MEASURE APPLICATIONS PARTNERSHIP

Advancing Person-Centered Care for Dual Eligible Beneficiaries through Performance Measurement:

2015 Recommendations from the Measure Applications Partnership

FINAL REPORT

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NATIONAL
QUALITY FORUM

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EXECUTIVE SUMMARY

More than 10 million Americans are eligible to be covered by both Medicare and Medicaid. These consumers are one of the nation's most vulnerable populations. Two thirds of these individuals are low-income elderly adults, and one third are people under 65 with disabilities.[1] Often, these individuals are challenged by long-lasting healthcare issues and complex social circumstances.

Better healthcare, care coordination, and supportive services for dual eligible beneficiaries have the potential to make significant differences in their health and quality of life. Improvements for this population also have the potential to address the disproportionate cost of their care. Twenty percent of Medicare beneficiaries are dually eligible, but these individuals account for 34 percent of the program's spending—a total of nearly $500 billion each year. Meanwhile, the 14 percent of Medicaid beneficiaries who are dually eligible account for 34 percent of spending in that program—a total of about $340 billion each year.[2]

Quality measurement is an essential catalyst to stimulate needed healthcare improvements and more value-driven use of services for the population of dual eligible beneficiaries. The National Quality Forum (NQF) convenes the Measure Applications Partnership (MAP) as a public-private collaboration of healthcare stakeholders. 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. This report, the sixth in a series, describes the latest round of guidance from MAP on the use of performance measures to assess and improve healthcare for people eligible for both Medicare and Medicaid.

MAP builds upon its previous work in this report by updating its list of the best available measures for dual eligible beneficiaries. Stakeholders are calling for use of the same, aligned measures across the health system to reduce data collection and reporting burden. MAP promotes selection of aligned measures within programs that serve dual eligible beneficiaries by publishing a Dual Eligible Beneficiaries Family of Measures. It provides a varied list of potential measures from which program administrators can choose a subset most appropriate to fit individual program needs. This review added 18 new measures to the MAP Family of Measures for Dual Eligible Beneficiaries, including 12 new behavioral health measures, one care coordination measure, and five admission/readmission measures.

To inform MAP regarding the use of measures in the family, NQF conducted an analysis to document the use of measures across a range of public and private programs. It revealed numerous measures that are frequently used in programs, but none focused on a health issue reflective of the health and social complexity that make dual eligible beneficiaries distinct from other healthcare consumers. MAP continues to urge more rapid development of new measures that are relevant for dual eligible beneficiaries in topic areas such as person-centered, goal-directed care; access to community-based long-term supports and services; and meeting psychosocial needs. MAP recognizes the need for financial and scientific support for the measure development community to facilitate progress.

The report also contains feedback from stakeholders about the use and utility of the measures MAP recommends. A series of semi-structured stakeholder interviews revealed that measurement is primarily dictated by external reporting requirements and that limited resources are available to conduct detailed analyses of high-need populations. Stakeholders reported discomfort with applying measures designed, developed, and evaluated in the general population to complex or at-risk beneficiaries. This discomfort results from tension between the goal of providing high-quality care to vulnerable individuals and the concern that the measures may include clinically inappropriate targets or otherwise lead to unintended consequences. Participants noted success in improving quality and outcomes in situations where they could promptly identify and address barriers to access and unmet social needs.

Collaboration is needed to achieve an improved future state. MAP favors the use of targeted, appropriate measures that can support program goals and drive improvement in consumer experience and outcomes. To produce better health and quality of life for dual eligible beneficiaries and other at-risk groups, MAP recommends that HHS and other stakeholders do away with nonessential measurement, attestation, and regulatory requirements to free up system bandwidth for innovation. MAP also suggested wider use of measure stratification to better understand the impact of health disparities in the dual eligible population and to speed progress in addressing them. A reinvigorated, person- and family-centered system should adopt specialized care models designed to meet individuals' complex medical and social needs.

INTRODUCTION

The National Quality Forum (NQF) convenes the Measure Applications Partnership (MAP) as a public-private partnership of healthcare stakeholders. 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**). This report describes the latest round of guidance from MAP on the use of performance measures to assess and improve healthcare in the population of individuals dually eligible for Medicare and Medicaid.

Individuals become eligible for Medicare health insurance primarily when they reach the age of 65, or as the result of a disabling disease or condition. The Medicare program is administered at the federal level, nationwide. In contrast, Medicaid programs, benefits, and eligibility are determined and executed by states, with federal oversight and financial contribution. Individuals become eligible for Medicaid mainly based on household income, and in the case of children, their age. Among these two broad enrollee populations, a significant minority of approximately 10 million beneficiaries are dually eligible for both Medicare and Medicaid benefits.

This group of Medicare-Medicaid dual eligible beneficiaries includes individuals who have multiple, complex clinical conditions that are compounded by social disadvantages, namely poverty. Additionally, this group makes up a fraction of total Medicare and Medicaid enrollees, but accounts for a disproportionate amount of spending. In Medicare, dual eligible individuals comprise 20 percent of beneficiaries and 34 percent of spending—a total of $498.9 billion annually. It is even more drastic in Medicaid, where 14 percent of beneficiaries are dually eligible and 34 percent of program spending is dedicated to them—a total of $340.5 billion annually.[3]

This is further evidence that many people who receive benefits from both programs can be considered "vulnerable" or "high-need" for both medical and social support services. As a result, stakeholders prioritize understanding and improving quality of care for these individuals.

MAP includes a 24-member multistakeholder MAP Dual Eligible Beneficiaries Workgroup (**Appendix B**). This is one of four workgroups responsible for advising the MAP Coordinating Committee on the use of measures to encourage performance improvement based on the MAP Measure Selection Criteria (MSC) and other inputs (**Appendix C**). MAP also convenes task forces on specialized topics, including the MAP Medicaid Task Forces that provide direct input on core sets of measures for Medicaid beneficiaries. As part of its commitment to transparency and collaboration, NQF invited public comments on this report, receiving 36 comments from 14 organizations (**Appendix D**). The Coordinating Committee issues all final MAP recommendations.

Summary of Progress

MAP's work on measures for dual eligible beneficiaries is now in its fourth year, and this is the sixth report on the subject. At this juncture, we reflect on the progress made towards ensuring high-quality care for dual eligible beneficiaries and the results of MAP efforts. During MAP deliberations, staff from the Centers for Medicare & Medicaid Services (CMS) Medicare-Medicaid Coordination Office (MMCO) noted that the MAP Dual Eligible Beneficiaries Workgroup discussions and reports provide them with a roadmap for issues of healthcare quality. MAP's guidance has grown progressively more detailed since its first report to HHS. This depth is afforded by the opportunities to regularly convene diverse stakeholders and explore important issues through research and open communication. This latest round of input applies new emphasis on the experience of implementing measures within the uniquely complex and heterogeneous dual eligible beneficiary population. This has deepened MAP's understanding of issues related to measure use.

MMCO reported using MAP's Family of Measures for Dual Eligible Beneficiaries as a starting point from which it can select or recommend measures for use in specific programs, including the Financial Alignment Initiative (FAI). The family of measures makes MAP's measurement priorities for dual eligible beneficiaries clear to CMS and other stakeholders. Consistent use of relevant measures improves the availability of information about the population; even baseline data had been difficult to obtain in the past. Lack of data specific to dual eligible beneficiaries is one of the most significant challenges to performance measurement and improvement. Measures recommended by MAP are in use across the healthcare system, but they are not consistently used in a manner that allows for separate analysis of the quality of care for dual beneficiaries. Specifically, the investment and expertise needed to successfully merge Medicare and Medicaid data is a barrier that CMS is working diligently to address.

MAP directly and indirectly influences the MMCO's current activities and priorities for quality measurement and collaboration. Examples include:

- Pursuing stratification of measures within existing programs by dual eligible beneficiary status to illuminate potential disparities in care. This requires partnership with measure developers and program administrators, but is vital to identifying and understanding differences in quality. The initial focus of stratification has been on topics of care where dual eligible beneficiaries make up a large proportion of the patients, including end-stage renal disease (ESRD) and inpatient psychiatric care.
- Funding and facilitating measure development in MAP's priority gap areas, including measure concepts related to person-centered planning and care coordination.

- Providing technical assistance to states to make Medicare data available and usable for quality improvement and care coordination. States can now request Medicare Parts A, B, and/or D data on claims, events, eligibility, and enrollment from the State Data Resource Center. Experts can help state staff link databases, determine ways to use the available information, and address any limitations.

Advancing quality of care for dual eligible beneficiaries is important, complex work that will continue to present challenges. CMS is using a multi-pronged approach to address quality that underpins their performance-based payments to states under the FAI, quality standards for health plans, and the forthcoming evaluation of the demonstrations. CMS is interested in further input from MAP and other stakeholders as the environment continues to evolve and mature.

ALIGNMENT ANALYSIS

The Growing Importance of Measure Alignment

The field of quality measurement has grown in recent years, increasing both the total number of performance measures available and the volume of requirements across the health system for reporting. The time, effort, and resources dedicated to quality measurement have likewise mushroomed. Stakeholders across the quality measurement enterprise have questioned whether the benefits accrued from data collection and reporting justify the increased investments and time burden now required.

Measurement is valued for its ability to highlight problems, provide consistency in assessing process and outcomes across diverse venues, promote action to improve quality, and document success. Additionally, consumers, healthcare purchasers, and other groups consult publicly available quality measurement information to make informed choices about where and from whom to seek healthcare services. However, little doubt remains that the measurement system itself is inefficient, with problems stemming from the volume of measures now required and the lack of synchronization among the panoply of independently operated programs. Different measures are used to satisfy different information needs, each with its own importance, but the overall volume of data required and information generated leads to confusion.

In response, stakeholders are calling for better alignment, that is, using the same measures across programs when appropriate. Measure alignment is achieved when sets of measures work well across settings or programs to produce meaningful information without creating extra work for those responsible for the measurement.

MAP has identified alignment as an important characteristic of measure sets in the MAP Measure Selection Criteria. Subcriterion 7.2 states, “Program measure set places strong emphasis on measures that can be used across multiple programs or applications.” Measure alignment can streamline information flow and improve the probability of effective performance measurement. When different programs use variations of the same or similar measures, it can be both wasteful and burdensome to the healthcare providers and other entities being asked to provide data. When present, measure alignment also increases stakeholder buy-in about measurement and quality improvement efforts by demonstrating efficiency and coordination.

Providers and health plans serving dual eligible beneficiaries tend to be at the intersection of many competing state, federal, and other reporting requirements. Although the experience varies by provider or health plan type, it is common for Medicare, Medicaid, multiple private payers, and other state and local programs to each dictate separate requirements. According to a 2015 report from the Institute of Medicine (IOM) on the topic of alignment, if our nation is to achieve better health and lower costs, attention on what matters the most will be required from all stakeholders. The report also states that renewed attempts to align and harmonize measures to reduce redundancies may now succeed due to the significant changes in the measurement environment. Electronic health records (EHRs) and health information technology have spread quickly with significant influence on data collection and reporting. These tools also have the potential to improve the timeliness of information sharing for processes like care coordination and inform organizations' quality improvement goals.[4]

Beyond NQF and IOM, other organizations are promoting greater alignment and harmonization of measures. One of the resources NQF used while conducting its analysis of alignment was research performed by Bailitt Health Purchasing on behalf of **Buying Value**.[5] Buying Value is an initiative of private healthcare purchasers, employers, leading business health organizations, union health funds, and NQF to promote the use of aligned measures, with a focus on ambulatory care and supporting states with measure selection. Buying Value's data revealed a significant lack of alignment among current state and regional measure sets. The most commonly used measures were from nationally recognized sources, including measures endorsed by NQF, from The Joint Commission, and from the National Committee for Quality Assurance (NCQA) HEDIS program (Healthcare Effectiveness Data and Information Set). Even when measures were drawn from these standard sources, the specifications were frequently changed by individual programs. In addition, Buying Value noted that many states are using their own "homegrown" measures.

Approach

MAP promotes alignment of measures and selection decisions within programs that relate to the services and supports provided to dual eligible beneficiaries. The MAP Dual Eligible Beneficiaries Family of Measures (**Appendix E**) was intended to facilitate alignment by providing a varied list of potential measures from which program administrators could choose a subset most appropriate to fit individual program needs. It functions like a menu, offering measures that match MAP's previously published priority topics for measurement and that are designed to be used in various settings (e.g., hospitals, physician offices), across many levels of analysis (e.g., health plans, individual providers), and drawing upon diverse data sources (e.g., administrative claims, consumer surveys). HHS and MAP have been working in partnership to select measures for program use that are well-aligned and to remove outliers. At the same time, much remained unknown about the landscape of other public and private programs, especially the programs and measures relevant to the unique needs of dual eligible beneficiaries.

