey (MHSS) Measure Steward: NCQA **Starter Set Measure**	Composite	The Medical Home System Survey (MHSS) assesses the degree to which an individual primary-care practice or provider has in place the structures and processes of an evidence-based Patient Centered Medical Home. The survey is composed of six composites. Each measure is used to assess a particular domain of the patient-centered medical home. Composite 1: Enhance access and continuity Composite 2: Identify and manage patient populations Composite 3: Plan and manage care Composite 4: Provide self-care support and community resources Composite 5: Track and coordinate care Composite 6: Measure and improve performance	Clinician: Group/ Practice, Individual	

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
1927 Endorsed Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications Measure Steward: NCQA	Process	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.	Health Plan; Integrated Delivery System; Population: State	
1932 Endorsed Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) Measure Steward: NCQA	Process	The percentage of individuals 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed any antipsychotic medication and had a diabetes screening during the measurement year.	Health Plan; Population: State	State Duals Demonstration: IL
2079 Endorsed HIV medical visit frequency Measure Steward: HRSA - HIV/AIDS Bureau	Process	Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.	Clinician: Group/Practice, Facility	
2091 Endorsed Persistent Indicators of Dementia without a Diagnosis - Long Stay Measure Steward: American Medical Directors Association	Process	Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.	Facility	
2092 Endorsed Persistent Indicators of Dementia without a Diagnosis - Short Stay Measure Steward: American Medical Directors Association	Process	Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.	Facility	

NQF Measure Number, Endorsement Status, Title, and Steward	Measure Type	Measure Description	Level of Analysis	Other Known Uses and Program Alignment
2111 Endorsed Antipsychotic Use in Persons with Dementia Measure Steward: Pharmacy Quality Alliance, Inc.	Process	The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.	Health Plan	
2152 Endorsed Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling Measure Steward: AMA-PCPI	Process	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.	Clinician: Group/ Practice, Individual, Team	
2158 Endorsed Payment-Standardized Medicare Spending Per Beneficiary (MSPB) Measure Steward: CMS	Cost/Resource Use	The MSPB Measure assesses the cost of services performed by hospitals and other healthcare providers during an MSPB hospitalization episode, which comprises the period immediately prior to, during, and following a patient's hospital stay. Beneficiary populations eligible for the MSPB calculation include Medicare beneficiaries enrolled in Medicare Parts A and B who were discharged from short-term acute hospitals during the period of performance.	Facility	

Appendix E: Alignment in Use of Family of Measures for Dual Eligible Beneficiaries Across Selected Federal Programs

Federal Quality Measurement Programs	Measures from Family Currently Used In Program*
Ambulatory Surgical Centers Quality Reporting Program	
End Stage Renal Disease Quality Initiative Program	
Home Health Quality Reporting	1
Hospice Quality Reporting Program	
Hospital-Acquired Condition Reduction Program	
Hospital Inpatient Quality Reporting Program	4
Hospital Outpatient Quality Reporting	
Hospital Readmissions Reduction Program	
Hospital Value-Based Purchasing Program	2
Inpatient Psychiatric Facilities Quality Reporting	5
Inpatient Rehabilitation Facility Quality Reporting	
Long-Term Care Hospital Quality Reporting	1
Medicaid Adult Core Quality Measures Program	11
Medicaid Children's Quality Measures Program	1
Medicaid Health Home Core Quality measures	6
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	13
Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals	
Medicare Part C	7
Medicare Part D	2
Medicare Shared Savings Program	10
Nursing Home Quality Initiative and Nursing Home Compare	2
Physician Compare	
Physician Feedback Program	10
Physician Quality Reporting System	20
PPS-Exempt Cancer Hospital Quality Reporting Program	1
Value-Based Payment Modifier	

*A measure is "in use" when a final decision has been made to implement a measure in one or more federal programs. At least one of the following actions occurs: 1) data collection for computing the measure begins; and/or 2) measure results are computed using data that was previously collected.

Endnotes

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NATIONAL QUALITY FORUM

Measure Applications Partnership: 2014 Report on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid

DRAFT REPORT FOR COMMENT

July 9, 2014

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Contents

Introduction and Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF). MAP provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs (Appendix A). MAP has also been charged with providing input on the use of performance measures to assess and improve the quality of care delivered to adults who are enrolled in Medicaid.

The charge of the MAP Medicaid Task Force is to advise the MAP Coordinating Committee on recommendations to HHS for strengthening and revising measures in the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set) as well as the identification of high priority measure gaps. The task force consists of MAP members from the MAP Coordinating Committee and MAP workgroups (Appendix B).

Guided by the MAP Measure Selection Criteria (MSC) (Appendix C), MAP considered states' experiences implementing the Adult Core Set in making its recommendations. To inform MAP's review, CMS provided detailed summaries of the number of states reporting each measure, deviations from the published measure specifications, technical assistance requests, and actions taken in response to questions and challenges. This report summarizes select states' feedback on collecting and reporting measures. It also includes measure-specific recommendations, high-priority gaps, and potential gap-filling measures (Appendix D). In addition, MAP identified several strategic issues related to the programmatic context for the Adult Core Set. This report follows an Expedited Review MAP performed in 2013 and contains more detailed information.

Background on Medicaid and the Adult Core Set

Medicaid is the largest health insurance program in the US and the primary health insurance program for low-income individuals. Medicaid is financed through a federal-state partnership; each state designs and operates its own program within federal guidelines.

Medicaid Adult Population

In 2013, 72.8 million individuals were enrolled in Medicaid at some point in time, of which about half were adults.[1] Before the enactment of the Affordable Care Act of 2010 (ACA), federal funding for Medicaid could only be used for specific categories of low-income individuals: children, pregnant women, parents of dependent children, individuals with disabilities, and people age 65 and older. In other words, most low-income non-elderly adults without dependent children were excluded from Medicaid. States now have the option to expand Medicaid eligibility to nearly all non-elderly adults with incomes at or below 138% of the federal poverty level (FPL).[2] In 2014, the 138% of FPL for an individual is $16,105 and $32,913 for a family of four.[3]

Each state will decide whether to expand their Medicaid eligibility.[4] To date, 27 states including the District of Columbia are implementing expansion in 2014, 3 states are still debating expansion, and 21 states are not moving forward with expansion at this time.[5] Enrollment data for April 2014 indicate enrollment growth in states that have expanded Medicaid to low-income adults has outpaced the national average and is significantly higher than growth in non-expansion states (15.3% vs.3.3%).[6]

Because nonelderly adults covered by Medicaid are more likely than uninsured adults to report receiving timely health care visits, the expansion offers an important opportunity to improve access and health outcomes.[7]

Because Medicaid expansion is a state decision, an eligibility "coverage gap" is created for adults in states that opt not to expand who would otherwise be eligible for the Medicaid expansion. Nearly 80% of the 4.8 million uninsured adults who fall into the coverage gap live in Southern states, and the coverage gap in the South disproportionately affects people of color.[8]

Due to the strong correlation between poverty and poor health, Medicaid beneficiaries have a poorer health profile compared with both the privately insured and the uninsured. [9] Among adults with similar income, those with Medicaid report both worse overall health, worse mental health, and also higher rates of both multiple chronic conditions and activity limitations.[10] A recent analysis by the Healthcare Cost and Utilization Project (HCUP) found that non-elderly Adult Medicaid beneficiaries experienced a total all-cause, 30 day hospital readmission rate of 14.6 per 100 admissions, totaling approximately 700,000 readmissions in 2011 at a cost of approximately $7.6 billion.[11]

Medicaid Adult Core Set

In addition to the expansion of Medicaid coverage to adults, ACA also called for the creation of a core set of health care quality measures to assess the quality of care for adults enrolled in Medicaid. While many states were already monitoring and seeking to improve quality in Medicaid, the core set of measures will standardize and align measurement efforts. HHS established the Adult Medicaid Quality Measurement Program to standardize the measurement of health care quality across state Medicaid programs, assist states who elect to collect and report on the measures, and facilitate the use of the measures for quality improvement.[12] HHS published the initial Adult Core Set of measures in 2012 and offered grant support for a two-year period to assist states in building capacity to participate in reporting. CMS' three-part goal for the Adult Core Set is:

1. Increase number of states reporting Adult Core Set measures
2. Increase number of measures reported by each state
3. Increase number of states using Core Set measures to drive quality improvement

The measures in the Adult Core Set were compiled to address quality issues related to general adult health, maternal/reproductive health, complex health care needs, and mental health and substance use. The Statute also requires HHS to make annual updates to the Adult Core Set, starting in January 2014, and MAP's input directly informs these changes.[13]

ACA requires annual reports on the reporting of adult Medicaid quality information. The 2014 Report to Congress: HHS Secretary's Efforts to Improve the Quality of Health Care for Adults Enrolled in Medicaid highlights CMS's use of the National Quality Strategy (NQS) to guide health care improvement efforts and to measure progress toward achieving the goals of better care, healthy people/healthy communities, and affordable care. [14] This report also includes a summary of technical assistance and analytic support provided to states in the first year of reporting Adult Core Set measures.

Characteristics of the Medicaid Adult Core Set

The Adult Core Set used in FFY2013 contains 26 measures (Appendix D) that cover all six areas of the NQS and CMS Quality Strategy priorities (Exhibit 1).

Exhibit 1: NQS and CMS Quality Strategy Priorities

NQS and CMS Quality Strategy Priorities	Number of Measures in the Adult Core Set (n = 26)
Patient Safety	7
Person- and Family-Centered Experience of Care	1
Effective Communication and Care Coordination	6
Prevention and Treatment of Chronic Disease	2
Healthy Living and Well-Being	8
Affordability	1

It also contains a mix of structure, process, outcome, and patient experience of care measures. Six of the measures are sensitive to known healthcare disparities. Additionally, the Adult Core Set is well-aligned with other quality and reporting initiatives: 15 of the measures are used in one or more federal programs, 3 in the Medicaid Children's Core Set, and 12 are included in the Health Insurance Marketplace Quality Rating System Beta Test Measure Set.[15,16] Representing the diverse health needs of the adult Medicaid population, the Adult Core Set measures span clinical conditions (Exhibit 2).

Exhibit 2: Clinical Conditions Covered by Measures in the Medicaid Adult Core Set

Clinical Conditions	Number of Measures in the Adult Core Set (n = 26)
Preventive Screening and Care	6
Behavioral Health and Substance Use	5
Cardiovascular Disease and Diabetes	5
Care Coordination and Experience of Care	4
Maternal and Prenatal Health	3
Respiratory Care, COPD, and Asthma	2
HIV/AIDS	1

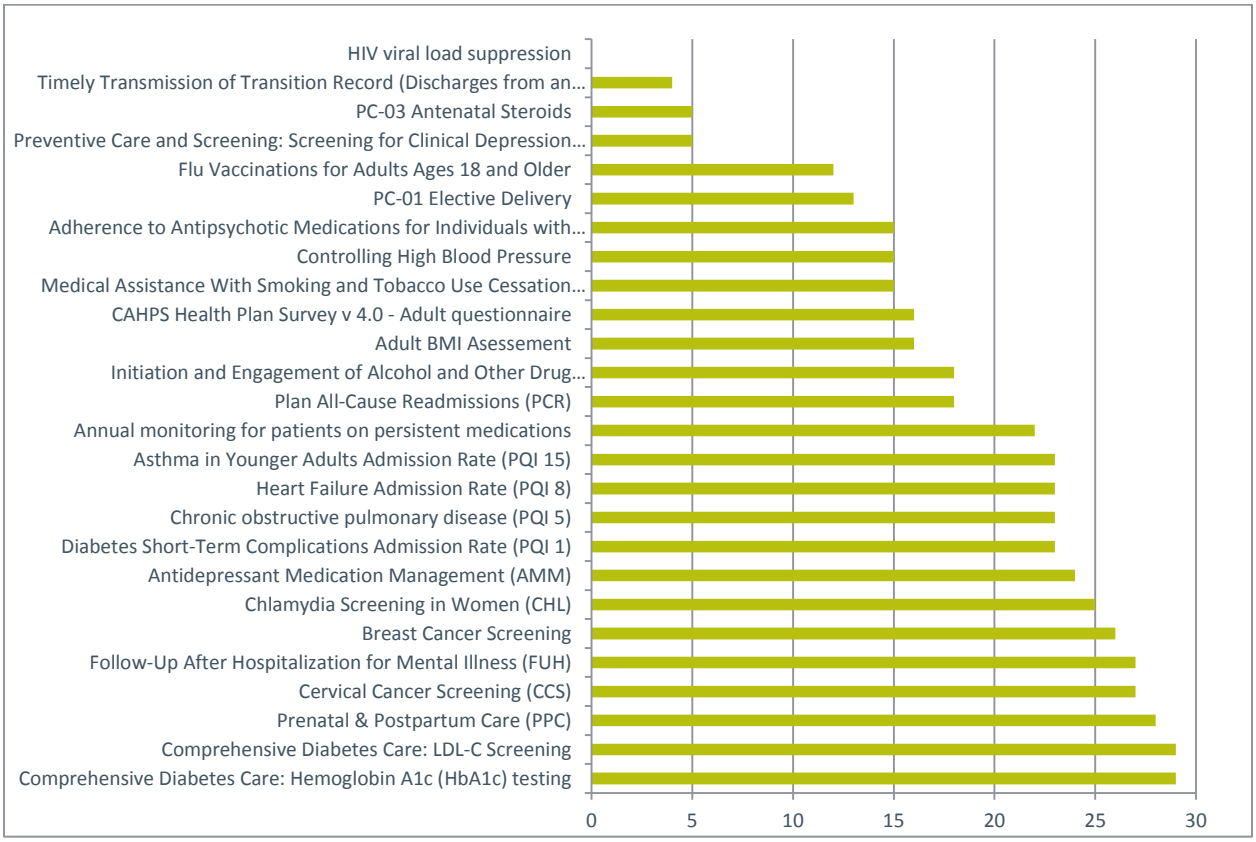
State Experience Collecting and Reporting the Core Set

MAP values implementation and impact information about measures and uses this feedback to inform its decisionmaking. MAP received feedback on the implementation of the Adult Core Set from CMS and states in three formats: FFY 2013 Medicaid Adult Core Set Implementation information, presentations from reporting states, and communication of barriers from non-reporting states. These valuable inputs informed the measure-specific and strategic recommendations for the Adult Core Set to achieve CMS' three-part goal.