To inform MAP regarding the use of measures in the family, NQF conducted an analysis to document the use and alignment of measures across a range of public and private programs. Please see the **project page** for the **spreadsheet** with the complete alignment analysis to accompany this report. The goal of this work was to understand the uptake of measures from the 2014 MAP Dual Eligible Beneficiaries Family of Measures—and by extension—the degree to which measure use is aligned. It was not possible to prove a causal relationship between the inclusion of measures in the family and measure use in programs; rather, the intention of the analysis was to document the current state.

Programs and Data Considered

CMS and states are testing models to better align the financing of Medicare and Medicaid; this

Financial Alignment Initiative (FAI) intends to integrate primary, acute, behavioral health, and long-term services and supports for Medicare-Medicaid enrollees. Because the FAI includes the most significant programs measuring quality *specifically* for dual eligible beneficiaries, it was a focus of the NQF analysis. In addition, the demonstrations are a major priority of states, advocates, health plans, and other partners seeking to better integrate care for the population. MAP reviewed information on nine capitated models from the states of California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia. MAP also assessed two managed fee for service (FFS) models in Colorado and Washington. In addition, Minnesota is independently pursing an alternative model for integration of care for dual eligible beneficiaries; data from this state were also included.

In addition to the demonstrations, the analysis included 43 national or other state initiatives that were relevant to the dual eligible beneficiary population. Examples of these include CMS Health Home Measure Set, Joint Commission Accountability Measures, CMS Medicaid Adult Core Set, the Comprehensive Primary Care Initiative, and the CMS Medicare Part C & D Star Ratings. Programs that did not include any measures from the family of measures were not included in the final display of information. A list of all programs included in the measure alignment tool is provided in **Appendix F**.

MAP also explored state-specific measures identified in the Buying Value initiative to see if any showed promise for further development, testing, and wider use to fill gaps in current measures. Potential gap-filling measures from the alignment analysis are listed in **Appendix G**.

Results

In total, the state-level financial alignment demonstrations include approximately 60 percent of the family of measures. MAP did not expect 100 percent uptake of the family of measures within the FAI because the demonstrations are designed to measure integrated care delivered by health plans and many measures in the family are designed for levels of analysis or care settings outside the scope of the demonstrations. Additionally, MAP recognized that a finite pool of resources would be available for quality measurement and that it is not possible or practical to use all measures that might be of interest.

The capitated models have greater uptake from the family of measures than the FFS model demonstrations. The capitated demonstrations each include between 18 and 25 measures from the family. In contrast, the fee for service demonstrations include 6 to 8 measures each. This is likely because many of the measures MAP supported are HEDIS measures, which a large number of states with managed care delivery models were already collecting and using for other purposes. In the case of the states using an FFS approach, the measures in the family were different from what the states had previously collected.

Uptake of measures from the family in other national or state initiatives varied greatly. Measures from the family were most frequently used in the CMS Physician Quality Reporting System (PQRS) and the CMS Value-Based Payment Modifier programs, including approximately 21 measures each. A reason for large uptake in these programs is that each contains a long list of measures from which participating physicians can select a small subset to report. Measures in the family are least frequently used in the CMS Nursing Home Quality Initiative, CMS Long-Term Hospital Quality Reporting, and CMS Home Health Quality Reporting programs, which included only one or two measures in each program. Other programs, excluded from our analysis, did not use any measures from the family. In general, programs with low uptake have a more narrow focus and are more likely to be setting-specific. When MAP initially created the family of measures, it favored the inclusion of cross-cutting rather than setting-specific measures because they were better able to promote alignment through widespread use.

A subset of measures was identified in an effort to understand the qualities of the most frequently adopted measures (Table 1). These 16 most-aligned, or most frequently used, measures are used in three or more state financial alignment demonstrations and three or more national or other state initiatives. Among these, the six measures with the greatest uptake are used in nine or more state financial alignment demonstrations and eight or more national or other state initiatives; these are noted with an asterisk in Table 1.

TABLE 1. SIXTEEN MOST-ALIGNED MEASURES FROM THE MAP DUAL ELIGIBLE BENEFICIARIES FAMILY OF MEASURES

NQF #	Measure Title	Measure Steward
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*	National Committee for Quality Assurance (NCQA)
0006	CAHPS Health Plan Survey v 4.0 - Adult questionnaire	Agency for Healthcare Research and Quality (AHRQ)
0018	Controlling High Blood Pressure*	NCQA
0022	Use of High-Risk Medications in the Elderly	NCQA
0032	Cervical Cancer Screening	NCQA
0034	Colorectal Cancer Screening*	NCQA
0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	NCQA
0105	Antidepressant Medication Management*	NCQA
0201	Pressure Ulcer Prevalence (Hospital Acquired)	The Joint Commission
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan*	Centers for Medicare & Medicaid Services (CMS)
0421	Adult Weight Screening and Follow-Up	CMS
0553	Care for Older Adults (COA) – Medication Review	NCQA
0554	Medication Reconciliation Post-Discharge	NCQA
0576	Follow-Up After Hospitalization for Mental Illness	NCQA
0648	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	American Medical Association - Physician Consortium for Performance Improvement
1768	Plan All-Cause Readmissions*	NCQA

The most-aligned measures were then examined in accordance with selected MAP Measure Selection Criteria. Specifically, measures were compared to the National Quality Strategy (NQS) priorities and their relevance to high-need subgroups of the dual eligible beneficiary population. Among the top 16 most-aligned measures, five of six NQS priorities were addressed. None of these 16 most-aligned measures addressed the NQS priority of affordability. The sum of the values for all categories exceeds 16 because some measures belong to more than one category.

Additionally, NQF observed a relatively even distribution of measures addressing health issues relevant to the four high-need subgroups MAP has previously defined within the dual eligible population: people with physical disabilities, complex older adults, individuals with behavioral health needs, and individuals with cognitive impairment. MAP recognizes that the subgroups are not mutually exclusive. Instead, MAP looks to ensure that measures related to all of the groups are present as a method to estimate comprehensiveness of measures for a range of health and long-term care needs. The sum of the values for all categories exceeds 16 because some measures belong to more than one category.

FIGURE 1. TOP 16 MOST-ALIGNED MEASURES BY NATIONAL QUALITY STRATEGY PRIORITY AREA

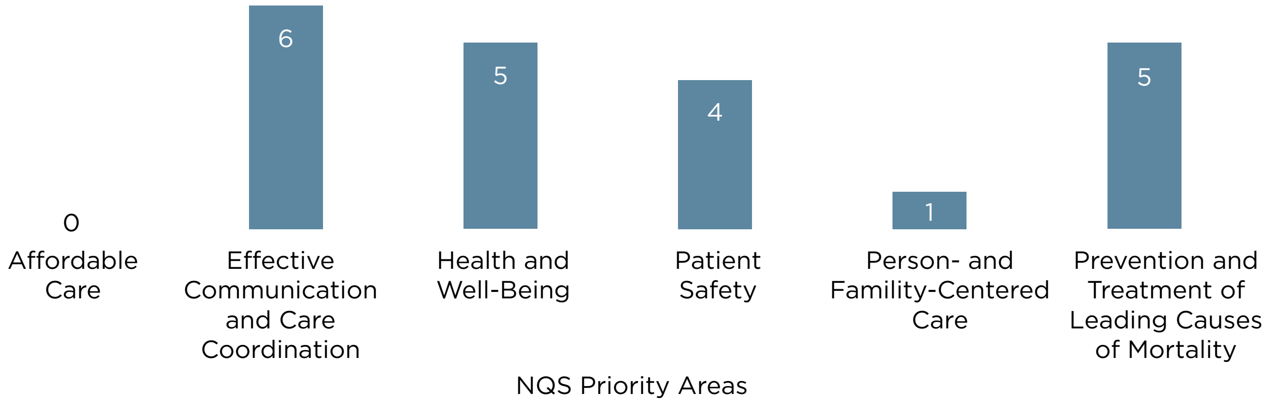
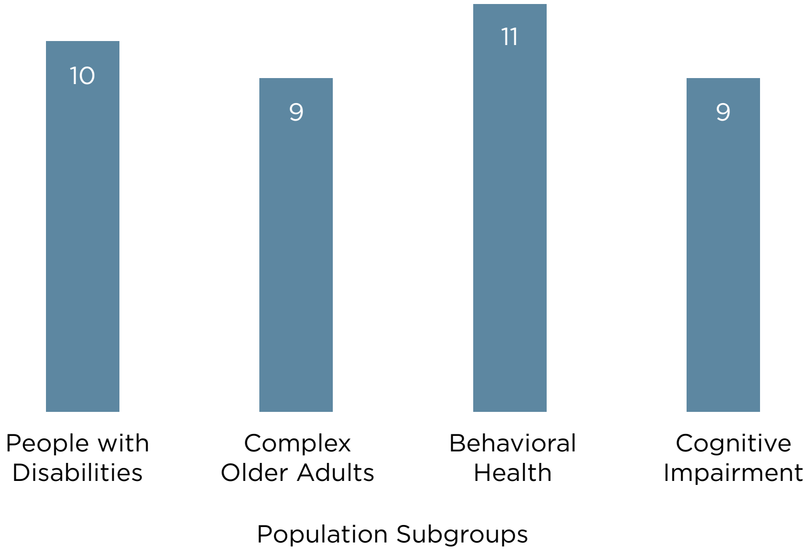


FIGURE 2. TOP 16 MOST-ALIGNED MEASURES BY POPULATION SUBGROUPS



MAP Discussion of Alignment Analysis

The MAP Dual Eligible Beneficiaries Workgroup acknowledged the importance of the alignment analysis in illuminating patterns of measure use. However, many members expressed dissatisfaction that the most frequently adopted measures didn't capture issues that would assess quality of care and address the health and social complexity that make dual eligible beneficiaries distinct from other healthcare consumers. MAP members requested that measures in the family be categorized into three groups:

1. measures in use in state demonstrations
2. measures not in use for a reason that can be identified (e.g., they are designed to be used in a part of healthcare that is outside the scope of the demonstration)
3. measures that are not in use and for which there is no clear disqualifier

This categorization is designed to identify measures in the third category for which MAP may want to advocate in the future. It yielded one measure, NQF #2111 Antipsychotic Use in Persons with Dementia, which does not have any obvious disqualifiers for program use. It is a claims-based measure designed for use by health plans. We hypothesize that the reason it is not yet included in the demonstrations is that it first gained NQF endorsement in 2013, making it relatively new when compared to other measures. Please see **Appendix H** for the complete categorization of measures.

Commenters encouraged the continued use of cross-program alignment as a criterion for measure selection and emphasized the importance of alignment in managing the resources required for measurement by reporting organizations. Additionally, coordinated measurement will help to create a stronger system of accountability and a more uniform discussion to guide system improvement. One commenter highlighted the importance of alignment across diverse providers of long-term supports and services to promote linkages. Others voiced support for the widespread use of a targeted number of measures that meet specific health care quality goals, such as ability to improve health outcomes while reducing avoidable costs.

FEEDBACK FROM STAKEHOLDERS ON MEASURE USE

Grounding MAP Decisionmaking in Real-World Experiences

The diversity of the quality measurement enterprise is demonstrated by the range of those measuring and being measured, measure types and features, measurement topics and foci, and the applications and uses of measures.[6] Measures are increasingly applied in high-stakes public reporting and pay-for-performance programs, making the selection of appropriate measures paramount. NQF-endorsed measures have demonstrated compliance with specific criteria, including those for feasibility and reliability, and use and usability. NQF endorses measures based on five criteria for evaluation: importance to measure and report; scientific acceptability of measure properties; feasibility; usability and use; and determination of related and competing measures. (For more information please see the **Measure Evaluation Criteria**.)

Despite the rigor of the endorsement process, less is known about the use and ability of individual measures to drive quality improvement, specifically in care delivered to vulnerable populations. MAP members and others across stakeholder groups have sought more feedback about the use experience and utility of measures across the enterprise. This information is critical for MAP's ongoing decisionmaking, particularly in the most vulnerable populations where the opportunities for beneficiaries' improved health outcomes are palpable.

Approach

NQF staff began to address the lack of information by collecting feedback about the performance and utility of measures from the Dual Eligible Beneficiaries Family of Measures. Staff gathered information from representatives of multiple stakeholder groups representing the interests of the Medicare-Medicaid dually eligible and other vulnerable populations. Eight organizations not currently represented among MAP members participated: three health plan organizations, two consumer advocacy groups, one state program, and two companies supporting measurement in the industry.