Participation in Reporting Measures

During the first year of data collection and reporting, CMS recorded feedback from states on the implementation experience of each Adult Core Set measure. The number of states that reported each measure ranged from a low of four to a high of 29 states (Exhibit 3). The most common reason given for not reporting a measure was that the information was not collected because the measure was not identified as a key priority this year. MAP considered the number of states that were able to report each measure and sought to understand states' priorities to inform its recommendations.

Exhibit 3: Number of States Reporting Measures in Medicaid Adult Core Set in FFY 2013



In the January 2014 update to the measure set. CMS replaced the measure Annual HIV/AIDS Medicaid Visit with NQF #2082 HIV Viral Load Suppression.[17] MAP recommended this substitution because the original measure had NQF endorsement removed and its process focus was thought to be less important that the intermediate outcome of viral load suppression. As a result, FFY 2014 is the first year in which the measure of viral load suppression will be reported. No other additions, deletions, or substitutions were made in this first update.[18*]

[*] MAP also previously recommended measures #2372 Breast Cancer Screening (formerly #0031), #2371 Annual Monitoring for Patients on Persistent Medications (formerly #0021), and #0039 Flu Shots for Adults be updated and resubmitted for NQF endorsement. Since that time, the measure stewards have completed and submitted updates to NQF. At the time of this report, measures #2371 and #2372 received support in the early stages of the endorsement process and are currently available for comment.

Implementation Feedback from Reporting States

Three states–Louisiana, New Hampshire, and Virginia–shared their implementation experiences collecting and reporting measures to CMS to inform the MAP review of the Adult Core Set. These voices are a sample and not representative of all state Medicaid programs. This dialogue was highly informative and MAP will continue to pursue opportunities to receive direct feedback from users of measures to guide decisionmaking.

Louisiana

In the state of Louisiana nearly 500,000 adults received Medicaid services in 2010.[19] Until 2011, Louisiana Medicaid operated in a fee-for-service model; since 2012 almost all beneficiaries have been enrolled in a Managed Care benefit with one of the five participating health plans across the state. Louisiana is a recipient of an Adult Medicaid Quality Grant and reported 19 of the 26 measures in the core set. Prior to the grant program, Louisiana Medicaid collected 18 HEDIS measures and 10 Children's Core Set measures.

Facilitated by the grant, the State is collecting nine additional measures. When selecting measures, Louisiana selected those that matched their interests and purposefully avoided those requiring medical record review. From the state perspective, medical record review is thought to be labor intensive, require a specific skill set, and relatively costly. To collect and report additional measures from the Adult Core Set, Louisiana built new capacities, partnered with others in the state, and demonstrated successful innovations that will be useful across the state Medicaid programs.

Linking Claims Data and Vital Records: Louisiana celebrated the creation of a link between vital records and claims data for the collection and reporting of #0469 PC-01 Elective Delivery. This method has been validated by the National Perinatal Information Center/Quality Analytic Services (NPIC/QAS) and has the potential to eliminate the need to review medical records for this measure.

Medical Record Review: Though challenging from the outset, Louisiana selected and successfully reported #1517 Prenatal and Postpartum Care (Postpartum care rate only). This measure was collected through hybrid data collection. The state selected this measure because administrative claims data was already available, but later observed it produced inaccurate results due to the clinical importance of timing of care for this measure and missing data due to bundled payments including postpartum care. Therefore, Louisiana Medicaid formed a new partnership with the Louisiana Office of Public Health Nursing Services to implement a new medical record review process.

This new process, developed over several months, uses administrative claims data that is highly familiar to the state for HEDIS reporting to streamline data collection and improve the efficiency of medical record review. The ultimate result was improved measurement accuracy. The state hopes to use this method for other measurement efforts and to share this best practice with other states. Despite successfully developing methods to reduce the burden of medical record review, the state recommends the set contain measures that use automated methods such as claims and e-measures.

Measurement Driving Improvement: Representatives from Louisiana identified several avenues through which Adult Core Set measures are helping drive improvement. As a result of the grant program, Louisiana has enhanced capacity for analyzing and reporting quality measures across all

Medicaid programs. The results are used to steer state-level Medicaid policy and interventions to improve outcomes in the population.

Other recommendations from Louisiana's representatives to CMS and MAP for the core set focused on reducing burden. CMS and MAP are encouraged to consider alignment of the measures in the Adult Core Set with other measurement programs. Representatives also suggested including additional measures to address needs of large segments of the population, such as asthma, appropriateness of care, access to preventive care and ambulatory care, and emergency department utilization.

New Hampshire

The State of New Hampshire provided Medicaid-funded health care services to approximately 68,000 adults in 2010.[20] In 2014, New Hampshire chose to expand Medicaid coverage through provisions in ACA. Beginning July, 2014, the effective lower income limit for tax credits in New Hampshire will be 138% of poverty for adults.[21] As a result, 30% of the currently uninsured adult population is expected to gain Medicaid eligibility. During the first year of participation in the quality reporting program, New Hampshire submitted 16 measures in the Adult Core Set to CMS. To select and report these measures, state officials balanced political, logistical, and financial realities. Three key features influenced the selection of measures to report: feasibility, efficiency, and capacity building.

Feasibility: The state preferred measures that did not present significant challenges in collecting or reporting the data. The state sought measures that had clear specifications; unclear specifications increase the resources required to collect and report a measure. Representatives encouraged the continued availability of clear, thorough manuals to improve the data collection process, accuracy, and ability to eventually compare results between states.

Efficiency: Related to feasibility, measurement imposes a burden of cost. Measures with relative high-cost of reporting, and potentially less efficient, compared to others in the Adult Core Set were not reported. Specifically, measures collected through administrative claims data were heavily favored over medical record review. In the future, understanding the efficiency and return on investment of measurement and identification of the measures best available to drive improvement would be highly valuable in state measure selection.

Capacity Building: The state appreciated the flexibility to use grant funds to explore linking data sets to collect data for measures. Once established, this infrastructure and knowledge could improve the feasibility and efficiency of future collection. Linked data sets were pursued for measures #0576 Follow-up After Hospitalization for Mental Illness, and #0469 PC-01 Elective Delivery, and ultimately successful for the former. The state identified value in formally linking data sets, which yielded techniques that may contribute to other state-wide quality improvement efforts. The measures not reported this year were thought to be important, though the state lacked capacity to collect them all. Over time, the state will build additional capacity to report additional measures.

Overall, New Hampshire representatives communicated their appreciation for the new reporting program and the associated grant opportunity. They support the structure of the program and its voluntary nature, the common core set, and the ability for states to select measures from the core to report. Over time, representatives encouraged CMS to make the results of the measures transparent to allow for comparisons between states that would drive improvement. Important measure gaps were

identified in long-term supports and services, beneficiary and consumer experience, and quality of Medicaid administration and services.

Virginia

The Commonwealth of Virginia Department of Medical Assistance Services funds Medicaid services for more than 350,000 adults.[22] Enrollees receive services through managed care health plans, all of which are required to maintain National Committee for Quality Assurance (NCQA) accreditation. This full-risk model for health plans provides budgetary certainty for the state and opportunities for marketplace competition and innovation. Virginia was not a recipient of the grant and voluntarily reported 8 measures in the Adult Core Set.

Quality Strategy: Virginia maintains a Medicaid Managed Care Quality Strategy with a population health focus. The Quality Strategy defines the quality measures required by all participating health plans and prioritizes HEDIS to align with NCQA accreditation requirements. The state currently requires health plans to report 18 HEDIS measures. The Quality Strategy will be updated over the course of the next year to identify the priority quality measures for performance improvement and consider the demographics of Medicaid enrollees and medical trends.

Performance Measure Incentive Program: Virginia is implementing a financial incentive program for quality and cost containment outcomes. The program will reward health plan performance and phase in over three years. The state program focus is on quality through the assessment of three HEDIS measures and three health plan administration process metrics. Fiscal awards will be proportionate to the achievements of the health plan against the benchmark for each measure.[23]

In the first year of reporting, Virginia submitted 8 of the HEDIS measures from the Adult Core Set to CMS. State representatives identified participation in the Adult Core Set as a valuable opportunity because it is the first national core measure set for Medicaid programs for adults. The representatives recommend that the measures' results be available for valid benchmarking and comparisons through consistent the collection across states. To enable this, they advocate the measure specifications in the data entry system be clear and up to date with HEDIS, NQF endorsement, clinical practice guidelines, and other nationally recognized standards. They also recommend that the Adult Core Set continue to align across public and private measurement programs and focus on improving population health.

Non-Reporting States

Roughly half of Medicaid programs did not submit data on measures in the Adult Core Set to CMS for this voluntary reporting program. A primary goal of CMS is to increase the number of states participating in reporting measures in the Adult Core Set. To inform its recommendations, MAP sought feedback from non-reporting states to identify barriers to reporting and avenues to overcome them. Representatives from two states shared their reasoning with MAP. While not identified for purposes of confidentiality, their perspectives added helpful insights to inform measure-specific and general recommendations. MAP encouraged subsequent reviews of the Adult Core Set to be informed by additional discussions with non-reporting Medicaid programs. Several themes arose from non-reporting state feedback, some of which are congruent with feedback from reporting states:

- Broad factors influence state decisions to report, including political, feasibility, and financial concerns;

- Stakeholders were uncertain about the reporting requirements and use of data for comparisons or public reporting in the new program;
- Ability of the measures to compare states' performance may be compromised due to differences in benefit structures, payment models, diverse populations, or other factors;
- Some states have already invested in tailored quality measurement programs that have longitudinal results comparing providers within the state and externally to national benchmarks;
- Measurement priorities include access to care, primary care, and preventative care and should be aligned with other programs.

MAP Review of the Medicaid Adult Core Set

MAP reviewed the measures in the Adult Core Set and provides the following recommendations to strengthen the measure set and support CMS' stated goals for the program. To conduct this review, MAP applied the measure selection criteria (MSC) and feedback from the first year of state implementation to carefully evaluate and identify opportunities to improve the Adult Core Set. MAP also identified priority measure gap areas to address health care quality for the Adult Medicaid population.[24]

The MSC are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. The criteria favor the selection of high-quality measures that optimally address the NQS, fill critical measurement gaps, and increase alignment across programs. In the application of the MSC to the Adult Core Set, MAP noted the following:

- The Adult Core Set is adequate to advance CMS' stated goals for the program;
- The Adult Core Set's strong alignment with other program sets and parsimonious number of measures should continue;
- While the mix of measure types is satisfactory, MAP encourages the inclusion of relevant outcome measures in future iterations of the set;
- MAP strongly prefers the set contain the most current NQF-endorsed measures to ensure validity and reliability.
    - MAP observed changes had been made to several measures to enable state-level reporting, including the use of a more restricted age range, setting a specific date for age calculation, and changing denominator populations from 'enrollees' to 'member-months.'
    - An observed modification that constitutes a significant change is use of a different risk adjustment methodology.
    - For measures that have not been endorsed or have had endorsement removed, CMS should consider updates or substitutions.