Semi-structured phone interviews were adapted to each stakeholder and the organization's role in using or influencing measurement. The interviews targeted data collection in the areas of measure selection or adoption, alignment, usability, and challenges, with a focus on measures in MAP's family of measures for this population. Please see **Appendix I** for additional measure-specific feedback. The interviews also explored measure gap areas and promising development activities.

This initial effort was conducted on a relatively small scale, with the potential for expansion and further data collection in later iterations. The MAP Dual Eligible Beneficiaries Workgroup reviewed preliminary results from the first four interviews conducted. This review guided subsequent interviews and presentation of results in this report. Final results of this initial effort are intended to further inform MAP's guidance to HHS and a potential larger-scale effort to collect further data. Public feedback reflected significant agreement with the findings of the feedback loop conversations.

Results

Measure Selection

It is well known that measures are used for a variety of purposes including formal performance measurement programs and accreditation, internally focused quality improvement, and exploration or research.[7] Through the interviews, staff found that health plans and providers' choices of measures for collection and reporting are primarily determined by external program reporting requirements, especially those in which participation is mandatory for payment. Organizations in our sample reported struggling to find the resources to complete these requirements and have little or no leftover bandwidth to collect other measures for quality improvement or research purposes. Any additional measures are few and generally selected based on the organization's improvement priorities for the population it is serving.

Applying the axiom "what gets measured gets done," some organizations choose to measure impactful care outcomes or processes known to be effective but which are inconsistently followed. This "strategic steering" is highly applicable to process measures, such as those of care coordination (noted by one consumer advocacy group) or known disparities such as colon cancer screening (noted by one health plan). In this way, purchasers, payers, and consumers are using measures to influence provider behavior. This method is applicable to all types of measurement programs, including required reporting, pay-for-reporting, public reporting, and pay-for-performance programs.

Among available measures, there are some that are considered duplicative or overlapping. Stakeholders expressed disappointment when they observe investment in the development and use of measures that are similar to those already in existence. Rather than moving the field forward, it can create confusion and strain the already resource-limited environment by diverting capacity away from other measure gap areas. NQF addresses this issue, in part, through endorsement criteria considering if measures are related or competing.[8,9]

Addressing At-Risk Populations

Stakeholders interviewed generally expressed a strong desire to better understand the quality of care received by dual eligible beneficiaries and other vulnerable populations. Participants viewed this knowledge as fundamental to inform changes to care processes and improve outcomes. However, participants cited limited resources as the primary barrier to conducting detailed analyses of potential disparities in quality across groups and developing programs to address them. Health plans interviewed were fully occupied with efforts to track and improve the quality of care for their total enrollee populations, hoping that their efforts would in turn also improve care for vulnerable individuals. These organizations would like to progress to better addressing disparities among their enrollees in the future.

Even in the absence of measure stratification, participants cited opportunities to improve quality of care for dual eligible beneficiaries. Multiple participants from across stakeholder groups identified the need to evaluate how well care processes are identifying and responding to each individual's needs. For example, early identification of barriers to access, unmet social needs, and other factors create the opportunity for providers to connect beneficiaries with additional resources and improve related health outcomes. Providers, health plans, states, and others are hindered in understanding and improving the quality of care by the lack of common identifiers and missing data connections between different payment and records systems.

Concerns Regarding Measure Application in At-Risk Populations

Stakeholders are generally uncomfortable applying measures designed, developed, and evaluated in the general population to complex or at-risk beneficiaries. Some of this discomfort results from tension between the goal of providing high-quality of care to vulnerable individuals and concern that the measures may have unintended consequences.

For example, few clinical trials of medical interventions enroll individuals with multiple chronic conditions, older adults, and people with disabilities, in part to limit confounding factors and risks in research. However, the lack of study in these populations results in a vacuum of evidence to support performance measurement in these same populations.

The organizations interviewed also encouraged the quality measurement field to:

1. Include targets that are clinically relevant and appropriate for vulnerable populations. Be especially careful when defining thresholds for blood pressure control and blood glucose control, as potential harms may outweigh potential benefits for individuals who are elderly or seriously ill. Participants also commented that fall prevention is a priority, but benchmarks need to be chosen carefully because it would be unrealistic to expect providers to eliminate falls within a very frail population or that doing so could lead to practices that conflict with consumer preferences about mobility and independence.

2. Consider measure denominator exclusions. Measures should allow for the flexibility to remove cases where care is preference-sensitive, contraindicated, or against medical advice. However, the rigorous use of exclusions could reduce the denominator population size to a level that is no longer reliable and valid, rendering the measure unusable.

3. Assign accountability appropriately, ensuring measures are applied to those who have the ability to influence the results. For example, health plan representatives expressed frustration about measures that would require direct influence over or partnership with other entities. MAP has attempted to promote shared accountability and create systemness by recommending that health plans have a role in care transitions, for example. In general, health plan representatives were uncomfortable being evaluated by a measure they feel reflects more on the facilities providing direct care. Similarly, participants encouraged use of risk adjustment for socioeconomic factors so that safety net providers are not disadvantaged. Additionally, some plan representatives who have pursued partnerships with the delivery system report that plans serving vulnerable populations have less purchasing power and influence over provider behaviors compared to payers with higher reimbursement rates.

Comments revealed an additional perspective on these issues not collected in the stakeholder interviews. In response to the finding that “health plan representatives expressed frustration about measures that would require direct influence over or partnership with other entities,” others argued that dual eligible beneficiaries are served and supported by multiple community-based entities and it is appropriate to expect integration of both clinical and social support organizations to support the overall health and well-being of consumers. Regarding the feedback that the use of measures be strongly linked to the actions of the accountable entity, commenters both concurred and noted that metrics reflecting overall experience (and shared accountability) could buffer the concerns of individually-measured entities.

Data Limitations

Any type of measurement is limited by available data. Medical records are primarily designed for collecting clinically relevant information; data abstracted from them is subject to the level of completion by providers and other users. Participants reported that chart data is time-consuming and costly to collect and evaluate. Administrative and claims data are likewise designed for purposes of program administration and billing; measurement information is a byproduct. Neither these nor any other commonly available data sources collect the totality of relevant information about consumers, providers, facilities, or health plans. As a result, measurement opportunities are constrained.

Other important information may not have an obvious place in these records or may not be compatible with the format. These include sociodemographic information, documentation of efforts to connect individuals to needed community resources, provider education programs, and collaborations between organizations to address issues such as care coordination. This information may drive, inform, or be part of improvement efforts, but there is not a systematic way in which it is collected and analyzed for quality measurement.

Stakeholders that use measure information report frustration by the long lag time of some measure results. Some measures are only collected and reported on a semi-annual or annual basis. Because of this, the results may be slow to demonstrate the effect of an improvement effort and opportunity for rapid-cycle adjustment would have been missed. Similarly, changes in processes or practice may take months or years to yield clinically significant outcomes. These delays can hamper buy-in for improvement efforts unless organizations can create more nimble systems for internal use. On the other hand, some participants with experience developing and implementing new processes were aware of changes and improvements in advance of the measure results. This information can originate from anecdotal stories, improved outcomes for a few outspoken individuals, or efficiencies observed by providers. Though these results are not immediately demonstrated in quality measures, they are tangible and can be significant in preserving momentum for the continuation of improvement efforts.

One interview participant from a health plan described an effort conducted by their organization across several states to improve the rates of preventive cancer screening among their enrollees diagnosed with serious mental illness. The health plan integrated care managers in local offices to facilitate access to the services, expecting to see an increase in the screening rates in the next reporting cycle. Though measure results will not be available for 6 months, they continue the intervention because they are interested in addressing the disparity.

One commenter stressed the importance of contracts that provide for the sharing of data needed for measurement. For example, a laboratory testing blood samples should report the results of a test to both the provider that ordered it and the health plan that is reimbursing the service. One commenter suggested the use of uniform data sets and assessments across the delivery system to address data limitations. Finally, MAP also received feedback that low adoption of electronic health records among behavioral health and long-term services and supports providers will hinder use of measures built on these platforms.

Promising Areas for Measure Development

Participants generally concurred with MAP's prioritized measure gap list for the dual eligible beneficiary population. Participants also offered topics they perceive as gap areas and suggested further nuances for the previously identified gaps. Commonly described gap areas included:

- Feedback, experience, and perspective of the beneficiary, as well as this information reported by a beneficiary's caregivers (if applicable);
- Access to home and community-based services, rebalancing long-term care away from institutional settings, and care transitions and care coordination for individuals in the community;
- Health and general well-being, shifting from purely clinical processes and outcomes;
- Influence of social determinants of health and how they should inform care, services and supports, and improvement efforts for beneficiaries.

Participants also suggested measure concepts to fill persistent gaps, listed in Appendix G.

MAINTAINING THE MAP FAMILY OF MEASURES FOR DUAL ELIGIBLE BENEFICIARIES

As described earlier, the Family of Measures for Dual Eligible Beneficiaries is a group of the best available measures to address the unique needs of the dual eligible beneficiary population. The family of measures functions like a menu that stakeholders can consult to select subsets of measures that best suit the needs of particular programs. The current family of measures was selected based on the MAP Measure Selection Criteria and refined over time.

MAP periodically revisits the Family of Measures for Dual Eligible Beneficiaries to ensure that it reflects the best available measures. In doing so, MAP considers removing measures that are no longer NQF-endorsed because the loss of endorsement can signal a shift in clinical guidelines, known problems with the measure, or that the measure's steward has decided to stop maintaining it. When a measure is identified for removal, MAP considers alternative measures in that topic area. In addition, new measures are continuously being developed and may warrant inclusion.

Changes to the Family of Measures in MAP's 2015 Review

MAP considered two measures in the family that recently had endorsement removed, and available alternatives to replace them.

- #0007 CAHPS Health Plan Supplement was retired by the measure steward. Different measures of shared decisionmaking and coordination of care are in development and the survey will be re-submitted by the steward when these updates are complete. Despite a lack of NQF endorsement, MAP voted to retain the measure in the family until the replacement measures are available because this CAHPS supplement may still be in use and it is highly relevant to the population.
- #0111 Bipolar Disorder: Appraisal for Risk of Suicide was retired by the steward and is no longer being maintained. Two alternatives were considered by the workgroup: #0104 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment and #1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder. MAP voted to include #0104 to measure suicide risk assessment, though the measure does not completely fill the gap.

Addition of Newly Endorsed Measures

MAP continues to monitor the NQF portfolio of endorsed measures for new additions that could be included in the family of measures. For measures to be included, they should address either a gap area or one of MAP's high-leverage opportunities for measurement in the dual eligible population: quality of life, screening and assessment, mental health and substance abuse, care coordination, and structural measures. MAP reviewed measures endorsed by NQF since the 2014 update to the family of measures. MAP voted to include a total of 18 new measures, including 12 new behavioral health measures, 1 care coordination measure, and 5 admission/readmission measures. The additions to the family of measures are listed in Table 2, below. A majority of the newly-added measures are harmonized with those already in the family of measures, meaning they are designed and specified to be compatible. The entire family of measures is described in Appendix E. Additionally, the updated family of measures is also available in the spreadsheet accompanying this report posted to the project page.

TABLE 2. NEW ADDITIONS TO THE MAP FAMILY OF MEASURES FOR DUAL ELIGIBLE BENEFICIARIES

NQF #	Measure Title	Measure Steward
0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (replaced #0111: Bipolar Disorder: Appraisal for Risk of Suicide)	American Medical Association – Physician Consortium for Performance Improvement
2380	Rehospitalization During the First 30 Days of Home Health	Centers for Medicare & Medicaid Services (CMS)
2456	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	Brigham and Women´s Hospital
2502	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)	CMS
2505	Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health	CMS
2510	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	CMS
2512	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs)	CMS
2597	Substance Use Screening and Intervention Composite	American Society of Addiction Medicine
2599	Alcohol Screening and Follow-Up for People with Serious Mental Illness	National Committee for Quality Assurance (NCQA)
2600	Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA
2601	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	NCQA
2602	Controlling High Blood Pressure for People with Serious Mental Illness	NCQA
2603	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing	NCQA
2604	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy	NCQA
2605	Follow-Up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	NCQA
2606	Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)	NCQA
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA
2608	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA
2609	Diabetes Care for People with Serious Mental Illness: Eye Exam	NCQA

MAP added a large volume of behavioral health measures because integration of mental health and primary care is critical for many dual eligible beneficiaries. Individuals with serious mental illness are at risk for poor management of other chronic conditions such as diabetes and cardiovascular disease. These health risks are compounded by the side effects of many psychotropic medications. Knowing this, MAP was very supportive of measures that examine intermediate outcomes like blood pressure control and hemoglobin A1c control for people with mental illness. In addition, several measures of admissions and readmissions to various types of facilities were newly endorsed and available for consideration. Dual eligible beneficiaries frequently use these services (e.g., home health, skilled nursing care) and readmission rates are a known opportunity for quality improvement. MAP supported the addition of these measures to the family. Several commenters agreed with the addition of the newly endorsed measures, specifically those related to behavioral health.

MEASURE GAPS: PRIORITIES, CHALLENGES, AND OPPORTUNITIES

MAP identifies gaps in performance measures throughout its work and advocates for measure development in priority areas. Measure gaps are an important piece of each family of measures. A measure set recommended by MAP is only whole when the available, selected measures and the gaps are considered together.

Noteworthy progress has been made in the implementation of existing quality measures recommended by MAP for use in dual eligible beneficiary populations, as observed in the introduction and the results from the alignment analysis and stakeholder interviews. Despite this good news, there remains a great divide between the current state and the ideal state of quality measurement. The problem is not the overall lack of measures, as demonstrated by the more than 600 currently endorsed by NQF; rather, it is the lack of the measures that assess aspects of care that are relevant to the medical and social complexities present in the dual eligible beneficiary population. These gaps are as important as they are challenging.

Significant, but not insurmountable challenges stand between the current state of measurement and the ideal state. This section of the report highlights the prioritized measure gap areas for dual eligible beneficiaries, explores challenges for measure development to fill these gaps, and highlights promising concepts for potential investment.

Prioritized Gaps in the Family of Measures for MAP Dual Eligible Beneficiaries

MAP determines the priority measure gaps through deliberations that consider available measures to address high-leverage opportunities, program, and population needs. The high-priority gap areas were aspirational from the outset and continue to persist in the current environment. As a result, the list of gaps has not been changed since the previous report. (The MAP **Dual Eligible Beneficiary Population Interim Report 2012** includes a more expansive list of measure gaps for dual eligible beneficiaries.) This consistency emphasizes that new and improved measures are still urgently needed to evaluate:

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

Commenters continued to support the prioritized measure gaps for dual eligible beneficiaries. Two voiced concern about the lack of measures applicable to people who are frail and/or older than age 75. Another organization suggested addressing measure gaps by building new measures of experience of care on existing clinically-oriented measures. Another commenter suggested MAP further define the gap in psychosocial needs to support measure development in this area, offering one recently published by the Institute of Medicine. It defines psychosocial as "interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social or environmental factors with the aim of reducing symptoms of disorders and improving functioning or well-being."[10]

The Challenge of Measure Development

Gaps in Measure Methodology to Address Priority Areas

The prioritized measure gaps persist in part because they are difficult topics to assess and may require new or complex methodology. MAP's **2014 Input on Quality Measures for Dual Eligible Beneficiaries**, described activities by measure developers that directly address the high-priority gaps in assessment and care planning, as well as goal assessment and achievement. Instead of relying solely on existing methods, measure developers are putting forth significant effort and innovation in measurement science.[11] For example, it is difficult to quantify subjective concepts such as the gap area of "beneficiary sense of control/autonomy/self-determination" and to determine a fair target. This work to develop and test new methodologies may take time and resources, but promising progress is already being made.[12]

Similar to the previously discussed challenge of involving vulnerable populations in clinical research, measures are rarely constructed with complex beneficiaries in mind. It is not typical to separately test measures for reliability, validity, and other features in a dual eligible beneficiary population. MAP recommends testing applicable measures across populations to understand and appropriately encourage their use. Several commenters encouraged the appropriate testing of measures in dual beneficiary and high-need sub-populations. One commenter suggested that lower thresholds for validity and reliability may be acceptable when using measures in at-risk populations, provided that this experimentation takes place outside of payment programs. This could allow the field to gain more knowledge and improve the scientific properties of measures and their performance over time.

Support for New and Existing Measure Developers Is Needed

The MAP process has yielded many interesting and promising ideas for measure concepts that would greatly expand the current portfolio of relevant measures. However, a relatively small number of organizations have been responsible for the creation of NQF-endorsed measures to date. Others interested in participating in measure development lack a clear path forward and find the process daunting. Measure development requires sophisticated technical expertise, financial resources—up to hundreds of thousands of dollars per measure for full development and NQF endorsement—and significant time spent by staff, expert committees, and partners participating in real-world testing. It is typical for the development of a measure to take two to three years, and this varies based on the complexity of the measure and the testing process.[13] Testing alone is highly time-consuming, with steps such as convening an advisory group for review, field testing through multiple measurement periods, and provisionary use for a year or more. Entities new to measure development may struggle to navigate these complexities, despite resources such as the CMS Measure Management System Blueprint.[14] One commenter identified several organizations with promising measure sets in need of additional resources to complete field testing. Some stakeholders called for a more streamlined and transparent measure development process, where successes, failures, and best practices can be shared and benefit everyone.

NCQA has estimated the average cost to develop a measure or measure set is about $500,000.[15] These costs are perceived to be increasing along with other activities in healthcare. Common funding sources are public and private grants or contracts. Recent pieces of legislation make additional opportunities available.[16,17] However, the business case for measure development is shifting. Some stakeholders have a strong interest in making measures freely available. While desirable from the perspective of the public good, unlimited access to measures detracts from the incentive that developers would otherwise have to derive revenue from licensing their products.[18]

Emerging Opportunities to Address Measure Gaps

Home and Community-Based Services Project

MAP members recommended coordination with another NQF project, **Measuring Home and Community-Based Services (HCBS) Quality**. That project is guided by a multistakeholder committee and charged with developing a conceptual framework for HCBS measurement and performing an environmental scan to address performance measure gaps in home and community-based services. The Committee will then make recommendations for HCBS measure development efforts. MAP viewed that this coordination was particularly critical due to the fact that many people who use HCBS are dual eligible beneficiaries who need long-term services and supports to remain independent. The environmental scan, in particular, may reveal findings of interest to MAP.

Measure Concepts

MAP often has the opportunity to react to measure concepts throughout the development process, typically providing suggestions for further refinement or preliminary guidance for use in the dual eligible beneficiary population. Most recently, MAP noted a variety of interesting measure ideas or concepts from the alignment analysis and interviews to collect feedback on measure use. **Appendix G**, Potential Gap-Filling Measure Concepts, includes these potential measure concepts in topics such as HCBS, consumer experience, shared decisionmaking, and beneficiary sense of control and autonomy.

ADVANCING THE AGENDA OF PERSON- AND FAMILY-CENTERED CARE

One theme that has united MAP's body of work on quality measurement for dual eligible beneficiaries is recognition of the need to move quickly toward a more person- and family-centered approach to delivering healthcare services and long-term supports. Person- and family-centered care (PFCC), as defined by NQF's 2014 **Measure Gaps: Person-Centered Care and Outcomes** project, is an approach to planning and delivery of care across settings and time that is centered on 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 priorities, goals, needs, and values. PFCC helps set a high standard that all should strive to surpass.

MAP members discussed a broader interpretation of the PFCC concept, emphasizing that the term "care" is not appropriate in the disability community and that healthcare is just one part of achieving the well-being desired by dual eligible beneficiaries. They noted that systems should mirror the needs of consumers, empower self-direction and self-help when possible, and provide for continuity of care. Person-centered approaches to delivering services and supports, such as shared decisionmaking, are not always intuitive or straightforward. Rather, they are competencies that must be learned.

MAP's long-term interest in advancing PFCC stems from the recognition that performance measurement is a tool to document and quantify healthcare quality. As a tool, it provides evidence of the underlying success, or failure, of the healthcare delivery system in achieving positive outcomes for consumers. It is not measurement itself, but rather the quality improvement strategies implemented by practitioners, health plans, and others in the delivery system that are the most influential in achieving change. With MAP's Family of Measures for Dual Eligible Beneficiaries now well-established as its guidance for measure selection and use, MAP explored and discussed practical strategies for enhancing PFCC.

Health Disparities and Sociodemographic Status (SDS)

There are nearly 10 million people in the United States currently eligible for both Medicare and Medicaid.[19] It is widely recognized that, on the whole, dual eligible beneficiaries are in relatively poor health, affected by a markedly high rate of all types of disabilities and chronic medical conditions, likely to be socially isolated, and more costly to the Medicare and Medicaid programs than other enrollees.[20] Further, dual eligible beneficiaries who are part of racial, ethnic, and/or linguistic minority groups experience additional barriers throughout the healthcare and LTSS systems. An estimated 44 percent of dual eligible beneficiaries are from communities of color, compared to 17 percent of the Medicare-only population.[21,22] Each of these factors can individually contribute to disparities in healthcare; when the risks are combined, their effect is even more powerful.

The population of dual eligible beneficiaries is heterogeneous, yet unified by the common characteristics of complex medical and social needs, low income, and the experience of seeking care in a fragmented system ill-suited to provide holistic supports. In these ways, the poverty in which they live is much more textured than a simple lack of cash. Dual eligible beneficiaries' health and quality of life are also influenced by a persistent lack of social capital and informal resources. The Robert Wood Johnson Foundation has published a series of maps illustrating the dramatic impact that living in an impoverished community can have on lifelong health, with double-digit differences in life expectancy observed in neighborhoods just a few miles apart.[23]

Can We Better Understand and Address Disparities with Measurement?

Health disparities are the result of numerous complex influences, and consumers' socioeconomic and other demographic factors influence outcomes through a variety of pathways. This complexity poses a challenge to equitable measurement of quality in the healthcare delivery system. Following the core principle that disparities in health and healthcare should be identified and reduced, NQF has been working to identify and examine the issues related to risk-adjusting measures for SDS.

Risk adjustment is a statistical method to account for patient-related factors when computing scores, generally producing a ratio of observed-to-expected performance. The inclusion of SDS in risk adjustment models has been controversial. One view of the issue is that adjusting for SDS factors will mask disparities, while another holds that adjusting for SDS is necessary to avoid making incorrect inferences in the context of comparative performance assessment. NQF has begun a two-year trial period during which it is allowing for the inclusion of SDS factors in measures submitted for endorsement review, provided that there is a conceptual basis and empirical evidence for the effect of the factors used and the endorsed measure also includes stratification for transparency.

This debate intersects with the work of the Dual Eligible Beneficiaries Workgroup because this population typically receives services from safety net providers and specialized health plans such as Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). Quality information is increasingly available to beneficiaries when choosing providers and health plans, and it is essential that adequate and accurate information be provided to dual beneficiaries along with other healthcare consumers. When measurement programs use a national average (rather than peer groups) to determine a benchmark or performance threshold and measures within the program are not risk-adjusted, entities that serve a higher proportion of dual eligible beneficiaries may be disadvantaged.[24] Specifically, the Hospital Readmission Reduction Program and Medicare Advantage Star Ratings deserve continued scrutiny to determine how they could be more equitable in promoting improved quality without reducing the system's willingness to enroll or treat complex consumers. MAP will continue to monitor the evidence and debate related to sociodemographic risk adjustment to inform future work.

Several commenters supported the NQF two-year trial period to explore and further understand the implications of risk adjustment of some measures for sociodemographic status variables. Other comments were mixed; MAP heard concern about both the presence and the absence of adjustments for SDS factors. Opinions diverged regarding the approach believed to be most accurate.

Strategies to Better Address the Unique Needs of Dual Eligible Beneficiaries

To better understand how safety net providers and health plans are responding to the complex health and social needs of the dual eligible beneficiaries they serve, MAP sought information from practitioners in the field. The care delivery models described below have proven successful, and MAP encouraged wider dissemination and uptake of their practices. Public comments were also supportive of MAP's interest in models of person-centered care.

Promoting Health Resilience Through Trauma-Informed Care and Reduction of Polypharmacy

CareOregon, the largest Medicaid managed care plan in Oregon, is gaining recognition for their successful Health Resilience Program (HRP) to provide trauma-informed care management. The majority of HRP clients have a history of adverse childhood experiences such as exposure to violence, neglect, or parents who experienced mental illness and/or substance abuse. It is now well understood that these types of experiences have lifelong effects on health as well as decisionmaking skills, communication, and ability to trust authority.[25]

Acknowledging that traditional methods of telephonic and clinic-based case management are not sufficiently person-centered for HRP enrollees, the program instead uses a team of Master's level social workers embedded in primary health homes and specialty practices. These Health Resilience Specialists enhance the practices' ability to provide individualized and community-oriented high-touch support to complex beneficiaries. Guiding principles for the HRP include reducing barriers to relationship-building, avoiding judgment and labels, and staying community-based.[26] Specialists "meet clients where they are" both literally and figuratively, seeking out homeless and transient enrollees and seeking to understand each person's individual history, strengths, and goals.