MAP recognized the investment made in the initial version of the Adult Core Set measures as well as the need for states and CMS to gain experience with their use. As such, making drastic changes to the measures in the first two years of program implementation would be premature. Such changes could have the unintended consequence of discouraging states' participation in quality measurement and

quality improvement. Therefore, the most important efforts for CMS to undertake now to achieve the program goals are to address known challenges in data collection and reporting, monitor the program's continuing development, and consider the measure-specific recommendations in this report.

Measure-Specific Recommendations

MAP supported the majority of the measures in the Adult Core Set for continued use in the program. Appendix D provides further details on MAP's measure-specific recommendations and decision rationale. Although MAP discussed concerns about the feasibility of reporting complex measures that require hybrid specifications, medical record review, or data linkages, members were comfortable retaining them in the set to pose a challenge to states. As previously discussed, it is important that the measure set remain stable to enable states to gain experience and build capacity for reporting.

Measures for Phased Addition to the Adult Core Set

MAP recommends that CMS consider three measures for phased addition to the Adult Core Set. Their use would strengthen the measure set, but MAP is aware that additional resources are required for each new measure and grants CMS the flexibility to add the measures gradually and only if they are found to be feasible to implement at the state level.

1. First, MAP prioritized the addition of #0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) to the Adult Core Set to address the highly prevalent condition of diabetes and facilitate state efforts to drive quality improvement on the risk factor of poor HbA1c control. A measure of HbA1c testing is currently a part of the measure set, but MAP is more interested in measuring the intermediate outcome than the process.
2. Second, MAP recommended the addition of #1799 Medication Management for People with Asthma as a complement to #0283 Asthma in Younger Adults Admission Rate (PQI 15) because it focuses on upstream activities to control asthma symptoms. There is thought to be a relatively low incidence of asthma admissions in the Medicaid adult population.
3. Third, consistent with prior recommendations, #0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) was supported for addition to the Adult Core Set. This measure is paired and intended to be used with #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care), which had relatively low levels of reporting by states because of data collection challenges. Care coordination is an important topic area and using these measures together may improve the feasibility of the measures.

Measures with Conditional Support for Continued Use in the Adult Core Set

MAP conditionally supported the continued use of three measures.

Medication Management and NQF#2371 Annual Monitoring for Patients on Persistent Medications

Medication management is critical to achieving high quality care and positive health outcomes; measures of this topic are very important quality indicators. The set contains NQF#2371 Annual

Monitoring for Patients on Persistent Medications.[†] This measure had NQF endorsement removed at one point in time but has now been updated and gained the approval of the Safety Standing Committee. MAP conditionally supported the continued use of this measure if its endorsement is renewed but considers it to be narrowly designed. As is the case with this measure, the focus on a single point in time, condition, or prescription fail to reflect the overall quality of medication management. MAP would prefer the inclusion of a measure of adherence or shared decision-making about medication choices.

MAP suggests further review of issues related to medication management and inclusion of a more comprehensive measure. However, the group did not reach consensus on the addition of a specific measure that is presently available. MAP remains sensitive to the need to maintain a relatively stable measure set and the cost of adding new measures. Exhibit 4 identifies potential measures to address medication management and will further consider input from the MAP Coordinating Committee and public comment on the matter of whether the current measure should be replaced or supplemented with another.

Exhibit 4: Medication Management Measures for Potential Addition or Substitution

Measure and Steward	Description	Data Source	Alignment and Level of Analysis
0097 Endorsed Medication Reconciliation Steward: National Committee for Quality Assurance	Percentage of patients aged 18 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days of discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist who had reconciliation of the discharge medications with the current medication list in the outpatient medical record documented. This measure is reported as two rates stratified by age group: 18-64 and 65+.	Administrative claims, Electronic Clinical Data	Alignment: Medicare Shared Savings Program, PQRS Level of Analysis: Clinician: Individual and Clinician: Group/Practice
0419 Endorsed Documentation of Current Medications in the Medical Record Steward: Centers for Medicare & Medicaid Services	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration	Administrative claims, Electronic Clinical Data: Registry	Alignment: Meaningful Use Stage 2 – Eligible Professionals, PQRS Level of Analysis: Clinician: Individual and Population: National
0541 Endorsed Proportion of Days Covered (PDC): 3 Rates by	The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the	Electronic Clinical Data: Pharmacy	Alignment: Meaningful Use Stage 2 – Eligible Professionals, PQRS

[†] For HEDIS 2015, NCQA retired the Anticonvulsant-Monitoring rate; revised the numerator for angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), Digoxin and Diuretics rates to remove blood urea nitrogen as a substitute for serum creatinine; and revised the Digoxin rate to include serum digoxin monitoring. These updates would take effect in the Medicaid Adult Core Set as part of updated Technical Specifications to be released in 2015.

Measure and Steward	Description	Data Source	Alignment and Level of Analysis
Therapeutic Category Steward: Pharmacy Quality Alliance	following medication categories: Beta-Blockers (BB), Renin Angiotensin System (RAS) Antagonists, Calcium-Channel Blockers (CCB), Diabetes Medications, Statins		Level of Analysis: Clinician: Group/Practice and Clinician: Team/Health Plan

Hospital Readmission and NQF #1768 Plan All-Cause Readmissions (PCR)

NQF has endorsed two measures related to all-cause hospital readmissions. The two measures differ in their approach and underlying specifications due to the purposes for which they were designed. Measure #1768 Plan All-Cause Readmissions (PCR) is currently included in the Medicaid Adult Core Set. However, CMS is considering whether measure #1789 Hospital-Wide All-Cause Unplanned Readmission Measure would offer greater fit-for-purpose in the program. MAP urges CMS to consider the many potential uses of the measurement information and determine which one is primary because different "use cases" lead to different conclusions about which measure would be superior in this context. In particular, issues of alignment with other programs and the feasibility of data collection

Unless CMS makes a determination that #1789 better fits the needs of the program, MAP supports the continued use of #1768 Plan All-Cause Readmission in the Adult Core Set to address the critical quality issue of hospital readmission. However, MAP remains concerned about the lack of risk adjustment methodology available for the Medicaid adult population. Without an appropriate risk-adjustment methodology, one cannot determine if differences in performance are due to overall quality, the characteristics of the denominator population, or randomness due to availability of data and collection methods and extrapolation for analysis. The health of the adult Medicaid population has been shown to be significantly different than the general population and justifies use of an appropriate risk adjustment methodology. MAP supports CMS' planned effort to work with the measure steward to address this. MAP will gather additional input from the MAP Coordinating Committee and public comment on how CMS should approach the choice of the most appropriate all-cause readmission measure for use in the Adult Core Set.

NQF#2372 Breast Cancer Screening

Measure #2372 Breast Cancer Screening had NQF endorsement removed at one point in time but has been re-submitted, approved by the standing committee, and is currently in the Public and Member Commenting Phase of the Consensus Development Process. The measure is expected to regain endorsement. MAP supports its continued use contingent upon endorsement.

Measures for Removal from the Adult Core Set

NQF#0063 Comprehensive Diabetes Care: LDL-C Screening

MAP noted that clinical guidelines for lipid management have recently changed; as such, the continued use of #0063 Comprehensive Diabetes Care: LDL-C Screening may no longer be appropriate. NCQA is the steward of this measure and decided to retire the measure from the 2015 version of HEDIS. MAP recommends that CMS remove the measure from the Adult Core Set.

Recommendations to Address High Priority Gaps

MAP identified numerous gaps in the Adult Core Set from state feedback, the review of current measures, and data on conditions associated with hospital readmissions. They include:

- Access to care
- Beneficiary-reported outcomes
- Cultural competency
- Care Coordination
- Efficiency
- Inappropriate emergency department utilization
- Integration of health and human services
- Inter-conception health
- Long-term supports and services
- Poor birth outcomes (e.g., premature birth, low birth weight)
- Post-partum care and complications
- Primary care and behavioral health integration
- Primary prevention and wellness
- Treatment outcomes for behavioral health conditions and substance use disorders
- Workforce

Although the Adult Core Set includes measures pertaining to some of these topics, they were not perceived as sufficient. For example, several measures in the Adult Core Set relate to the conditions causing hospital readmissions, but others are available and could be considered for future addition to the set (Appendix E). MAP placed particular emphasis on three gap areas for future action: maternal health relating to risks for poor birth outcomes, behavioral health and substance abuse, and access to primary care.

Maternal Health

Pregnancy is among the eligibility criteria for adults to qualify for Medicaid benefits and nearly half of all births in the United States are covered by Medicaid. MAP identified reproductive, maternal, and prenatal care as an essential area for measurement to drive positive population health outcomes. MAP specifically suggested measures related to progesterone use to prevent premature birth, low birth weight, inter-conception health, contraception (e.g., LARC insertions), and maternal mortality.

Behavioral Health

In addition to the Medicaid adult population reporting high rates of poor mental health, 4 of the 10 most common conditions for readmission are behavioral health and/or substance use disorder (SUD) diagnoses. These conditions are often undiagnosed and/or untreated. One member suggested routinely integrating mental health screening in primary care visits and routine follow-up as a prime measurement opportunity.

MAP learned of joint efforts of the National Committee for Quality Assurance (NCQA) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to address measure gaps related to comorbid conditions among the behavioral health population. Research shows that low rates of ambulatory care contribute to poor performance on quality measures. Currently in its third year, the project is

developing measures that assess screening and follow up care for adults with serious mental illnesses such as schizophrenia, bipolar disorder, major depression, alcohol and other drug dependence. MAP members discussed the lack of services available to the behavioral health population and will continue to monitor these measure development efforts for their potential to address measure gaps.

Though not a priority for immediate use, MAP recommends that future reviews of the Adult Core Set consider potential complements to the current measure on antipsychotic adherence: NQF#1927 Cardiovascular Screening for People with Schizophrenia or Bipolar Disorders Who Are Prescribed Antipsychotic Medications and NQF#1932 Diabetes Screening for People with Schizophrenia or Mood Disorders Who Are Using Antipsychotic Medications.

Access to Primary Care

Finally, MAP emphasized the importance of measure development in access to preventive health services and wellness. Poor access and lack of care coordination contribute to overuse of emergency department and hospital services. In general, the Adult Core Set lacks measures of social determinants of health and access to primary care that contribute strongly to individual health outcomes. MAP specifically recommends measure development in the areas of person-centered care that can track longitudinal progress toward a health or quality of life goal.

Strategic Issues

During MAP's review of measures in the Adult Core Set, members discussed numerous cross-cutting and strategic issues. While not specific to the use of particular measures, these observations can guide ongoing implementation of the measurement program and inform future iterations of the set.

Building State Capacity

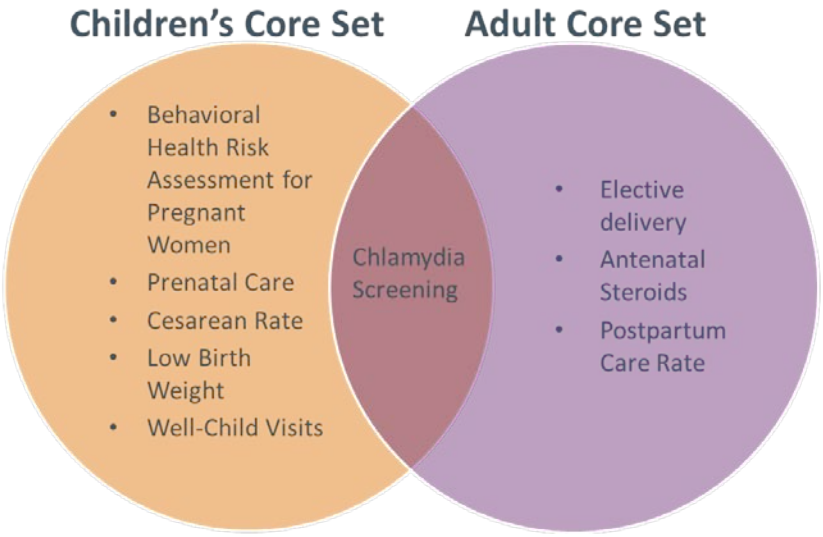
Since the start of the program just two years ago, many of the states participating in reporting the Adult Core Set have greatly increased their capacity and ability to use measures to advance quality improvement. State representatives enthusiastically discussed the vital importance of Medicaid in supporting low-income Americans in accessing basic health services, at the same time acknowledging that all Medicaid programs are under-resourced. State representatives described the benefit of CMS' grant program in providing funding that allowed the Medicaid agencies to form data-sharing partnerships with the public health system and other key stakeholders. Developing linkages to vital records systems, for example, assisted with the calculation of some measures and will benefit other population health monitoring efforts. In addition, state staff are growing more practiced in and expanding their uses of analytics to understand the health of their enrolled populations. MAP members shared the view that while investment in measurement requires sustained funding, a lack of action in addressing quality is costly and detrimental to population health in the long term.