CareOregon has also developed interventions to break the cycle of medication trauma they observe among members using multiple medications and experiencing negative outcomes.[27] It follows the philosophy that, "fewer medications taken the right way for the right length of time is better than lots of medications taken the wrong way and stopped due to side effects, drug interactions, confusion, and fear." Among 1,000 high-risk members studied, individuals averaged 30 different drug/dosage/strength combinations and 12 different prescribers in a single year. CareOregon developed a simple chart for consumers' use in self-management and organized a network of pharmacists to screen and manage high-risk beneficiaries. To date, the program has been a win-win—reducing polypharmacy produced better outcomes for consumers and a significant return on investment for the health plan.

Integrating Behavioral Health

Mental illness and substance abuse conditions, especially common among dual eligible beneficiaries under age 65, are major drivers of disability and cost. However, only a small number of consumers are able to access services and treatment for behavioral health conditions, and even fewer are in contact with trained mental health professionals. Without access to specialty care, most behavioral health services are delivered through primary care. Evidence-based integrated models have emerged that include the use of care managers, behavioral health consultants, and behavioralists to improve the efficacy of treatment. For example, Unützer's IMPACT (Improving Mood – Providing Access to Collaborative Treatment) model integrates depression treatment into primary care and has proven more effective and less costly than traditional approaches.[28] The model has been adapted to treat depression and other mental disorders in a wide range of consumers, including those with diabetes and cancer. Other scalable models have been developed by the Massachusetts Child Psychiatry Access Project, California's Integrated Behavioral Health Project, Cherokee Health Systems, and the Institute for Clinical Systems Improvement.[29]

Behavioral health integration can also be approached from a systems perspective. Denver Health is a public safety net health system that has achieved national recognition as a leader in high-quality healthcare. Their stellar performance can be attributed to many factors, among them a strong emphasis on LEAN process engineering and a diverse network of wraparound services and community partnerships. For example, the organization operates Comprehensive Addictions Rehabilitation and Evaluation Services (Denver CARES), a 100-bed, nonmedical facility that provides a safe detox setting for individuals found inebriated in public and transported by an emergency service patrol, avoiding a more costly and less appropriate trip to a hospital emergency department or police custody.[30] Denver Health also works closely with schools, the public health system, and social services to address whole-person wellness and improve outcomes.

Team-Based Care for Geriatric Conditions

In the population of dual eligible older adults, consumers with multiple chronic illnesses and functional limitations can benefit from specialized approaches. MAP explored the Geriatric Resources for Assessment and Care of Elders (GRACE) model as one example. GRACE provides person-centered care planning and implementation, integrating medical and social care for complex older adults. Using an in-home geriatric assessment, GRACE identifies unmet needs for care and supports and improves diagnosis of geriatric syndromes by primary care physicians. Service delivery from an interdisciplinary team is driven by use of specific protocols and a network that integrates pharmacy, mental health, hospital, home health, and community-based services. The improved quality and lower costs associated with the GRACE model have been successfully replicated in a variety of healthcare environments.

GUIDANCE FOR SYSTEM IMPROVEMENT

Examining quality of care and performance measurement from the perspective of a population—namely, dual eligible beneficiaries—consistently challenges MAP to craft recommendations that are consumer-centered. As a result, MAP's input on the future direction of quality measurement is consistently aspirational and will require the collective action of stakeholders across the health and LTSS systems to innovate the future state.

MAP's 2015 review involved a large volume of information about performance measures and their use, yet discussion repeatedly circled back to the recognition that consumers' health outcomes and quality of life should be the primary driver of a redesigned, integrated system. Participants emphasized a well-understood but frequently forgotten fact: the purpose of healthcare and LTSS is to help consumers live the lives they want to live. The delivery system must respond by putting consumers in control of setting health-related goals and providing them with adequate supports and information to engage them as equal partners. To put it simply, "people will not do what's good *for* them unless it's important *to* them."

In this report, MAP has expanded on its body of recommendations to HHS regarding the use of quality measures in the dual eligible beneficiary population. Though much collaboration is needed to achieve an improved future state of measurement and of healthcare and LTSS generally, MAP also explored and supported a variety of short-term actions. First, align current reporting requirements by focusing on measures from the MAP-supported Family of Measures for Dual Eligible Beneficiaries that demonstrate good fit-for-purpose with program goals. Second, eliminate nonessential measurement, attestation, and regulatory requirements to free up system bandwidth for innovation. Next, to better understand the impact of disparities in the dual eligible population (and to enable future action to address them), stratify measures using variables of interest. Finally, to produce better outcomes for dual eligible beneficiaries and other at-risk groups, stimulate the adoption of specialized care models that are designed to meet their unique needs. These actions are consistent with the goals of the NQS and the ongoing quest to create a more person- and family-centered system.

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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.[1]

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 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 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.

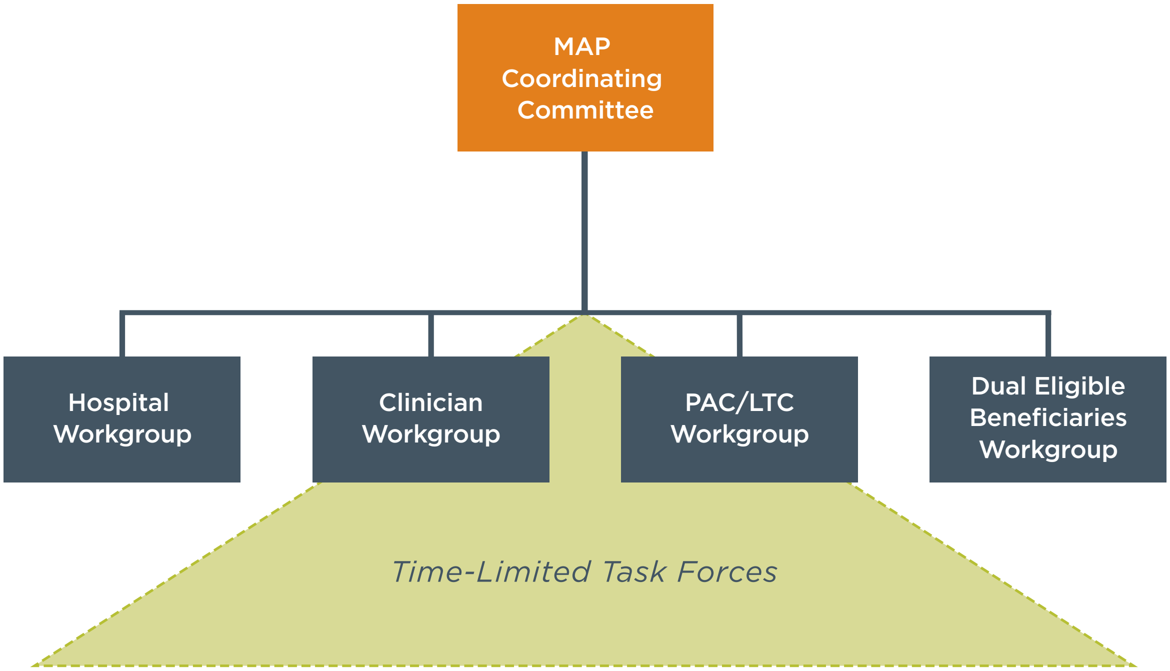
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for 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 whether 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 Exhibit A1). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and provides 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.

EXHIBIT 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 2015 Pre-Rulemaking Deliberations**).

Additionally, MAP engages in strategic activities throughout the year 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 and Child Core Sets and the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces.

ENDNOTE

[1] Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014.2010: p.260. Available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Last accessed August 2015.

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

MAP Dual Eligible Beneficiaries Workgroup

CO-CHAIRS (VOTING)
Jennie Chin Hansen, RN, MS, FAAN
Alice Lind, MPH, BSN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
AARP Public Policy Institute	Susan Reinhard, RN, PhD, FAAN
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Gregg Warshaw, MD
American Medical Directors Association	Gwendolen Buhr, MD, MHS, MEd, CMD
America’s Essential Hospitals	Steven Counsell, MD
Center for Medicare Advocacy	Kata Kertesz, JD
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE
iCare	Thomas H. Lutzow, PhD, MBA
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Mady Chalk, MSW, PhD
Anne Cohen, MPH
James Dunford, MD
Nancy Hanrahan, PhD, RN, FAAN
K. Charlie Lakin, PhD
Ruth Perry, MD
Gail Stuart, PhD, RN

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Office of the Assistant Secretary for Planning and Evaluation	D.E.B. Potter, MS
Centers for Medicare & Medicaid Services	Venesa J. Day
Administration for Community Living	Jamie Kendall, MPP

Measure Applications Partnership Coordinating Committee

CO-CHAIRS (VOTING)
Elizabeth McGlynn, PhD, MPP
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Lynda Flowers, JD, MSN, RN
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Shaun O’Brien
America’s Health Insurance Plans	Aparna Higgins, MA
American Board of Medical Specialties	R. Barrett Noone, MD, FAcS
American College of Physicians	Amir Qaseem, MD, PhD, MHA
American College of Surgeons	Frank Opelka, MD, FACS
American HealthCare Association	David Gifford, MD, MPH
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
Blue Cross and Blue Shield Association	Trent T. Haywood, MD, JD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip N. Kahn, III, MPH
Healthcare Financial Management Association	Richard Gundling, FHFMA, CMA
The Joint Commission	Mark R. Chassin, MD, FACP, MPP, MPH
The Leapfrog Group	Melissa Danforth
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Steve Wojcik
National Committee for Quality Assurance	Mary Barton, MD, MPP
National Partnership for Women and Families	Carol Sakala, PhD, MSPH
Network for Regional Healthcare Improvement	Elizabeth Mitchell
Pacific Business Group on Health	William E. Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher M. 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

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Richard Kronick, PhD/Nancy J. Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MH, FACP
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD, FACP

NQF Project Staff

STAFF MEMBERS	TITLE
Megan Duevel Anderson	Project Manager
Sarah Lash	Senior Director
Zehra Shahab	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 relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set.

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.

Subcriterion 1.1	Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need
Subcriterion 1.2	Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs
Subcriterion 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:

Subcriterion 2.1	Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment
Subcriterion 2.2	Healthy people/healthy communities, demonstrated by prevention and well-being
Subcriterion 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.

Subcriterion 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)
Subcriterion 3.2	Measure sets for public reporting programs should be meaningful for consumers and purchasers
Subcriterion 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)
Subcriterion 3.4	Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program
Subcriterion 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

Subcriterion 4.1	In general, preference should be given to measure types that address specific program needs
Subcriterion 4.2	Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes
Subcriterion 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

Subcriterion 5.1	Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination
Subcriterion 5.2	Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives
Subcriterion 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).

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

Subcriterion 7.1	Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)
Subcriterion 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:
Public Comments Received

General Comments on the Draft Report

American Psychiatric Association

Samantha Shugarman

The American Psychiatric Association, the world's largest psychiatric organization representing a growing membership of more than 36,000 psychiatrists, appreciates the opportunity to comment on this report.

America's Health Insurance Plans

Carmella Bocchino

Overall the report is very well written and communicates the issues clearly. We support the effort for alignment with other programs however question the large amount of measures for the Dual Eligible group which is over 70 measures as shown in **Appendix [E]**. MAP should recommend an optimal number of measures for the program that is less burdensome and results in meaningful quality measurement and improvement.

A more effective approach would be to implement a targeted number of measures that meet specific health care quality goals such as evidence-based quality of care and a reduction of unwarranted overutilization of services. MAP should consider alignment and stratification of current measures where possible and prioritizing measures to help with reducing the number of measures in programs.

We also encourage more research on dual eligible populations (e.g. determine what this population needs and or expects from the health care system?) Determining more appropriate levels of engagement and patient-centered care for the unique duals populations will help with continued quality improvement.

We also believe that the report should focus more on outcomes that emphasize improvements in beneficiaries' health as opposed to process measures. We encourage the selection of outcomes measures with more direct linkage to the actions and influences of a health plan rather than those that have a broad focus and are influenced by a number of external variables outside the immediate control of a plan. In particular, we suggest greater weight be given to measures, based on rigorous scientific and evidence-based information, than to measures that are constructed from enrollee surveys, which may be subject to imperfect recall. Survey responses are also difficult to translate into actionable or targeted improvements because answers are often not specific.

In measuring and holding accountable health plans for providing high quality coverage to all beneficiaries, the challenges associated with providing care to the dual eligible population should be taken into account especially as a plan's share of low-SES membership increases.

Center for Medicare Advocacy, Inc.

Kata Kertesz

The Center for Medicare Advocacy (Center) appreciates the opportunity to comment on the draft report.

The Center, founded in 1986, is a national, non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality healthcare. We draw upon our direct experience with thousands of individuals and their families to educate policymakers about how their decisions affect the lives of real people. Additionally, we provide legal representation to ensure that beneficiaries receive the health care benefits to which they are legally entitled, and to the quality health care coverage and services they need.

We agree with the NQF assessment in this draft report that "measurement is valued for its ability to highlight problems, promote action to improve quality, and document success. … consumers [use quality measurement information] to make informed choices about where and from whom to seek healthcare services." (Pg 5). We therefore take this opportunity to underscore our concern regarding NQF's two year trial allowing for the inclusion of socioeconomic status/ socio demographic status (SES/SDS) factors in measures submitted for endorsement review. We continue to be concerned that such risk adjustment may lead to masking disparities in care for dual eligibles.

The draft report indicates in several areas that the concern exists that without risk adjustment for SES/SDS factors, safety net providers would be disadvantaged. We urge NQF to address the potential concern that dual eligibles would be disadvantaged through risk adjustment alongside the discussion of the potential provider disadvantages. Though the report does mention the concerns regarding potentially masking disparities through risk adjustment, and that there is an ongoing debate regarding this issue, we request that the final NQF report convey this concern alongside the concern of safety net providers being disadvantaged that is mentioned in the report, as well as emphasize the established lack of data currently available on this issue.

We are encouraged that NQF is only using a trial period, while continually monitoring evidence and the debate related to SDS risk adjustment. We look forward to reviewing the final report regarding the data collected, in order to ensure the dual eligible beneficiaries are not negatively impacted by risk adjustment for SDS.

Community Catalyst

Renee Hodin

Community Catalyst is a national consumer health advocacy organization whose mission is to organize and sustain a powerful consumer voice to ensure that all individuals and communities can influence the local, state and national decisions that affect their health. Through our Voices for Better Health project, we have been deeply involved in supporting a successful implementation of the Financial Alignment Initiative for dual eligible beneficiaries at both the national and state levels. We understand how important the goal of coordinated, integrated care is for these beneficiaries with complex health and social needs and that being able to appropriately measure quality that captures true patient and family centered care is an integral part of achieving this goal. We were pleased to offer feedback during the development of the draft report and are impressed with the final draft.

Our comments are intended both to reinforce many of your findings and recommendations and to urge NQF to move ahead with work on the high priority measure gaps documented in the interim July 2013 and the February 2014 reports to CMS and with the additional four high priority measure gaps (pages 14-15) that include beneficiary experience, HCBS access and rebalancing, health and general well-being (shift away from purely clinical outcomes) and social determinants of health.

Consortium for Citizens with Disabilities

E. Clarke Ross

American Association on Health and Disability (AAHD): applauds NQF for retaining the 2013-2014 high priority measure gaps and for the expanded discussion and insights on these needs and complexities. AAHD reinforces the important themes in the report, such as measure alignment (pages 5-6), effective communication and care coordination (page 9), the balance between persons with disabilities-behavioral health-cognitive impairment (page 10), and the addition of behavioral health measures (page 17).

Florida Hospital

John Hood

I am writing on behalf of Adventist Health System (AHS) to share our comments on the MAP Dual Eligible Beneficiary Performance Measurement Draft Report. AHS includes 44 hospital campuses located across 10 states and comprises more than 8,000 licensed beds. Our organization provides inpatient, outpatient and emergency room care for four million patient visits each year.

It is our view that the National Quality Forum (NQF) has identified the relevant key issues surrounding measure development for this population. The draft report recognizes the complexity of establishing measures for the dual eligible beneficiary population due to the prevalence of complicated medical needs.

It also discusses significant challenges relating to the sociodemographic factors affecting the health of this population. This is a clear recognition and illustration of the necessity of risk adjustment. The report does well to recognize the problems of polypharmacy, access to care and the high presence of mental health and substance abuse issues in this population.

Henry Ford Hospital

David Nerenz

Henry Ford Health System appreciates the opportunity to comment on the recently-released Measures Application Partnership (MAP) report on performance measurement for the dual eligible population. We generally support the approach taken by MAP in this report and in the specific recommendations on alignment of measures in the MAP Dual Eligible Beneficiaries Family of Measures.

HFHS serves many Medicaid beneficiaries, including dual-eligibles, across the region. Henry Ford Hospital, our main hospital located in midtown Detroit, is a Disproportionate Share Hospital facility, which is committed to the equitable delivery of culturally appropriate care to beneficiaries within its service area. HFHS, through its subsidiary HAP Midwest health plan, also participates in Michigan Medicaid programs, including the new dual-eligible demonstration project, called MI Health Link

Dual eligibles are either low income seniors or adults under age 65 with severe physical disabilities and/or substance abuse and mental health issues, and are a challenging population to serve. As hospitals, physicians, health systems and health plans assume more risk for managing the care of dual eligibles, it is critical that financial and quality performance measures are sensitive to characteristics of this unique population. We strongly agree that socio-demographic status (SDS) be included in risk adjusting performance measures for the dual-eligible population and applaud the two-year trial that NQF has begun, which will include SDS factors in measures submitted for endorsement review (p. 21). We urge NQF to go further, and look for ways to prioritize updates to the existing Family of Measures for the dual eligible population that would include SDS factors.

The SNP Alliance

Richard Bringewatt

The SNP Alliance is pleased to respond to the National Quality Forum's request for comment on the draft report titled, Advancing Person-Centered Care for Dual Eligible Beneficiaries through Performance Measurement: 2015 Recommendations from the Measure Applications Partnership.

The SNP Alliance is a national membership organization dedicated to improving policy and practice of Medicare Advantage Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). The Alliance represents 31 Managed Care Organizations that collectively operate 266 SNPs (141 D-SNPs, 79 C-SNPs and 46 I-SNPs) in 39 States and the District of Columbia.

Member organizations also operate 29 MMPs that operate in all nine states currently in the capitated Financial Alignment Initiative. All D-SNPs exclusively enroll dually eligible beneficiaries and two-thirds of SNP Alliance members operate plans certified as Fully Integrated Dually Eligible Special Needs Plans (FIDESNPs). In addition, a large proportion of beneficiaries enrolled in I-SNPs and C-SNPs also are dually eligible.

The Alliance is very supportive of NQF's efforts to improve performance measurement and the quality of care for dual eligible beneficiaries. We are pleased to be represented on the MAP Dual Eligible Beneficiaries Workgroup and to submit the following comments on the draft report.

The SNP Alliance appreciates the continued efforts of the Measure Applications Partnership (MAP) to improve the quality of care of dual eligible beneficiaries by considering how their unique characteristics and needs should be addressed in the context of performance measurement. This is an area of great concern to the SNP Alliance, which has advocated since the implementation of the Medicare Advantage (MA) Star Rating System for the development of a parsimonious set of performance measures specific to the characteristics and needs of dual eligible beneficiaries as well as specialize needs individuals, many of whom are served by dual eligible plans. While progress has been made due to the efforts of the MAP and others, much work remains to be done.

The current dual eligible beneficiaries family of measures is helpful to payers/plans/providers/consumers but remaining measurement gaps are large and prevent us from measuring performance in key areas for duals including care coordination, care planning, care for frail elders—the “old-old,” beneficiary autonomy, etc. and in measuring the collective performance of related providers. We strongly support NQF efforts to move performance measurement forward in these key areas, while at the same time adhering to the important principle of parsimony.

We, along with others referenced in the report, have major concerns that the continued proliferation of measures will lead to increased data collection and reporting requirements without a commensurate benefit in quality and cost performance. The volume of measures, even within the draft report, has the potential to diffuse focus on targeted improvement and even hinder progress in some priority areas. The SNP Alliance is strongly committed to using performance measurement for accountability purposes and to enabling performance improvement in areas of priority interest. However, we believe it would be much more prudent to focus oversight activity on a very targeted set of measures where there is clear evidence of a strong relationship to improving total quality and cost performance. We believe this value proposition should be applied to Star metrics as well, with particular regard for the contribution of each metric to improving the total quality and cost performance of care for high-risk/high-need beneficiaries.

We also believe it is important to give priority to issues of importance in serving defined population segments, primarily in relation to advancing the collective performance measurement of related providers in serving defined population segments. Most performance metrics today are excessively weighted on monitoring specific interventions, by specific providers, at specific points in time and fail to address the multi-dimensional, interdependent, and ongoing nature of care for frail, disabled, chronically ill persons as their volatile and complex needs evolve over time and across care settings.

In addition, we appreciate the continued attention that the MAP has given to the relationship between individuals’ sociodemographic characteristics and performance measurement in this report and reiterate our support for the NQF’s decision in 2014 to implement a trial period during which measures are adjusted for sociodemographic factors. In order to accurately assess the relative performance of plans and/or providers that serve dual eligible beneficiaries, it is critical that measure scores are adjusted for differences in the socio-demographic characteristics of individuals over which plans and/or providers have little control. We also believe measurement must account for factors, such as obesity, substance abuse, and mental illness, that also affect quality rating of dual beneficiaries, independent of standard medically-related interventions. This is especially important when performance results are used to inform consumer choice and in pay-for-performance models such as the Medicare Star rating system. Simultaneously, stratification of measures allows for identification of disparities that must be addressed.

WellCare Health Plans, Inc.

Kiersten Adams

WellCare appreciates the opportunity to comment on the Dual Eligible Beneficiaries Family of Measures. Reporting numerous measures for different organizations can be a challenging and lengthy task for health plans and providers. After reviewing the Dual Eligible Beneficiaries Family of Measures, WellCare believes that many of these measures coincide with the National Committee of Quality Assurance (NCQA) set of measures. This greatly reduces the burden of reporting. WellCare believes that further coordinating these measures with NCQA and the Healthcare Effectiveness Data and Information Set (HEDIS) will provide a greater opportunity to consolidate the Family of Measures, thus facilitating the measure reporting process for health plans and providers.

WellCare appreciates the continued recognition of the effects that sociodemographic factors including socioeconomic status have on the dual eligible population. We are concerned about the implications these measures may have on health plans and providers that serve large proportions of dual eligibles. Because dual eligibles tend to have a higher chance of experiencing adverse outcomes, plans and providers that service large portions of this population may suffer from data misrepresentation if these measures are not properly accommodating for risk within the dual eligible population. We urge the MAP to consider testing the impact of risk adjustment and stratification on the Dual Eligible Beneficiaries Family of Measures.

Comments on Alignment and Feedback Loops

American Psychiatric Association

Samantha Shugarman

While we agree that alignment should be a priority, we want to remind the MAP not to overlook the naunced specifications of measures that could create potential harms when inserting a measure into a new program for the purposes of alignment.

Considering the time and expense required in measure development and maintenance, before a measure development effort begins, it should be a strong recommendation made by the MAP and communicated by CMS of the developer to research any pre-existing measures that already track the process or outcome, or look for measures that could harmonize with the new concept.

The APA is concerned that due to the lower adoption rate of EHR's by psychiatrists, this could affect the alignment of behavioral health and substance use measures.

America's Health Insurance Plans

Carmella Bocchino

We agree with the alignment of measures with relevant programs and the feedback loops regarding use and utility of measures. We support the work to use measures that work well across all settings and programs to not burden providers and plans.

Community Catalyst

Renee Hodin

Community Catalyst supports the AAHD's recommendation that the MAP add the beneficiary perspective, including those of persons with disabilities, to the statement on page 13: "health plan representatives expressed frustration about measures that would require direct influence over or partnerships with other entities."

Consortium for Citizens with Disabilities

E. Clarke Ross

American Association on Health and Disability (AAHD): request that the beneficiary perspective, including those of persons with disabilities, be added to the page 13 statement: "health plan representatives expressed frustration about measures that would require direct influence over or partnerships with other entities." The fundamental reality is that dually eligible persons are served and supported by multiple community-based entities - both clinical and social support entities. To measure the quality and appropriateness of whole health and the whole person, health plans must integrate with and report activities with these other entities. We request that this beneficiary perspective be added after this statement about health plan representatives' frustration.

Florida Hospital

John Hood

AHS commends the Measure Application Partnership (MAP) for recognizing the dearth of alignment of dual eligible population measures across measurement programs. Again, this reflects the complexity of the population being addressed.

We strongly support the position taken by the NQF that non-essential measurement attestation and regulatory requirements need to be eliminated in order to free up systems' bandwidth for innovation. In order for systems to improve their approach toward general and special populations, the measurement and accountability process must be simplified. An overabundance of measures reduces the resources available to invest in quality improvement because they are consumed by data collection and reporting efforts. We do not think complicated measures are better. Our position is that measurement programs should prioritize a smaller set of measures that are highly reliable and have high correlation with meaningful patient outcomes. This will ensure that we are in fact measuring quality, while at the same time not inordinately committing resources to measurement just for the sake of measurement.