Alignment of Measures across Adult and Children's Core Sets

When making recommendations about measures for the Adult Core Set, MAP recognized the importance of coordinating the selected measures with those contained in the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Children's Core Set). Though the two measurement programs are separate, both CMS and States regard them as working together to provide

an overall picture of quality within Medicaid. This is especially apparent when considering the quality of the continuum of the prenatal, maternity, and postnatal care of mothers and infants. As shown in Exhibit 5, several measures are in the Children's Core Set because they are more closely tied with the health outcomes of the child, while one is common to both sets and three others are unique to the Adult Core Set. It is necessary to view the two programs together to see the full spectrum of measures that promote better birth outcomes.

Exhibit 5: Overlapping Maternal and Child Health Measures in the Medicaid Quality Programs



Other quality issues are important to all age groups and are also common to both measure sets. A measure of follow-up after hospitalization for mental illness is currently included in the Children's and Adult Core Sets. MAP has also recommended a measure of medication management for people with asthma be added to the Adult Core Set. This measure is currently in the Children's Core Set. The alignment achieved by including the same chlamydia, asthma, and follow-up after hospitalization measures in both programs, rather than similar but different measures, is vitally important in controlling reporting burden on states and directing quality improvement efforts efficiently.

Impact of Payment Models

Input from states brought to light two issues related to potential impact of payment models on measurement. First, bundled payment, the reimbursement of health care providers on the basis of expected costs for clinically-defined episodes of care rather than fee-for-service (FFS), can limit the availability of data. Specifically, bundled payments for maternity care can include postpartum visits and states expressed concern that results on the Postpartum Care Rate Measure would be underreported if based solely on claims. While a hybrid measure specification is available to address this issue, chart review is resource-intensive and not preferred by participating states. Second, it is standard practice to audit measures derived from managed care data but this is not routinely performed in FFS systems. This inconsistency might lead to poorer accuracy of measures based on FFS claims unless they are reviewed by an organization external to the state Medicaid agency. While no immediate solutions were found, these factors directly relate to the feasibility of implementing measures and merit continued

consideration. The variation in state payment models and implications for data collection could affect the comparability of measure results across states.

Incorporating Beneficiaries' Perspectives on Quality

MAP found the Adult Core Set to be strong on many fronts, including its parsimonious size, its alignment with other programs, and its responsiveness to chronic conditions that are common in the Medicaid population. However, members were not confident that the measures would reflect the issues that matter most to Medicaid enrollees. A first step to ensuring that the measure set is responsive would be to gather evidence on the quality measures that most resonate with the population of adults with Medicaid to guide future decision-making. Specifically, MAP would benefit from more detailed information on the services that are most important to Medicaid enrollees to help prioritize improvement efforts.

The measure set currently gauges beneficiary experience of care through a CAHPS survey, but the scope of CAHPS items was felt to be limited. Implementation of CAHPS is uneven across states, with sixteen states reporting this measure to CMS in FFY 2013. While CMS plans to perform a nationwide CAHPS survey of adult Medicaid enrollees that will mitigate data collection burden on states somewhat, the measure set could be further strengthened with regard to incorporating beneficiaries' perspectives on quality.[25] For example, MAP also urges the future inclusion of performance measures based on patient-reported outcomes, to the extent those measures are available for state-level programs.

Balancing Rigor and Voluntary Participation

States vary in their infrastructure, political climates, and other factors that influence their participation in quality reporting. With the voluntary nature of the reporting program in mind, state representatives expressed different opinions on how challenging the measures within the Adult Core Set should be. At one end of the spectrum, some stakeholders believe that the role of a core measure set is to provide a modest baseline set of measures that are highly feasible for all to report. At the opposite end, others believe that the measure set should demand more significant and sophisticated analysis to understand and change health outcomes. Fortunately, states are not required to submit all of the measures in the Adult Core Set to CMS; they can select those that most closely meet their needs and capabilities. While MAP felt the current set to be balanced in its level of rigor, it is not well-understood how the measures themselves might have affected the decision of some states not to participate in reporting. Further outreach to representatives of non-participating states could be conducted to inform subsequent reviews.

Ultimate Uses of Measurement Information

The intention of measuring quality and performance in the health system is to provide data that informs and motivates improvement. One of the most straightforward uses of a quality measure is for a single entity to track its own data over time, monitor the trend, and initiate actions that would improve the results. This type of internally-focused quality improvement effort is usually an appropriate starting place. Quality measures can also be used to compare an entity's performance to a benchmark level or to its peers to illuminate differences. Understanding one's own performance relative to others can be critical for understanding success. However, making comparisons across states must be done carefully to avoid reaching inaccurate conclusions. Populations of Medicaid enrollees vary tremendously by state

and it would not be fair to expect measured performance to be the same across the country. Causes of variation include, but are not limited to, urban/rural mix, financial and categorical eligibility policy, distribution of chronic diseases, age, gender, and other factors. The stakes would be further raised if the comparative performance information was made public or tied to a financial incentive.

While CMS is required to issue annual reports to the HHS Secretary about states' use of the Adult Core Set, they do not plan to publish any results or state-identifiable information in the next summary. Given that this was the first year of program implementation and some technical specifications were refined mid-year, there is not enough confidence in the accuracy of the data to make it available. As this improves over time, measure results could be publicly reported as they are for the slightly older Children's Core Set.[26] Further statistical support for risk adjustment or other methods would be needed to enable cross-state comparisons or national benchmarking. Some states have already expressed a strong desire to rate their own performance against others.

Conclusion

MAP's recommendations to HHS on the Medicaid Adult Core Set are intended to strengthen the program measure set and assist in meeting the three-part goal to increase state participation in reporting and quality improvement. In summary, MAP suggests the continued use of most measures in the set to provide stability and the opportunity to gain additional experience and data. In the case of three measures, continued use is conditional upon further exploration or NQF endorsement of the measures. MAP also recommends that one measure be removed from the set because it no longer conforms to current clinical guidelines. Finally, MAP noted three measures for phased addition to the program measure set over time, beginning with a measure of poor hemoglobin A1c control among people with diabetes.

States' perspectives on the use of measures during their first year of implementation contributed greatly to MAP's discussion and decisionmaking process. State representatives enthusiastically described the value of participating in the quality measurement program and how they have used information to inform direct quality improvement efforts. MAP encourages further state efforts to report additional measures and capitalize upon the infrastructure and partnerships being developed. MAP endeavored to maintain a measure set that is feasible for states' continued engagement and reflective of the diversity found in state Medicaid programs, including variability in enrolled populations, capacity for data analysis, and quality issues of interest.

In the long term, MAP recommends that CMS continue to support states' efforts to gather, report, and analyze data that informs quality improvement activities. Uses of quality data are expected to gradually mature from an internal focus on accuracy and year-over-year improvement to a more sophisticated approach involving benchmarking and public reporting. At the same time, CMS and MAP remain conscious of the voluntary nature of participation in submitting data on the Adult Core Set; rigor must be tempered with a realistic understanding of abilities and potential trade-offs. The program measure set will continue to evolve in response to changing federal, state, and stakeholder needs and should be considered a long-term strategic process.

Appendix A: MAP Background

Purpose

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, and other programs. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[27]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures that 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 progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable. Accordingly, MAP informs the selection of performance measures to achieve the goal of **improvement, transparency, and value for all**.

MAP's objectives are to:

1. **Improve outcomes in high-leverage areas for patients and their families**. MAP encourages the use of the best available measures that are high-impact, relevant, and actionable. MAP has adopted a person-centered approach to measure selection, promoting broader use of patient-reported outcomes, experience, and shared decisionmaking.
2. **Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy based on value**. MAP promotes the use of measures that are aligned across programs and between public and private sectors to provide a comprehensive picture of quality for all parts of the healthcare system.
3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden**. MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

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 and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology 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 enterprise that includes:

Setting priorities and goals. The work of the Measure Applications Partnership is predicated on the National Quality Strategy and its three aims of better care, affordable care, and healthy people/healthy communities. The NQS aims and six priorities provide a guiding framework for the work of the MAP, in addition to helping align it with other quality efforts.

Developing and testing measures. Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies).

Endorsing measures. 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.

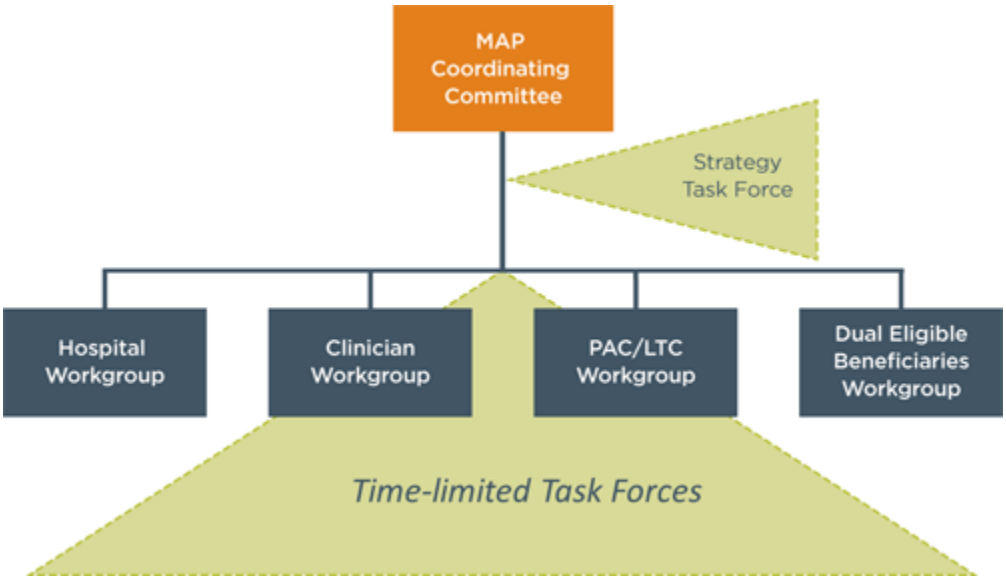
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.

Impact and Evaluation. Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate if measures are having their intended impact and are driving improvement, transparency, and value. Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements. MAP seeks to engage in bidirectional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

Structure

MAP operates through a two-tiered structure (see Figure A1). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with developing "families of measures"—related measures that cross settings and populations—and a multiyear strategic plan provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

Figure A1. MAP Structure



All MAP activities are conducted in an open and transparent manner. The appointment process includes 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.

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see MAP 2014 Pre-Rulemaking Report).

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall to inform MAP's pre-rulemaking input. To date MAP has issued a series of reports that:

- Developed the **MAP Strategic Plan** to establish MAP's goal and objectives. This process identified strategies and tactics that will enhance MAP's input.
- Identified **Families of Measures**—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities—to facilitate coordination of measurement efforts.
- Provided input on **program considerations and specific measures** for federal programs that are not included in MAP's annual pre-rulemaking review, including the Adult Core Set and the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces.

Developed **Coordination Strategies** intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives.

Appendix B: Rosters for the MAP Medicaid Task Force and MAP Coordinating Committee

Roster for the MAP Medicaid Task Force

CHAIR (VOTING)
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
Humana, Inc.	George Andrews, MD, MBA, CPE, FACP
L.A. Care Health Plan	Jennifer Sayles, MD, MPH
March of Dimes	Cynthia Pellegrini
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Consumer Voice for Quality Long-Term Care	Lisa Tripp, JD
National Rural Health Association	Brock Slabach, MPH, FACHE

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
Medicaid ACO	Ruth Perry, MD
Mental Health	Ann Marie Sullivan, MD
State Medicaid	Marc Leib, MD, JD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Centers for Medicare & Medicaid Services (CMS)	Marsha Smith, MD, PhD, FAAP

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

Roster for the MAP Coordinating Committee

CO-CHAIRS (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Gerry 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	Lisa McGiffert
Federation of American Hospitals	Chip Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Shari Davidson
National Partnership for Women and Families	Alison Shippy
Pacific Business Group on Health	William Kramer, MBA
Pharmaceutical Researchers and Manufacturers of America (PhRMA)	Christopher Dezii, RN, MBA,CPHQ

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
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 (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Health Resources and Services Administration (HRSA)	John E. Snyder, MD, MS, MPH (FACP)
Office of Personnel Management/FEHBP (OPM)	Edward Lennard, PharmD, MBA
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD, FACP

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

NQF Staff

Megan Duevel Anderson	Project Manager
Elizabeth Carey	Project Manager
Laura Ibragimova	Project Analyst
Sarah Lash	Senior Director
Allison Ludwig	Senior Project Manager
Yetunde Ogungbemi	Project Analyst

Appendix C: MAP Measure Selection Criteria

The Measure Selection Criteria (MSC) are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Although competing priorities often need to be weighed against one another, the MSC can be used as a reference when evaluating the strengths and weaknesses of a program measure set, and how the addition of measures would contribute to the set.