Henry Ford Hospital

David Nerenz

We support the MAP's position of better alignment of performance measures across programs that serve dual eligible beneficiaries and developing a "family" of measures from which program administrators can select to best meet the needs of this vulnerable population (p. 5). We believe that ultimately this approach will improve providers' ability to focus limited resources on measures that most meaningfully impact patient care processes and patient outcomes. That said, we have some caution about widespread adoption of performance measures developed for the general population being used for the dual eligible group. We need to be sure that the performance measures developed for the dual eligible population appropriately reflect the vulnerabilities of this population.

The SCAN Foundation

Megan Burke

Thank you for the opportunity to comment. The SCAN foundation supports the continued efforts to develop measures for dual eligible beneficiaries, and recommends the following:

Measure Alignment: Measure alignment is critical to assessing and comparing quality across programs and regions. Barriers to comparability of long-term services and supports (LTSS) quality measures exist due to the limited number of LTSS measures and lack of alignment across states. Aligning quality measures will help to create a stronger system of accountability and a uniform discussion that can influence system improvement. However, in working towards alignment, usefulness and applicability of the quality measures cannot be sacrificed. The majority of the quality measures are clinically based, and do not translate well to measuring quality in the LTSS system. It is important work continues to develop quality measures specifically applicable to LTSS and its linkage to other services as part of an integrated system of care.

Person-Centered Care Measures: Most quality measures identify outcomes from an acute care systems perspective, rather than measuring quality from the individual's perspective. The problem with this approach is that the measures do not reflect the totality of the experience of the person receiving care, particularly for those who have serious chronic illness and functional limitations. New quality measures must get at the essence of how people experience care delivery and what their values are in these interactions, building upon the important clinically-oriented measures. Person-centered quality measures include measures that are based on the individual's goals, which are often focused on the ability to function in their day-to-day lives. Developing person-centered care measures focused on the individual experience, rather than the process, may also address the issue of alignment.

Universal Assessment: The report identifies data limitations present in using medical records, administrative, and claims data as they do not provide a fully informed picture of the individual. An individualized assessment process with connected uniform data elements that address both health and functional items (often referred to as "universal assessment") can be used to evaluate one's needs in a consistent manner and create a care plan tailored to that person's strengths, needs, and service/support preferences in an equitable manner. This information can be utilized not only for service delivery purposes, but also to support quality measurement by gathering information that can be used to construct LTSS quality measures.

The SNP Alliance

Richard Bringewatt

The SNP Alliance is pleased to respond to the National Quality Forum's request for comment on the draft report titled, Advancing Person-Centered Care for Dual Eligible Beneficiaries through Performance Measurement: 2015 Recommendations from the Measure Applications Partnership.

The SNP Alliance is a national membership organization dedicated to improving policy and practice of Medicare Advantage Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). The Alliance represents 31 Managed Care Organizations that collectively operate 266 SNPs (141 D-SNPs, 79 C-SNPs and 46 I-SNPs) in 39 States and the District of Columbia.

Member organizations also operate 29 MMPs that operate in all nine states currently in the capitated Financial Alignment Initiative. All D-SNPs exclusively enroll dually eligible beneficiaries and two-thirds of SNP Alliance members operate plans certified as Fully Integrated Dually Eligible Special Needs Plans (FIDESNPs). In addition, a large proportion of beneficiaries enrolled in I-SNPs and C-SNPs also are dually eligible.

The Alliance is very supportive of NQF's efforts to improve performance measurement and the quality of care for dual eligible beneficiaries. We are pleased to be represented on the MAP Dual Eligible Beneficiaries Workgroup and to submit the following comments on the draft report.

The SNP Alliance shares the concerns of the MAP and others that the overall performance measurement system is growing increasingly inefficient as the number of performance measures grows and related requirements increase. Efforts to focus attention on measures of greatest importance and to align these measures across programs are paramount.

While it is helpful to understand the extent to which measures in the dual family are used across programs, measures from the dual family constitute a small fraction of the measures that are being used in public programs. It would be helpful to undertake an alignment analysis to look at the consistency of measure use across Medicare and Medicaid to get a broader picture of the extent to which measures are aligned for these two programs. This would also provide insight into the extent to which quality goals are aligned and plans and different providers are incentivized to work towards common quality objectives.

We share the concerns of the MAP Dual Eligible Beneficiaries Workgroup that the most frequently adopted measures from the family of dual measures do not address issues that are specific to duals, most notably issues related to social demographic factors that adversely affect health outcomes among dual beneficiaries as well as factors that are particularly important in serving frail elders, adults with disabilities, and other persons with complex medical conditions, such as SPMI, ESRD, and HIV-AIDS—the most vulnerable and costly subsets of the dual population. To remedy this, we encourage the MAP to continue and, to the greatest extent possible, expand its focus on efforts to fill important measurement gaps.

Referring to the findings from the feedback interviews on measure use, the SNP Alliance's experience is consistent with much of what was reported, e.g., the intensity of resources required to respond to external program reporting requirements limits opportunities to collect other measures, and concerns regarding the application of general measures to high-risk populations. With respect to the latter, SNPs often are disadvantaged in comparisons with general Medicare Advantage plans due to the greater prevalence of high-risk/high-need beneficiaries among their enrollees. While HEDIS measures are important to all Medicare beneficiaries, the existing set of measures does not always include metrics or benchmark comparisons that are MOST important in serving major dual subgroups, such as persons with severe and persistent mental illness and persons with HIV-AIDS. This not only impedes a specialty care plan's ability to demonstrate its special expertise, but it creates disincentives to target certain high-risk/high-need subpopulations important to controlling long-term Medicare costs.

One issue that has been reported to us by a member plan, but was not raised in the report, relates to plans' ability to always obtain data needed for accurate performance measurement from contracted providers, e.g. lab results. This speaks to the importance of contractual and other provisions to ensure data availability and the need for interoperability of data systems used by plans and providers. Other members also have expressed concerns about the practicality of data collection processes involved with various measures, and the limitations of survey methods in measuring the performance of high-risk/high-need subgroups. We encourage NQF to continue its exploration of options for addressing the practical issues involved in performance measurement, particularly for plans that exclusively serve dual beneficiaries and plans that specialize in the care of high-risk/high-need subgroups, such as those with SPMI, in which dual beneficiaries constitute the majority of the special needs populations being served.

Further, we agree that data needed to improve performance measurement for dual eligible beneficiaries is lacking. In this area, we would like to comment specifically on the need for better data with which to identify health disparities and adjust performance measures for beneficiaries' sociodemographic characteristics. It is well known that a variety of individuals' sociodemographic characteristics impact health and health care outcomes. We strongly encourage NQF to focus on data limitations and ways to address them in its trial period during which risk adjustment of measures for individuals' sociodemographic characteristics is being tested.

Comments on the MAP Family of Measures for Dual Eligible Beneficiaries and Measure Gaps

American Association on Health & Disability

Clarke Ross

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities.

AAHD applauds NQF for retaining the 2013-2014 high priority measure gaps and for the expanded discussion and insights on these needs and complexities.

We reinforce the important themes in the report, such as measure alignment (pages 5-6), effective communication and care coordination (page 9), the balance between persons with disabilities-behavioral health-cognitive impairment (page 10), and the addition of behavioral health measures (page 17).

We request that the beneficiary perspective, including those of persons with disabilities, be added to the page 13 statement: "health plan representatives expressed frustration about measures that would require direct influence over or partnerships with other entities." The fundamental reality is that dually eligible persons are served and supported by multiple community-based entities – both clinical and social support entities. To measure the quality and appropriateness of whole health and the whole person, health plans must integrate with and report activities with these other entities. We request that this beneficiary perspective be added after the statement about health plan representatives' frustration.

As with recent NQF MAP reports to CMS on persons dually eligible, we respectfully ask NQF to again reference the National Core Indicators and Personal Outcome Measures as possible innovation models for addressing the whole person in an individualized manner.

NQF MAP (Measure Applications Partnership) Identification of Gaps

For emphasis and education of our sister organizations, we commend and repeat the draft discussion and insights on identification of gaps. We agree with the observation: "There is a lack of measures that assess aspects of care that are relevant to the medical and social complexities present in the dual eligible beneficiary population." (page 17)

The list of high priority measure gaps is reinforced and has not changed since 2013-2014. (page 18). Observations include:

1. Importance of coordination with NQF HCBS project (page 19)

2. "One theme has united MAP's body of work on quality measurement for dual eligible beneficiaries - the need to move quickly toward a more person and family centered care." "Person and family centered care is consistent with and respectful of and responsive to an individual's priorities, goals, needs, and values." "Person and family centered care is delivered across settings and time, centered around collaborative partnerships between individuals, families, and providers." (page 19).

3. Consideration of disparities and social-demographic status (page 20)

4. Importance of integrating behavioral health (page 22)

Participants surveyed by NQF MAP recommended 4 additional high priority measure gaps; these are (pages 14-15) (consistent with 2013-2014 gaps):

1. Beneficiary Experience
2. HCBS access and Rebalancing LTSS-transitions-care coordination
3. Health and general well-being (shift away from purely clinical outcomes)
4. Influence of social determinants of health

July 12, 2013 NQF to CMS Preliminary Findings report and February 28, 2014 NQF Interim Report to CMS – 7 High Priority Measure Gaps

1. Goal-directed, person-centered care planning and implementation
2. Shared decision-making
3. Systems to coordinate healthcare with non-medical community resources and service providers
4. Beneficiary sense of control/autonomy/self-determination
5. Psychosocial needs
6. Community integration/inclusion and participation
7. Optimal functioning (e.g., improving when possible, maintaining, managing decline)

Context: Consortium for Citizens with Disabilities (CCD) Task Force on Long-Term Services and Supports. In July 2012 CCD identified six gaps in existing quality standards as they directly relate to persons with disabilities. These provide a context for reviewing NQF work:

1. Consumer Choice and Participant-Directed Services
2. Satisfaction: Individual Experience with Services and Supports
3. % in employment or meaningful day activity
4. % in independent housing – Consumer choice, housing appropriateness, stability
5. Integrated primary and specialty care
6. Access to timely and appropriate care

America’s Health Insurance Plans

Carmella Bocchino

We support MAPs efforts to advance the quality of care for Medicare – Medicaid dual beneficiaries. We believe that it is essential to measure and address the specific needs of this population.

We suggest that minimizing the administrative burden on states and plans be explicitly considered when contemplating additions to the MAP Family of Measures (FOM) for Dual Eligible Beneficiaries. Measures which require medical record review are particularly challenging and involve resources, time and effort for data collection and evaluation.

Eleven of the new measures are behavioral health measures. As the states, including New York State for example, transition from Fee-for-Service to capitated and or managed care arrangements for measures with behavioral health conditions, these measure rates are likely to be unstable, both within and across the states. As such we suggest a phased-in approach to adding these measures over time. For example, for measures like # 0640 – HBIPS-2 Hours of physical restraint use, while measure specifications regarding restraint use may be clear, there is variation in how such data are captured in the medical chart. Similarly, measures that require at-home or documentation of home health practices have similar concerns.

We also continue to be concerned with the movement towards additional survey measures, such as #0228 - 3-Item Care Transition Measure (CTM-3) and #0008 - Experience of Care and Health Outcomes (ECHO) Survey questions can be subject to imperfect recall and bias. Responses to survey questions are frequently difficult to make actionable for plans, as there is not enough detail explaining what the plan should do to improve.

Finally, we suggest that the MAP prioritize these measures as in the Adult and Child Medicaid reports to recognize the reporting burden placed on providers and plans and facilitate the implementation process.

Center for Medicare Advocacy, Inc.

Kata Kertesz

The Center for Medicare Advocacy appreciates the opportunity to comment on the draft report.

We applaud NQF for studying the measure gaps for the dual eligible population and seeking to fill those gaps with appropriate quality measures in order to improve their care.

We support the observation in the draft report that there is a "lack of measures that assess aspects of care that are relevant to the medical and social complexities present in the dual eligible beneficiary population." (page 17). We request the beneficiary perspective be added to the page 13 statement: "Health plan representatives expressed frustration about measures that would require direct influence over or partnership with other entities." Dually eligible persons are served and supported by multiple community-based entities, which include both clinical and social support entities. Therefore, to measure the quality and appropriateness of the whole health and the whole person, health plans must integrate with and report activities with these other entities. We request this beneficiary perspective be added to this section on health plan frustration.

We agree with the commonly described gap areas in the report for this population. We also support the inclusion of the 11 new behavioral health measures, as this is an area lacking adequate quality measurement. We do, however, have concerns regarding the readmissions measures. While we agree that it is crucially important for appropriate care to be provided so as to limit unnecessary re-hospitalizations, we would like to highlight that readmissions figures are often inaccurate or skewed due to patients who are labeled "outpatient."