Criteria

1. NQF-endorsed® measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.

Sub-criterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need

Sub-criterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs

Sub-criterion 1.3 Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

2. Program measure set adequately addresses each of the National Quality Strategy's three aims

Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:

Sub-criterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

Sub-criterion 2.2 Healthy people/healthy communities, demonstrated by prevention and well-being

Sub-criterion 2.3 Affordable care

3. Program measure set is responsive to specific program goals and requirements

Demonstrated by a program measure set that is "fit for purpose" for the particular program.

Sub-criterion 3.1 Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)

Sub-criterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Sub-criterion 3.3 Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

Sub-criterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program

Sub-criterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

4. 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, composite, and structural measures necessary for the specific program

Sub-criterion 4.1 In general, preference should be given to measure types that address specific program needs

Sub-criterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

Sub-criterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

5. Program measure set enables measurement of person- and family-centered care and services

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

Sub-criterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

Sub-criterion 5.2 Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives

Sub-criterion 5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

6. Program measure set includes considerations for healthcare disparities and cultural competency

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, sexual orientation, age, 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).

Sub-criterion 6.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Sub-criterion 6.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

7. Program measure set promotes parsimony and alignment

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Sub-criterion 7.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

Sub-criterion 7.2 Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

Appendix D: Medicaid Adult Core Set and MAP Recommendations

In January 2012, HHS published a final notice in the *Federal Register* to announce the initial core set of health care quality measures for Medicaid-Eligible adults; a 2014 version followed. The table below lists the measures included in the Core Set along with their current NQF endorsement number and status. States voluntarily collect the Medicaid Adult Core Set measures using the 2014 Technical Specifications and Resource Manual. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's Quality Positioning System.

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0004 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Measure Steward: NCQA	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.	18 states reported FFY 2013 Alignment: Meaningful Use Stage 2 - Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review, as a result it is burdensome for states to report Measure requires data linkage, as a result it is burdensome for states to report
0006 Endorsed CAHPS Health Plan Survey - Adult questionnaire Measure Steward: NCQA	30-question core survey of adult health plan members that assesses the quality of care and services they receive.	16 states reported FFY 2013 (11 states reported using CAHPS 5.0H; 4 states reported using CAHPS 4.0H; 1 state used an agency-designed CAHPS-like survey) Alignment: Medicare Shared Savings Program, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Moderate levels of states reporting observed due to high costs to implementation Addresses NQS and CMS Quality Strategy priority area of Person- and Family-Centered Experience of Care

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0018 Endorsed Controlling High Blood Pressure Measure Steward: NCQA	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	15 states reported FFY 2013 Alignment: Meaningful Use Stage 2 - Eligible Professionals, Medicare Shared Savings Program, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review, as a result it is burdensome for states to report Addresses NQS and CMS Quality Strategy priority area Prevention and Treatment of Chronic Conditions
0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation Measure Steward: NCQA	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.	15 states reported FFY 2013 Alignment: PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0031 Submitted for Endorsement: In Public and Member Commenting Breast Cancer Screening Measure Steward: NCQA	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	26 states reported FFY 2013 Alignment: Meaningful Use Stage 2 - Eligible Professionals, Medicare Shared Savings Program, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Conditional support for continued use in the program pending NQF endorsement Measure has been submitted with updated specifications to meet clinical guidelines, has been recommended for endorsement by the Steering Committee
0032 Endorsed Cervical Cancer Screening Measure Steward: NCQA	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	28 states reported FFY 2013 Reason states did not report: measure was not identified as a key priority; other Alignment: Meaningful Use Stage 2 - Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program
0033 Endorsed Chlamydia screening in women [ages 21-24 only] Measure Steward: NCQA	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	25 stated reported FFY 2013 Alignment: Meaningful Use Stage 2- Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0039 Endorsed Flu shots for Adults Ages 18 and Over Measure Steward: NCQA	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.	12 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review, as a result it is burdensome for states to report
0057 Endorsed Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing Measure Steward: NCQA	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	29 states reported FFY 2013 Alignment: PQRS, HEDIS, Marketplace Quality Rating System	Support for continued use in the program MAP recommended the addition of # 0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) as a complement to address this high-impact condition in the Medicaid Adult population
0063 Endorsed Comprehensive Diabetes Care: LDL-C Screening Measure Steward: NCQA	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an LDL-C test during the measurement year.	29 states reported FFY 2013 Alignment: PQRS, HEDIS	Conditional support for continued use in the program Measure should be removed from the program if retired by NCQA and replaced by a measure that is consistent with clinical guidelines

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0105 Endorsed Antidepressant Medication Management (AMM) Measure Steward: NCQA	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	24 states reported FFY 2013 Alignment: Meaningful Use Stage 2 - Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program
0272 Endorsed Diabetes Short-Term Complications Admissions Rate (PQI 1) Measure Steward: AHRQ	The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	23 states reported FFY 2013 Alignment: N/A	Support for continued use in the program Disparities-sensitive measure for which there is a gap in care Addresses an important clinical condition for the Medicaid Adult population
0275 Endorsed Chronic obstructive pulmonary disease (PQI 5) Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	23 states reported FFY 2013 Alignment: Medicare Shared Savings Program	Support for continued use in the program
0277 Endorsed Heart Failure Admission Rate (PQI 8) Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	23 states reported FFY 2013 Alignment: Medicare Shared Savings Program	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0283 Endorsed Asthma in Younger Adults Admission Rate (PQI 15) Measure Steward: AHRQ	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.	23 states reported FFY 2013 Alignment: N/A	Support for continued use in the program MAP recommended the addition of #1799 Medication Management for People with Asthma as a complement to address this high-impact condition in the Medicaid Adult population
0418 Endorsed Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan Measure Steward: CMS	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.	5 states reported FFY 2013 [4 states reported Adult Core Set specifications; 1 state reported PCMH measure (includes screening for 24 mo. but not follow-up plan)] Alignment: MU Stage 2 - Eligible Professionals, Medicare Shared Savings Program, PQRS	Support for continued use in the program Addresses an important measurement gap in mental and behavioral health treatment and outcomes Measure requires medical record review, as a result it is burdensome for states to report
0469 Endorsed PC-01 Elective Delivery Measure Steward: The Joint Commission	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)	13 states reported FFY 2013 Alignment: Hospital Inpatient Quality Reporting, Meaningful Use Stage 2-Hospitals, CAHs	Support for continued use in the program MAP recommends the steward consider including the impact of psychosocial determinants (e.g., substance abuse, mental illness) in the measure Measure requires medical record review, as a result it is burdensome for states to report Measure requires data linkage, as a result it is burdensome for states to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0476 Endorsed PC-03 Antenatal Steroids Measure Steward: The Joint Commission	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	5 states reported FFY 2013 Alignment: N/A	Support for continued use in the program Measure requires medical record review, as a result it is burdensome for states to report Measure requires data linkage, as a result it is burdensome for states to report
0576 Endorsed Follow-Up After Hospitalization for Mental Illness Measure Steward: NCQA	This measure assesses the 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. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	27 states reported FFY 2013 Alignment: PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program MAP encouraged use of a longer follow-up period (e.g., 3-6 months) Addresses NQS and CMS Quality Strategy priority area of Healthy Living and Well-Being Measure requires data linkage, as a result it is burdensome for states to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0648 Endorsed Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation 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	4 states reported FFY 2013 Alignment: N/A	Support for continued use in the program Addresses NQS and CMS Quality Strategy priority area of Effective Communication and Care Coordination Measure requires medical record review and/or data linkage, as a result it is burdensome for states to report MAP recommends measures be implemented as endorsed and adding the paired measure: 0647 Transition Record with Specified Elements Received by Discharged Patients
1517 Endorsed Prenatal & Postpartum Care [postpartum care rate only] Measure Steward: NCQA	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	28 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review, as a result it is burdensome for states to report Measure requires data linkage, as a result it is burdensome for states to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
1768 Endorsed Plan All-Cause Readmissions Measure Steward: NCQA	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.	18 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Conditional support for continued use in the program MAP recommends the development and application of a risk-adjustment model for the Medicaid population
1879 Endorsed Adherence to Antipsychotic Medications for Individuals with Schizophrenia Measure Steward: CMS	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).	18 states reported FFY 2013 Alignment: HEDIS	Support for continued use in the program Addresses the needs of vulnerable population at greater risk of readmissions and non-adherence to medications Measure requires medical record review, as a result it is burdensome for states to report MAP recommends the steward consider refining this measure to simplify the data collection methodology

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
2082 Endorsed HIV Viral Load Suppression Measure Steward: HRSA	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.	Alignment: N/A	Support for continued use in the program. Measure addresses a high risk population and high priority gap area. MAP recommends careful consideration of the potential modifications required on the measure. As currently specified, the identification of the measure denominator and code sets pose feasibility challenges. An alternative HIV/AIDS measure may need to be considered in the future.
2371 Submitted for Endorsement: In Public and Member Commenting Annual Monitoring for Patients on Persistent Medications Measure Steward: NCQA	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the four rates separately and as a total rate : Rates for each: Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), Digoxin, diuretics, or anticonvulsants Total rate (the sum of the four numerators divided by the sum of the four denominators)	22 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Conditional support for continued use in the program pending NQF endorsement Measure requires data linkage which does not currently exist and has some coding challenges, as a result it is burdensome for states to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
Not Endorsed Adult Body Mass Index Assessment Measure Steward: NCQA	The percentage of Medicaid Enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	16 states reported FFY 2013 Alignment: Health Insurance Marketplace Quality Rating System	Support for continued use in the program MAP encourages the steward to submit this measure for NQF endorsement MAP recommends measure be maintained for stability of the set because of moderate levels of state implementation Measure requires medical record review, as a result it is burdensome for states to report MAP recommends improving the feasibility of data collection

Appendix E: Measures Associated with the Top 10 Conditions for Readmissions among Adults in Medicaid

A recent analysis by the Healthcare Cost and Utilization Project (HCUP) found that non-elderly Adult Medicaid beneficiaries experienced a total all-cause, 30 day readmissions rate of 14.6 per 100 admissions, adding up to approximately 700,000 readmissions in 2011. These readmissions cost approximately $7.6 billion and "the 10 conditions with the most all-cause, 30-day readmissions accounted for 34.1% of all Medicaid readmissions." These 10 conditions and how they relate to current or potential measures are outlined below.

Top 10 Conditions for Readmission[28]	Current Measures in the Medicaid Adult Core Set	Potential Additions
Septicemia (except in labor)	None	N/A
Congestive Heart Failure (nonhypertensive)	#0277 Heart Failure Admission Rate (PQI 8)	#0358 Congestive Heart Failure (CHF) Mortality Rate (IQI 16)
Diabetes Mellitus with complications	#0272 Diabetes Short-Term Complications Admission Rate (PQI 1) #0063 Comprehensive Diabetes Care: LDL-C Screening #0057 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	#0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) #0575 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Chronic Obstructive Pulmonary Disorder and Bronchiectasis	#0275 Chronic obstructive pulmonary disease (PQI 5)	#2020 Adult Current Smoking Prevalence
Other complications related to pregnancy	#1517 Prenatal & Postpartum Care	
Early or threatened labor	#0469 PC-01 Elective Delivery #0476 PC-03 Antenatal Steroids	
Schizophrenia and other psychotic disorders	Adherence to Antipsychotics for individuals with schizophrenia #0576 Follow-Up After Hospitalization for Mental Illness	#1927 Cardiovascular Screening For People With Schizophrenia Or Bipolar Disorders Who Are Prescribed Antipsychotic Medications #1932 Diabetes Screening For People With Schizophrenia Or Mood Disorders Who Are Using Antipsychotic Medications

Top 10 Conditions for Readmission[28]	Current Measures in the Medicaid Adult Core Set	Potential Additions
Mood disorders	#0576 Follow-Up After Hospitalization for Mental Illness #0105 Antidepressant medication management #0576 Follow-Up After Hospitalization for Mental Illness	#1880 Adherence to Mood Stabilizers for Individuals with Bipolar Disorder #0580 Bipolar animatic agent
Alcohol related disorders	#0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment #0576 Follow-Up After Hospitalization for Mental Illness	
Substance related disorders	#0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment #0576 Follow-Up After Hospitalization for Mental Illness	

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Comments Received on Draft 2014 MAP Report on Dual Eligible Beneficiaries

Commenter Name	Commenter Organization	Question	Comment
Joe Caldwell	National Council on Aging	1) General Comments	(1/2) Thank you for the opportunity to provide public comment on the National Quality Forum (NQF) Measure Applications Partnership (MAP): 2014 Report from Dual Eligible Workgroup. The National Council on Aging (NCOA) supports the work NQF has done in identifying high-priority measure gaps, including identified gaps in person-centered planning, self-determination, and community participation. We appreciate the work of NQF in highlighting work being done to attempt to fill these gaps. In particular, we acknowledge efforts to develop quality of life and consumer experience measures (e.g. National Core Indicators, Council on Quality and Leadership Personal Outcomes Measures, and Home and Community-Based Experience Survey). However, we remain deeply concerned that about the lack of any endorsed HCBS measures as states rapidly move forward with implementation of duals integration demonstrations and expansion of MLTSS programs. The path forward to endorsement of HCBS measures is unclear. We believe NQF should play a stronger leadership role in making specific recommendations to CMS about investments needed in HCBS quality measure development to expedite endorsement and guidance to states in this area.
Joe Caldwell	National Council on Aging	1) General Comments	(2/2) In addition, we believe there are many important domains missing from the list of priority measure gaps that reflect the paradigm of quality within HCBS. Rebalancing, self-direction, employment, family caregiver supports, and adequacy of the direct care workforce are some areas we believe deserve more attention. NCOA leads a coalition of 37 national aging and disability organizations (known as the Friday Morning Collaborative). The coalition focuses on HCBS issues and meets regularly. There is a lot of collective knowledge and expertise within the collaborative across the spectrum of individuals who are dual eligible and need long-term services and supports. We encourage you to consider us a resource and would be happy to offer additional assistance in the areas of HCBS quality measures.
Carmella Bocchino	America's Health Insurance Plans	1) General Comments	We applaud the MAP's efforts to focus its work on performance measure development in topic areas relevant to dual eligible beneficiaries and that support quality of life outcomes. We support the high-priority measure gaps, however, we recommend adding language to recognize that as measure gaps are addressed CMS should consider including such measures in federal quality programs and retiring existing measures to minimize measurement burden. MAP should continue to recommend a parsimonious measure set that builds on existing measures (e.g. NCQA, CMS Star Ratings, etc.). Utilizing measures that have been widely accepted and that are feasible, reliable, and valid, will minimize burden of data collection and administrative costs. We also recommend that the MAP focus measurement efforts on direct outcomes measures, instead of survey measures. Survey responses are often not specific enough for health plans to translate into actionable or targeted improvements. The MAP should also consider the number and frequency of surveys currently administered to health plan members and patients when determining what types of measures are most appropriate for the Dual Eligible population. Oftentimes members and patients are unable to remember pertinent information when responding to surveys. Recall bias is particularly problematic for the elderly and those with behavioral health problems.
Carmella Bocchino	America's Health Insurance Plans	1) General Comments	We support MAP's efforts to improve measure alignment across the Medicare and Medicaid programs, as well as across private-sector programs. Such alignment is important for ensuring that measurement is both meaningful and manageable and for reducing the overall measurement burden. Measures also should be tested and selected based on their ability to better identify, understand, and close the disparities that exist between and within target populations. In addition, while we encourage efforts to expand measurement of vulnerable populations, the operational bandwidth required to accommodate any new efforts must be kept in mind. One specific area of opportunity is to condense a given family of measures to those most connected to meaningful outcomes and eliminating measures that represent minor variations on the same measure concept. It is also important that stakeholders have access to the complete technical specification for each measure to ensure uniform measure implementation and the comparability of performance data.
Deborah Fritz	GlaxoSmithKline	1) General Comments	We commend MAPs efforts to improve the use of performance measures to assess and improve the quality of care delivered to this complex and vulnerable population of Dual Eligible patients. We support the approach taken to include the development of measures across the spectrum of care encompassing a holistic approach for the patient needs and outcomes. The gaps identified on page 6 of the report go well beyond the traditional clinical goals of care and represent important areas to address related to the quality of care provided to individuals. The efforts and consideration towards the harmonization of measures is also appreciated as the burden to provider organizations to meet disparate reporting requirements represents a tremendous strain on resources. We support your continued work to simplify measures recommendations across measures set where possible. Last, we applaud the diligence NQF and MAP display in maintaining a transparent and multi-stakeholder process to drive improvement in patient care.

Comments Received on Draft 2014 MAP Report on Dual Eligible Beneficiaries

Elizabeth Demakos	Uniform Data System for Medical Rehabilitation	1) General Comments	(1/3) UDSMR welcomes the opportunity to comment on the National Quality Forum's Measure Applications Partnership: 2014 Report from the Dual Eligible Beneficiaries Workgroup Draft Report from Comment, June 13, 2014. We appreciate the work that the NQF is doing to improve the health outcomes of the dual eligible population. UDSMRwas pleased to present the FIM®instrument to the Dual Eligible Workgroup and continues to maintain that the FIM®instrument and its derivatives are the best tools to measure function for this population across all venues of post-acute care. The Measures Application Partnership (MAP) has identified alignment as an important characteristic in measure selection criteria. MAP has also acknowledged that developing and testing measures is complex and time-consuming (and therefore can be costly). As you may be aware, Research Triangle Institute's (RTI's) November 2012 report,Analysis of Crosscutting Medicare Functional Status Quality Metrics Using the Continuity and Assessment Record and Evaluation (CARE) Item Set, referred to the well-respected FIM®instrument more than thirty times. One could surmise from this report that function was the only predictive measure across all settings of care.
Elizabeth Demakos	Uniform Data System for Medical Rehabilitation	1) General Comments	(2/3) Function would not be the only measure necessary to measure quality in each venue, but it is a sound anchor that cuts across all settings of care and can be easily compared and risk-adjusted to align quality measurement. The FIM® instrument has been used for over twenty-five years in the rehabilitation industry, has been tested for reliability and validity in all venues of care, imposes a low data collection burden, and has been used in the Medicare program for inpatient rehabilitation as a payment system for over ten years. Using an instrument with a proven, successful implementation reduces the cost and time of recreating or developing new measures. FIM® instrument benefits: 1. It predicts outcomes.Determines a patient's expected functional improvement, identify risk factors for readmission, and predicts many outcomes. 2. It is easy to monitor and audit.The rating criteria are easily identified in the patient's chart. 3. It classifies patients with similar resource needs. The tool assigns patients to case-mix groups; it can be used to establish payment categories for like patients. 4. It enhances facilities' quality improvement initiatives. FIM®gain, length-of-stay efficiency, and community discharge rates can be used to measure quality improvement initiatives.
Elizabeth Demakos	Uniform Data System for Medical Rehabilitation	1) General Comments	(3/3) 5. It helps clinicians and administrators manage their cases.Regional and national benchmarks available for managing care. 6. It can be used as the basis of a P4P system. Efficiency and quality metrics make an excellent starting point for a pay-for-performance initiative. 7. Reduces the data collection burden. Easierto use than other current and proposed instruments.Reducing data collection time increases time spent providing care improving efficiency and outcomes. UDSMRhas offered CMS a royalty-free license for the use of the FIM® instrument for inpatient rehabilitation and is willing to do the same for other venues of care as well. UDSMRhas submitted two functional change measures—Change in Mobility Score and Change in Self Care—to the NQF Person- and Family-Centered Care for endorsement. These measures are subsets of the FIM® instrument. We look forward to further discussions with NQF including the results of our research into the use of the FIM® instrument and its derivatives in acute and post-acute care, as well as assisting NQF improve the quality of health care
Lauren Agoratus	Family Voices NJ	1) General Comments	We understand that "MAP briefly considered…NQF #2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18)… found to be too narrow and would not address any gap areas" which is disappointing due to its importance as a high risk measure due to mortality rates. We urge NQF to reconsider this decision.
Joyce Chan	Healthfirst	1) General Comments	There is significant variation among dual eligible members. We recommend that measures be tested across those elements with great variability (i.e., primary language, residence in Health Professional Shortage Areas, residence in urban vs. rural communities, etc.). In addition, we encourage MAP to ensure that all measures are able to be evaluated without undue burden to stakeholders We support MAP's recommendation to align reporting requirements and measures across programs and stakeholder groups. This alignment will better focus stakeholder efforts on improvement and reduce resource burden. It will also support collaborative efforts among stakeholders (e.g., payors and providers) as they work on improving the same measures.

Comments Received on Draft 2014 MAP Report on Dual Eligible Beneficiaries

Anne Cohen	Disability Health Access, LLC	1) General Comments	I appreciate NQF's efforts to organize the complex set of potential measures into a "family of Measures set," this has made a difficult task more meaningful. I encourage NQF to continue to look at additional ways to make the reports more meaningful and usable to non-academic and industry representatives. I suggest reorganizing the appendix chart to create a color coded system indicating the measures that are in the 7 topic family measures and indicating the additional family measurement areas(population health, affordable care, and person- and family-centered care) currently being finalized. I also suggest further explanation of the concept of process measures, outcome measure, composite measures, engagement/experience measures, and efficiency measure. In particular as we continue to put emphasis on person-centered measures it would be useful to also indicate if an individual measure or a family of measures fulfills that concept.
E. Clarke Ross	Consortium for Citizens with Disabilities	1) General Comments	Presentation of measures is complex and daunting. We suggest that measures be ordered into major categories (e.g., community living, prevention of chronic illness, beneficiary choice and self-direction, etc). Color coding of measures by major category might help in the understanding and presentation. Suggest this report include language from the NQF MAP May 30, 2014 draft report - "one single term cannot apply to all individuals in all situations; in actuality, an individual with many needs may self-identify as a person, client, or patient at a single point in time....Use the word 'person' as an over-arching term to encompass the health and healthcare needs of all individuals, regardless of age, setting, or health status."
Valerie Wilbur	SNP Alliance	1) General Comments	It is important to be clear that the Family of Measures is a set of options – not a suggested mandate to use ALL 57 measures? I have had several SNP Alliance members indicate concern about the scope – number of measures, duplication across measures like several related to meds, etc. While we have told our members that it's intended to provide options, it has not sunken in and if our members have this concern, I'm thinking others may misunderstand too, so it was helpful to see that you reiterated it in this report.
Valerie Wilbur	SNP Alliance	1) General Comments	(1/2) The SNP Alliance appreciates the thoughtful work of the Dual Eligible Work Group. We urge NQF to continue to clarify that (1) the Family of Measures is intended to serve as a set of options -- not an all-inclusive measure set mandated for all plans/providers; and (2) when several measures are included for a particular category, such as medication management or care transitions, the idea is to offer options, not for plans/providers to report all measures. This is especially important for many of the CAHPS measures which have multiple questions and which could lead to significant duplication of reporting if, for example, CAHPS, HCAHPS, and CAHPS 4.0 were all required. Data fatigue is as important a consideration for enrollees as for plans and could reduce beneficiary submission rates. We strongly support the proposed focus for the path forward on alignment, impact of measures and fit-for-purpose embodied in the two key questions raised in the Report. Current Medicare measures are biased toward average Medicare beneficiaries, not high-risk/high-need populations. There are few MA Stars measures of unique importance to duals, no system-level measures that evaluate aggregate performance across time and care settings, and few outcome measures. There are also no measures to evaluate the degree to which Medicare and Medicaid benefits and services are being integrated. The need for risk adjustment of measures for high-risk beneficiaries also is needed to better align measures and expected outcomes with population specific needs and limitations. Below are SNP Alliance priorities for the 4 areas addressed in the path forward:
Valerie Wilbur	SNP Alliance	1) General Comments	(2/2) • High Leverage Opportunities: We would prioritize "visioning a future state for quality measurement." For healthcare to move from a provider-based, component-driven approach to a person-centered, system-oriented approach, with priority on advancing care for frail, disabled, chronically-ill persons, it is as important for the state of quality measurement to change as for health care delivery structures to change. • Additional Measure Topics: Prioritize development of structural measures to evaluate the degree of integration of Medicare/Medicaid benefits and services, distinguishing between care integration and program integration. • Other factors: Priority should be given to advancing risk adjustment of measures within the Dual Eligible Beneficiary Family of Measures. We strongly support performance measurement and accountability. We also know that performance is affected by the complexity of medical conditions and by social determinants of health, as recognized by the NQF SES Panel. Risk adjustment or stratification of measures is critical to performance measurement and the future of specialized care for the most needy, high-risk, and costly service groups. Primary care/behavioral health integration models also critical for duals, given the prevalence of behavioral health diagnoses among duals.
Valerie Wilbur	SNP Alliance	2) Updates to Family of Measures and GAPS	• We support identification of a new HIV-AIDS screening measure and inclusion of NQF #2079 as compliance with medical visits strongly influences morbidity and mortality. We strongly recommend adding NQF #2082 and NQF #2083. Viral load suppression and antiretroviral therapy can help prevent HIV from advancing to AIDS, assess the risk of disease progression and help guide initiation of therapy. These two measures were included in a set core indicators recommended by HHS and are consistent with the Institute of Medicine's recommendations for monitoring HIV services and those developed by the NQF and the NCQA. Another indicator on the HHS list that we strongly support is Retention in HIV Medical Care. • We strongly support MAP's objective to align measures across programs. More emphasis is needed on aligning metric selection, definitions, and oversight requirements for Medicare and Medicaid in measuring performance of the same service or function for plans and providers. • We agree that current measures fail to capture the complex array of conditions at play in chronically ill persons' lives over time or to respond to the systemic nature of chronic illness care as a condition evolves over time and across settings. Current measures focus on specific interventions, health professionals and points in time. We also support greater focus social issues that affect health outcomes in vulnerable populations and recommend that the Dual Work Group build on the work of the SES Risk Adjustment Panel by (1) reviewing the Dual Family of Measures to determine which should be adjusted or stratified for SES impacts; (2) identifying a "core group" of measures from the Dual Family that are particularly relevant in accounting for SES factors; and (3) identifying SES measurement gaps. • We urge the Dual Work Group to evaluate the validity and reliability of self-reported data from persons with behavioral, mental health or cognitive impairment diagnoses.

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Valerie Wilbur	SNP Alliance	2) Updates to Family of Measures and GAPS	• We support the development of Care Planning and Assessment measures, but recommend that they cover the full continuum of primary, acute, and long-term care services. Separate assessments and care planning for primary, acute and long-term care services fails to recognize the interdependence among the many unique service providers caring for individuals with complex medical problems covered by separate benefit programs. An integrated approach to assessment and care planning is needed to maximize financial and clinical outcomes and minimize the potential for adverse outcomes during care transitions. An integrated process also is consistent with the goal of patient centeredness since it reduces the burden of multiple assessments for the beneficiary and multiple meetings for family caregivers. • We agree that for persons with complex care needs, a face-to-face, in-home assessment is ideal, but not necessary for all beneficiaries and is inconsistent with telehealth trends. For those without complex health problems whose conditions are stable, a telephonic or mailed assessment may be appropriate and could increase the number of assessments performed as well as family/guardian participation in care planning. We suggest consideration of risk-stratifying in-home, telephonic and mail assessments by patient needs and preferences. • We suggest the following modifications to the proposed measures: (1) for all measures refer to "beneficiaries," not MLTSS beneficiaries; (2) add medication review to the core group of domains in the Assessment Composite measure; (3) change "shared" care plan to "common" care plan that is jointly developed among relevant providers and add a "care coordination" function that assesses provider collaboration around a common care plan; and (4) transmit the common care plan to relevant providers and health professionals. We urge NCQA to put the measures out for public comment before finalizing.
Joe Caldwell	National Council on Aging	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	On page 8, of the report, we recommend striking the following sentence, "It might be preferable to directly question the people involved in the care-planning process to gauge their experience, but this would be burdensome and subjective." The perspectives of consumers and family members are essential and the most valid way to assess true person-centeredness.
Carmella Bocchino	America's Health Insurance Plans	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	(1/2) NCQA is developing measures for Managed Long Term Services and Supports, and we recommend considering adding these to the Family of Measures once fully specified and tested. We also offer the following measure specific comments: 0022: This measure may result in the under-treatment of pain and depression in the elderly and thus should be monitored. Also, we recommend assessing whether high-risk medications are being appropriately prescribed. 0027: Health plan use of this measure is dependent upon state-specific Medicaid benefits. Smoking and tobacco use cessation is not a benefit in some states thus this measure is only useful for in-state comparisons. 0028, 0111, & 0710: It is unclear how data for these measures will be collected and from what sources. CMS must provide additional specifications to ensure standardized data collection. 0228: Given the numerous surveys (CTM-3 and HCAHPS) used to measure patient satisfaction with care transitions, we are concerned with the additional burden on members self-reporting care experience and its potential impact on the other surveys being used. 0554: Data for this measure can be difficult for plans to collect if pharmacy benefits information is unavailable due to carve-outs thus requiring burdensome sampling and chart review.
Carmella Bocchino	America's Health Insurance Plans	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	(2/2) 0573: Screening members for HIV is important, but barriers exist in transferring STD and HIV screening data among providers, health plans, and ASOs. The primary barrier is privacy restrictions requiring health plans to obtain consent before providing this information to others making it difficult to report complete data. We recommend excluding this measure or reporting by clinicians in the aggregate. 0709: For conditions such as CHF and COPD, health plans would be assessed based on an individual's health status progression, even though deterioration in health status is expected. This measure does not consider psychosocial determinants of health that impact the Dual Eligible population and is more appropriate for commercial and Medicare populations. 1626: Data for this measure cannot be obtained using the administrative claims reporting method and health plans will have to conduct burdensome chart reviews; often this material is not included in the chart but may be retained by the family. It would also be helpful to understand the Committee's reasoning for including this measure, as we question its value to the measure family. 1927: This measure requires annual screening and resource use that is not predicated upon evidence based medicine. Annual screening has not demonstrated better outcomes. 2111: It is challenging to influence and educate providers on the overuse of anti-psychotics among persons with dementia. We recommend excluding this measure. 2091 & 2092: It would be helpful to understand the Committee's reasoning for including these measures, as we question their value to the measure family.

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Shawn Terrell	Administration for Commuity Living	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	(1/3) One area that we see missing throughout this section is a discussion of the skill set necessary to perform the consumer engagement functions of person centered planning. It is generally agreed across many person centered planning approaches that without a trusting relationship between the consumer and the person centered planning facilitator, there is little reliability in the goals that find their way into the plan of care. This lack of reliability may significantly confound outcomes related to goal attainment. Without attention paid to the process of person centered planning and goal development to ensure that the goals are indeed created by the consumer in a non-coercive context, there is little one can say about the person centeredness of the outcome.
Shawn Terrell	Administration for Commuity Living	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	(2/3) A full environmental scan is needed to locate and assess methods for assuring person centered planning processes are followed to fidelity. Also, as in other professions, part of quality measurement is the confidence that the service is provided by appropriately trained and credentialed personnel. There are a number of training programs for various person-centered planning methods. These should also be identified and assessed through. Second, while a consumer experience survey might be burdensome, it is no more or less burdensome than other surveys that have been endorsed by NQF. A survey is subjective but that is the nature of any experience survey. Regarding outcomes, while person centered goal development is subjective by nature there seems to be no inherent barrier to developing a set of coding structures into which individual goals can be coded for purposes of measurement. The statement on page 8, second paragraph after the bulleted list states “Genuine person centeredness is not compatible with measures’ building blocks of standardized data.” It goes on to state in the last sentence in the paragraph “It might be preferable to directly question the people involved in the care-planning process to gauge their experience, but this would be burdensome and subjective.” While we are not entirely sure of the exact intended meaning of the sentences, we wonder if they essentially convey the conclusion that person-centered planning cannot be measured in any effective manner.
Shawn Terrell	Administration for Commuity Living	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	(3/3) If so, we believe that this conclusion is not warranted. It seems clear to us that there are two aspects to the person centered planning process that need to be looked at for measurement. First, the person-centered planning processes need to be evaluated for adherence to a set of standards for best practice. Here is an example a survey that measure person centered process (e.g. see http://www.eoutcome.org/Uploads/COAUploads/PdfUpload/PLQ-COA-OnePageQualityModules-V37.pdf). While he NCQA work is pointing in the right direction there needs to be a much more comprehensive approach to assessing person centered planning. We suggest starting with the person centered planning standards contained in the recent CMS Home and Community Based Services Rule section 441.725. https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider. These rules, while technically only applicable to specific CMS programs are in another sense the most highly vetted public national statement on what person centered planning is, and are the product of several rounds of public process and a two-year HHS wide internal developmental workgroup. These person centered planning standards provide the necessary framework for developing comprehensive and effective set of meaningful process and outcome measures.
Mary Kennedy	Association for Community Affiliated Plans	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	(1/2) The Association for Community Affiliated Plans (ACAP) is an association of 58 nonprofit and community-based Safety Net Health Plans (SNHPs) located in 24 states. Our member plans provide coverage to over 12 million individuals enrolled in Medicaid, the Children’s Health Insurance Program (CHIP) and Medicare Special Needs Plans and Medicare-Medicaid Plans for dually-eligible individuals. Overviewl. We appreciated the update to the Family of Measures and, as in previous comments, urge parsimony as new measures are considered. We support your exclusion of measures deemed to be too narrow as narrow measures can lead to an unwarranted and counter-productive proliferation of measures. NQF #2158-Payment Standardized Medicare Spending per Beneficiary We believe there should be risk adjustment and/or stratification where necessary for duals eligibles, SES markers, and health status. We were surprised at your recommendation to include the measure before these factors are developed. Promote Cross-Program Alignment across State and Private-Sector Programs In addition to alignment across Medicare and Medicaid, we urge that you also look at reporting requirements for the Exchange’s Qualified Health Plans.

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			(2/2) Measurement Gap We appreciate that you are looking at measurement gaps and look forward to NQF's upcoming work on care coordination and Alzheimer's disease and other dementias. We urge that NQF focus on evidence-based outcome measures over process measures. We especially support the inclusion of the optimal functioning measure as this is one of the most important factors in assessing the care received by the dual eligible population. MLTSS Measures There must be an accommodation in measures for people who actively refuse care assessment. We also ask that those people for whom the state does not have a current contact address or phone number, be excluded from the 90 day contact measure. We note that many care management systems are not standardized and it would be difficult to pull data from those systems. We urge NQF to support measures which use standardized, administrative data. We welcomed the discussion of new survey instruments. These measurements should be stratified and not have the biases inherent in current CAHPS tools.
Mary Kennedy	Association for Community Affiliated Plans	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	Research Priorities for PCORI We suggest that PCORI considers a measure that would assess the readiness of institutionalized individuals to return to their community. The current assessments focus on entry to care especially if institutional care is used. The Duals demonstrations have a goal to re-balance care towards use of community based MLTSS. Dual eligible individuals are a key group for research on socioeconomic status in healthcare
Deborah Fritz	GlaxoSmithKline	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	(1/2) We commend the hard work and effort put forth by the multi-stakeholder committee dedicated to improving the care of the Dual Eligible patients. The set of proposed measures is robust in many ways including addressing preventative measures of smoking cessation, cancer screenings, fall prevention, mental health and medication use evaluations. The inclusion of these measures is to be commended. The inclusion of several immunization measures is applauded including 0043 Pneumonia vaccination status for older adults, 0682 Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine, and 1659 Influenza Immunization. Additionally, we offer for consideration the following Immunization measures: 0041 Influenza Immunization – This measure provides an immunization measure for all patients seen for a visit during the flu season, not just those admitted to an in-patient facility
Deborah Fritz	GlaxoSmithKline	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	(2/2) 0399 and 0400 Paired Measure Hepatitis C: Hepatitis B Vaccination with high risk chronic conditions An observed gap within the Dual Eligible Family of Measures is around high-prevalent chronic diseases to this population. While a few measures do address chronic disease states including 0018 Controlling High Blood Pressure and 0729 Optimal Diabetes Care, measures for many of the most prevalent chronic disease states are absent. While not an exhaustive list of highly prevalent chronic diseases in this patient population, we offer the following measures for consideration for inclusion representing prevalent respiratory chronic disease states: COPD 0091 COPD: Spirometry Evaluation 0102 COPD: Inhaled Bronchodilatory therapy 1825 COPD: Management of Poorly Controlled COPD Asthma 1800 Asthma Medication Ratio 1799 Medication Management for People with Asthma 0047 Pharmacologic Therapy for Persistent Asthma 0548 Respiratory – Suboptimal Control of Asthma
Lauren Agoratus	Family Voices NJ	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	We understand that NQF is collaborating with CMS and Mathematica to develop 6 measures for MLTSS (Managed Long Term Services and Supports) including: • Assessment Composite which requires in-home assessment with the following components within 90 days of enrollment which we support. • Care Plan Composite which requires documentation of a care plan developed face-to-face within 30 days of completed assessment which we also support. • Shared Care Plan in which the care plan was transmitted to key long-term services and supports providers and the primary care provider within 30 days of development. We would hope this would even be done within 7 days for continuity of care. Other key measures we support include Assessment Update, Care Plan Update, and Reassessment and Care Plan Update After Discharge and we look forward to details on these.

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E. Clarke Ross	Consortium for Citizens with Disabilities	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	(1/2) Recommend deleting from this report - UDSMR FIM. They made a brief telephone presentation to the workgroup. They provided no measures. They provided no data. They provided no outcomes. They also expressed an attitude - why is NQF doing this work when the UDSMR FIM exists and no changes are needed. Inclusion of USSMR FIM at this point in time is premature. UDSMR FIM could be cited in the list of future topics fo the workgroup to consider. Recommend adding to the report - Council on Quality and Leadership (CQL) Personal Outcome Measures (POM). They made an in-person meeting presentation. They provided their measures. The provided their data. They provided outcomes. CQL POM has been included in previous NQF reports and should be recognized again. Add to the future topics for workgroup consideration - CMS-AHRQ pilot Medicaid home and community-based services personal experience approach. Delighted to see the stated need for the authentic beneficiary experience into the quality measurement process. The observation that directly asking people involved is "burdensome and subjective" was made by some workgroup members but was not a decision or consensus of the workgroup. Current use of National Core Indicators, Council on Quality and Leadership Personal Outcome Measures, and CMS HCBS personal experience approach affirm that such approaches are not automatically "burdensome and subjective." ADA, particularly the Supreme Court Olmstead decision, requires a person centered planning that begins withg the authentic beneficairy experience.
E. Clarke Ross	Consortium for Citizens with Disabilities	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	(2/2) We affirm the high priority measure gaps and affirm the report's observation that resources be devoted to research acitivities for these activities, especially non-clinical processes and person-centered outcomes. We affirm the observation that the field do more to address the social issues that affect health outcomes of vulnerable populations. We agree with the observtion that discussions revealed tensions and differences of opinion as to whether the NCQA measures are sufficiently consumer-oriented. We believe that the current NCQA work is "not" sufficiently consumer-oriented.
Valerie Wilbur	SNP Alliance	3) Quality of Life Outcomes	• The SNP Alliance strongly supports movement toward improving quality of life measurement. While we see a strong relationship between quality of life and the four areas identified as the focus for performance measurement, we're not ready to say these are THE vehicles for addressing this issue. We share a strong sense of caution that researchers and public administrators should not get ahead of their clear thinking by implementing new measures in this area too quickly. • We agree that the beneficiary should be the primary team member and final arbiter of the care plan and goals. We support advancing motivational interviewing skills as discussed at the Dual Work Group meeting to help clarify which goals are most important to consumers as part of the shared decision making process. We also believe that a single health professional should be accountable for health care oversight on the delivery side. The professional may change as a person's condition evolves. • We fully agree that providers need to be trained and compensated for providing navigation services as part of the shared decision making process. MAP should consider recommending that the provisions in the recent federal SRG legislation (S. 2110) that would have established CPT codes for care coordination be sufficiently broad to encompass these activities.
Carmella Bocchino	America's Health Insurance Plans	3) Strategies to Support Improved Quality of Life Outcomes	We are supportive of the four domains for measurement of quality of life; however, measurement in this area must demonstrate a cost benefit so that it does not add to the total cost of care and to the cost of achieving good health and well-being. In addition, the strategies to improve and assess the quality of life outcomes should focus on all determinants of health and drive accountability for results beyond the health care system. Targeting a broad set of drivers (care and non-care related) that contribute to patient reported outcomes and quality of life will be critical, as the health care sector oftentimes is seen wholly accountable when other contributors exist.
Shawn Terrell	Administration for Commuity Living	3) Strategies to Support Improved Quality of Life Outcomes	(1/4) The identification of quality of life outcomes as a "high-leverage" opportunity is a welcome addition to the MAP Duals work. The four domains listed are necessary but not sufficient from our perspective to cover the full range of needs commonly experienced by people with disabilities and older adults. We have two recommendations in this area. First, explicitly include domains for education, employment, housing, and community integration into the list of domains. Second, refer to the recent CMS Home and Community Based Services Rule section 441.530 on "settings." https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider. The settings language specifies the conditions under which home and community based services and supports may be reimbursed in HCBS programs. These rules, while technically only applicable to specific CMS programs, are in another sense the most highly vetted public national statement on home and community based settings and have great potential as a basis for developing measures and/or reviewing existing measures relate to quality of life. They are the product of several rounds of public process and a two-year HHS-wide internal developmental workgroup. These settings standards provide the necessary framework for developing comprehensive and effective set of meaningful process and outcome measures.
Shawn Terrell	Administration for Commuity Living	3) Strategies to Support Improved Quality of Life Outcomes	(2/4) A person centered planning method is best thought of as a skill set that, in its fullest application, often exerts pressures on traditional health and health related systems. For instance, the practice of person centered planning does not easily lend itself to highly structured approaches such that might be necessary for a functional assessment. Instead, person centered planning is a highly variable processes, tailored to the specific needs and interests of each individual. This point needs to be clearly discussed with emphasis on the implied measurement challenges. Also, because of its consumer driven nature, person centered planning methods often result in needs that extend well beyond the boundaries of any one or even a few programs. While this latter point was covered to a large degree in the document, it would need to be emphasized again in the context of the planning processes itself.

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Shawn Terrell	Administration for Commuity Living	3) Strategies to Support Improved Quality of Life Outcomes	(3/4) Our recommendations are that the Path Forward section of the document include the work developed over the last 30 years on person centered planning methodologies and the CMS settings rule discussed above. We appreciate the focus on shared decision making as an important recent development. However, SDM is but one of many planning methods that should be reviewed in the document. Other approaches include the following: Person Centered Planning Essential Lifestyle Planning MAPS PATH Wellness Recovery Action Planning Family Support Planning Motivational Interviewing Decision Support It should be noted that several of person centered planning methods mentioned above have an evidence base and tools to measure fidelity to the model. The environmental scan would be enhanced with a review of these measurement tools as well.
Shawn Terrell	Administration for Commuity Living	3) Strategies to Support Improved Quality of Life Outcomes	(4/4) The document should discuss the differences between functional assessments and person centered planning, particularly the role of functional assessments in the development of the person centered plan of care. It is our experience that there needs to be a clear delineation between the two. A person centered planning process is focused on determining the quality of life goals, dreams, and desires of the person and then reaching a balance between this person driven perspective and any health and safety issues that may arise during a functional assessment process. There then must be a consumer driven context within which to negotiate conflicts that may arise between these two distinct processes. Service and support needs flow from the results of the negotiation process. This negotiated outcome is the core of an effective person centered planning process. The document would benefit from a clear articulation of these differences.
Lauren Agoratus	Family Voices NJ	3) Strategies to Support Improved Quality of Life Outcomes	We also urge inclusion of the perspectives of consumers – both adults and parents of dual eligible youth – and organizations representing families of consumers (especially youth) in development of the measures. The MAP membership appears to be very heavily weighted toward adults.
Joe Caldwell	National Council on Aging	4) Approach to Constructing a Stakeholder Feedback Loop	On page 18, "Table 2: Potential Topics for Future Consideration by MAP," we recommend the following: We applaud a focus on "wellness-directed model over a disease-focused model." We recommend inclusion self-management of chronic conditions and health promotion for individuals with disabilities. (Fourth bullet in first section) We also support the consideration of interim measures in non-medical domains. We recommend a specific focus on HCBS measures because of the pressing need for measure. We recommend greater consultation with national aging and disability consumer organizations and coalitions about HCBS interim measures (Fifth bullet in first section). In addition, we also recommend greater consultation with national aging and disability consumer organizations and coalitions about measure gaps. We support the consideration of employment and workforce outcomes. However, recommend a specific focus on measures for the direct care workforce providing HCBS as well as measures to support family caregivers.
Carmella Bocchino	America's Health Insurance Plans	4) Approach to Constructing a Stakeholder Feedback Loop	We support the MAP's recommendation to align reporting requirements and measures across programs and stakeholder groups. Alignment will focus resources, help achieve improved outcomes, and reduce measurement "noise" or redundant reporting requirements.
Lauren Agoratus	Family Voices NJ	4) Approach to Constructing a Stakeholder Feedback Loop	(1/2) Regarding Table 2: Potential Topics for Future Consideration by MAP, we strongly support person-centered wellness. The Affordable Care Act focuses on shared decision-making and the importance of prevention/wellness, particularly the pediatric Bright Futures guidelines endorsed by the American Academy of Pediatrics. Under "Other factors related to quality of care" we strongly support "Primary care/behavioral health integrations models" as resulting in best outcomes. The National Alliance for Mental Illness has an initiative "Integrating Mental Health in Pediatric Primary Care" which has a study on efficacy and materials for providers and families, at http://www.nami.org/Template.cfm?Section=child_and_teen_support&Template=/ContentManagement/ContentDisplay.cfm&ContentID=120673. Regarding "Appendix D: Current Family of Measures for Dual Eligible Beneficiaries," we continue to support the endorsed measures. These include: 0005 CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys) The consumer satisfaction surveys are good measures of quality of care.

Lauren Agoratus	Family Voices NJ	4) Approach to Constructing a Stakeholder Feedback Loop	(2/2) 0097 Medication Reconciliation This is important as the primary cause of medical errors resulting in increased morbidity and rehospitalization. 0101 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls This is an important safety measure to prevent injury and improve outcomes. 0201 Pressure ulcer prevalence (hospital acquired) Again, this is another measure that prevents injury and promotes better outcomes. 0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) The use of health information technology will decrease medical errors, and prevent emergency room use and hospitalization. 1768 Plan All-Cause Readmissions This measure is important in examining inappropriate early discharge as well as preventable hospital acquired conditions. 1902 Clinicians/ Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy We strongly support this as the single largest barrier to healthcare access.
Anne Cohen	Disability Health Access, LLC	4) Approach to Constructing a Stakeholder Feedback Loop	It's critical for NQF to engage stakeholders that represent consumer voices. In order to do this I suggest creating a short usable and meaningful document that explains why different categories (family measures) are critical to ensure quality care for Dual Eligibles. I also encourage having an annual call with these consumer groups explaining NQF's mission and to seek feedback on the Family of Measures categories. NQF may also consider conducting interviews with Dual Eligible consumers, health plans, providers and state officials in pilot states to share the efforts of the workgroup and to identify possible quality areas that would indicate measurement gaps.
E. Clarke Ross	Consortium for Citizens with Disabilities	4) Approach to Constructing a Stakeholder Feedback Loop	We appreciate the identication of employment as a future topic of consideration We recommend that the workgroup further consider the application of the concept of "dignity of risk."
Valerie Wilbur	SNP Alliance	4) Stakeholder Feedback Loop	(1/2) 1. We strongly support the focus on alignment, impact of measures and fit-for-purpose as well as the focus on the 4 areas identified on page 17 of the report – identification of measures that are widely used, that have contributed to significant positive impact on quality, that are not functioning as intended, and that are a poor fit for a program's goals. We would support a specific recommendation that in the case of poor fit, the measure be discontinued. The SNP Alliance is particularly interested in addressing alignment requirements between Medicare and Medicaid and among SNPs, MMPs, general MA plans, and managed care and fee-for-service providers serving a similar population segment. 2. We request that MAP gather feedback from SNPs, MMPs, consumers, family caregivers, providers and state Medicaid and related entities. Since 85-100% of SNP and MMP enrollment, respectively, is composed of duals, the perspectives of these plans and their state partners is critical. Consumers should weigh in on which measures are most important to them and should address the burden produced by multiple consumer surveys. Providers should be polled on measure "fit-for-purpose" relative to the populations they serve and about the increasing reporting burden and what they recommend to reduce this burden relative to serving duals. NQF also should consider how to ensure accurate representation across consumers, recognizing the inherent bias of surveys toward healthier respondents, including having better recall of information such as procedures performed and satisfaction measures. Some plans, including the dual demos, have Consumer Advisory Committees that could serve as a source of information. Providers and plans also could help provide access to consumer input.
Valerie Wilbur	SNP Alliance	4) Stakeholder Feedback Loop	(2/2) 3. Additional measure refinement should include: (1) Measures related to social determinants of health such as health literacy, homeless and substance abuse; (2) Identification of additional behavioral health measures; (3) Examining and documenting the validity and reliability of self-report measures for persons with intellectual and/or cognitive impairments; and identifying alternative data collection methods, including clear rules for the use of proxy reporting, and the need for further risk adjustment of measures. (4) Modifications to the MA Star rating system that could include exclusion of selected irrelevant measures for specific dual subsets; addition of dual-relevant measures; allocation of greater weight to the Star measures most relevant to enrolled beneficiaries; and establishment of different cut points for Star rating thresholds for duals. (5) Identifying "core measures" within the Family of Measures of particular relevance to specific dual subsets. 4. These issues would be relevant to MAP, CMS, consumers and family caregivers; state Medicaid and related agencies with responsibilities related to the dual population; to SNPs and Medicare-Medicaid Plans; and to providers.