In many instances, patients who are labeled "outpatient" are actually receiving identical services and care to patients who are labeled "inpatient." In such instances, the difference is only in the classification the patient is assigned; it becomes a question of semantics and not treatment. We raise this issue in these comments to highlight the fact that these "outpatients" are not calculated into readmission statistics even though they are receiving the same care as "inpatients". We agree that it is important to study readmissions, but quality developers must balance the important goal of limiting unnecessary readmissions with the risk of increasing the number of "outpatients." We request that information regarding the increased use of the "outpatient" label be added to the section of the report on readmission measurement.

Community Catalyst

Renee Hodin

Community Catalyst appreciates the MAP's efforts to enhance the Family of Measures and to identify and prioritize essential measure gaps to be filled. In particular, we support

(1) the need for early identification of barriers to access and unmet social needs. Early findings from the FAI identified some of those barriers – including transportation, sufficient housing and workforce for community based long-term services and supports, and access to behavioral health services (Kaiser Family Foundation, http://kff.org/search/?s=early+insights)

(2) the addition of several behavioral health measures acknowledging that the integration of mental health, substance use disorders and primary care is critical. Many individuals with serious mental illness are at risk for poor management of other chronic conditions such as diabetes and cardiovascular disease.

(3) NQF's work to identify and examine the issues related to risk-adjustment that acknowledges health disparities and socio-demographic status.

(4) the acknowledgement of the benefit of an interdisciplinary care team that addresses geriatric conditions. A network that integrates primary care, pharmacy, mental health, hospital, home health, and community-based services has been shown to improve quality and lower costs as demonstrated with the GRACE model. We believe both geriatric competent care and disability competent care training is needed to serve the unique needs of dual eligibles.

We are pleased that the report concludes with an acknowledgment of the need to take action on the impact of disparities in the dual eligible population, and to "stimulate the adoption of specialized care models that are designed to meet their unique needs."

Finally, we are aware that the development of measures is a multi-year effort and urge NQF to support additional government funding to move forward on the high priority areas. Further, we hope NQF will encourage as part of this development process interim research be conducted to explore beneficiaries' experiences in the FAI so that both mid-term course corrections can be made and information could be used to assist in quality measures of "person-centered care." This was reinforced in a recent report to MACPAC that reported on focus groups with beneficiaries: "It will be important to revisit these sites at a later point to see how the demonstration is affecting access to care, quality of care and costs of care when implementation challenges are resolved and transition into the model is further along."

Consortium for Citizens with Disabilities

E. Clarke Ross

American Association on Health and Disability (AAHD): applauds NQF for retaining the 2013-2014 high priority measure gaps and for the expanded discussion and insights on these needs and complexities. We completely agree with the page 17 NQF observation: "there is a lack of measures that assess aspects of care that are relevant to the medical and social complexities present in the dual eligible beneficiary population." We agree with the observations on the importance of coordination with NQF HCBS (page 19), the need to move quickly toward a more person and family centered care (page 19), consideration of disparities and social-demographic status (page 20), and the importance of integrating behavioral health (page 22). We agree that the 4 high priority measure gaps identified by survey participants are consistent with the 2013-2014 stated high priority measure gaps.

Florida Hospital

John Hood

AHS does not have any disagreement with the measurement title or area of the listing of the newly endorsed measures to the MAP Family of Measures for Dual Eligible Beneficiaries. However, the measures will have to be significantly adjusted to allow for the nature of the population growth, particularly among the subgroupings of beneficiaries with substance abuse and serious mental illness. The changes of ongoing substance abuse and serious mental illnesses in the population may artificially inflate or deflate measure results. This will have to be factored into the calibration of measures intended for this population in order to collect consistent results.

We commend MAP for prioritizing the measure gaps for dual eligible measure development. This prioritization gives great recognition to the current weaknesses involved in measuring quality. By identifying these weaknesses, we can focus on closing these critical gaps.

We agree that measures must be tested for reliability, validity and other features in a dual eligible beneficiary population. A measure, particularly one that will be used for either payment programs or public reporting, must have a high degree of reliability. We recognize that it may be necessary to use an acceptable but lower reliability score when dealing with complex beneficiaries. For example, this could entail using a signal-to-noise reliability score of 0.70 when the standard really should be 0.80 or above. However, reliability standards should be raised over time as empirical testing for complex populations provides more information and enables greater refinement.

HealthPartners

Nancy Taff

Thank you for the opportunity to comment on this report. HealthPartners supports the continued conversation of defining appropriate measures for the dual population. With regards to the MAP family of measures:

HealthPartners specifically supports measures related to care coordination, a key service for this population.

HealthPartners is concerned for the lack of applicable measures for the frail and elderly (over age 75). This is a complex cohort of members than require specific and tailored measures to adequately measure the quality of care.

HealthPartners recommends a measure of post-discharge office visits occurring within 10 to 14 days, instead of the standard 30 days, due to the high risk of hospitalization for this population. This measure would also reflect effective care coordination for patients.

Thank you for your consideration of these comments.

Henry Ford Hospital

David Nerenz

We support the addition of the behavioral health measures that MAP included in the 2015 Family of Measures for dual eligibles, given the importance of integration of primary and mental health care in this population (p.16). We also agree with the interview participants that the experience of both the beneficiary and the caregivers is important in gaining a full understanding of the full patient experience (p. 14). We believe, however, there continues to be a gap in performance measures in some provide some areas to focus on for future measure funding and development.

In general, there is a need for more outcome measures. Of the 44 measures included in the Family of Measures, 29, or 65%, are process measures. Of the remaining 15 measures, seven (7) are outcome or composite measures that are based on patient engagement/experience as reported from survey results (e.g., various CAHPs, HCAHPS, ECHO). The remaining eight (8) outcome measures are: diabetes care, falls with major injury in long-stay nursing homes, falls with injury in adult acute care inpatient and adult rehabilitation facilities, blood pressure control, oral medication management at home, hospital-acquired pressure ulcers, patients with a chronic condition with a potentially avoidable condition and depression remission.

While processes and structure of care are important, they do not directly measure the impact of health care on the patient's health status. We need to better understand the impact the care has on the health status of the patient, and outcome measures are a more direct way to achieve that understanding. Outcome measures should be clinically appropriate for this population, and need to include measures for which this population is particularly at risk. The eight outcomes measures in the Family of Measures are general in nature and not particularly reflective of the health risks of the dual eligible population (although we recognize that some measures, including diabetes control, depression remission and oral medication management move us in the right direction). We suggest adding a priority for the development of outcomes measures that reflect the dual eligible population risks related to cardiovascular disease, end-stage renal disease, dementia, COPD, osteoporosis, cancer, mental health, substance abuse and tobacco use.

Ultimately, providers and others want to use the performance measures to drive quality improvement. The more specificity the measures provide the better able we will be able to achieve this goal.

National Association of Social Workers

Danielle Spears

Comments submitted to the National Quality Forum (NQF) on the Draft Report – Advancing Person Centered Care for Dual Eligible Beneficiaries through Performance Measurement: 2015 Recommendations from the Measure Applications Partnership (MAP).

On behalf of its 130,000 members, the National Association of Social Workers (NASW) welcomes the opportunity to submit comments to NQF regarding the draft report that will be submitted to the Centers for Medicare and Medicaid Services (CMS) regarding dual eligible beneficiaries. Social workers provide services to all persons who may be dual eligible beneficiaries in a multiplicity of settings. Services are provided in settings that are population-specific (e.g., services to older adults, services to persons with serious mental illness, and services to persons with intellectual and developmental disabilities) or in settings that are frequently accessed by dual eligible beneficiaries such as hospitals and other health care settings. Furthermore, social workers are the largest provider of mental health services in the United States.

As highlighted in the draft report (p. 3), persons who are both Medicare and Medicaid eligible are characterized by complex clinical conditions that are confounded by social disadvantages, namely poverty. The complex nature of this population requires a broad array of performance measures, beyond those that are specific to the delivery of medical services, and the MAP workgroup has regularly pointed out that there are significant measure gaps. NQF has consistently identified the measure gaps and reported that to CMS. While this report does an excellent job of laying out the alignment of existing measures, NASW would suggest that more specific information could be provided to CMS regarding the gaps in measures, especially measure gaps related to psychosocial needs. This is especially important since it is the inattention to these psychosocial issues that are often at the core of rehospitalizations, lack of preventive services, and difficulties in care coordination and communication, leading to poor outcomes. As stated on p. 17, “lack of the measures that assess aspects of care that are relevant to the medical and social complexities present in the dual eligible beneficiary population and that these gaps are as important as they are challenging.”

On p. 18, the report highlights that one of the major gap areas is psychosocial, however no definition is provided of psychosocial. NASW suggests that NQF adopt the definition of psychosocial that is provided in a newly released report from the Institute of Medicine, Psychosocial Interventions for Mental and Substance Use Disorders: A Framework for Establishing Evidence-Based Standards (http://iom.nationalacademies.org/Reports/2015/Psychosocial-Interventions-Mental-Substance-Abuse-Disorders.aspx). That definition is “interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social or environmental factors with the aim of reducing symptoms of disorders and improving functioning or well-being.” The absence of a description of what is meant by psychosocial can further lead to the widening of the measurement gap in this area. It might also be useful for NQF to include in this report some examples of areas where there are gaps in measuring psychosocial outcomes for persons who receive both Medicaid and Medicare Services. This can be accomplished by including some of the findings from the recent IOM report in regard to challenges in measure development. This would complement the examples of evidence-based strategies to better address the unique needs of dual-eligible beneficiaries that are provided on pp. 21 to 23.

Otsuka Pharmaceuticals

Molly Burich

Otsuka Pharmaceutical Development and Commercialization, Inc. (Otsuka) is a U.S.-based affiliate of Otsuka Pharmaceutical CO. Ltd., a global healthcare company committed to improving patient care by developing novel medicines and digital health products. Otsuka appreciates the opportunity to submit comments on the draft MAP Dual Eligible Beneficiary Report.

Leading estimates suggest that nearly 26 percent of the adult population in the U.S. has some type of behavioral health condition.Individuals with behavioral health conditions are also likely to have physical health comorbidities, and evidence suggests that inadequately treated behavioral health conditions contribute to poor physical health outcomes. As such, this population represents a vulnerable group of patients; many of whom reside as dual-eligible individuals.

Otsuka believes the development of measures that span the spectrum of behavioral health, with specific focus on outcomes is critical. The dual-eligible population is costly and complex, often with multiple chronic conditions and socioeconomic challenges. Otsuka appreciates MAP’s prioritization of behavioral health in providing guidance to HHS for measures for dual- eligible beneficiaries. Specifically, MAP identifies better integration of mental health and primary care as a priority area. A CBO report points out that dual eligible beneficiaries are three times as likely to have mental illness compared with Medicare beneficiaries.

Given the existing fragmented healthcare delivery system and the lack of care coordination and high-quality outcomes, Otsuka supports MAP’s identification of additional measures addressing management of comorbidities for patients with SMI. MAP prioritizes measures that address management of cardiovascular risk factors (e.g. body mass screening, blood pressure control) and diabetes care for patients with SMI. As MAP recognizes, patients with SMI are more likely to experience comorbid physical conditions. Furthermore, it is challenging to get physical health conditions under control without treatment of mental health conditions.

As a result of the existing fragmented healthcare system, Otsuka supports the inclusion of the additional measure that specifically addresses post-discharge follow-up. MAP has addressed a key gap area in identifying a measure for follow up after emergency department discharge for patients with SMI. Otsuka would encourage the inclusion of additional care-coordination measures that focus on additional settings of care including the inpatient setting. Better coordination of care for patients with SMI is likely to impact patient outcomes and costs.

Otsuka appreciates consideration of these comments and efforts to improve the quality healthcare delivered to dual-eligibles. In alignment with our commitment to improve care for those living with SMI, Otsuka welcomes the opportunity to work with NQF and MAP on this important initiative.

The SCAN Foundation

Megan Burke

Thank you for the opportunity to comment. The SCAN foundation supports the continued efforts to develop measures for dual eligible beneficiaries, and recommends the following:

Process Measures vs. Outcome Measures: It is encouraging to see measure concepts identified for home-and community-based services, consumer experience, and shared decision making in Appendix F. However, many of the potential gap-filling quality measures listed in this report continue to measure process (i.e., percentage of patients who have contact with a care manager). Individuals view success as the ability to live life at the highest functional level possible with the least intervention, whereas the system envisions success as providing a comprehensive range of services that meet total care needs. While challenging, we recommend efforts continue to develop and identify measures based on person-centered outcomes in order to support quality improvement and value-based purchasing policy.

The SNP Alliance

Richard Bringewatt

The SNP Alliance is pleased to respond to the National Quality Forum's request for comment on the draft report titled, Advancing Person-Centered Care for Dual Eligible Beneficiaries through Performance Measurement: 2015 Recommendations from the Measure Applications Partnership.

The SNP Alliance is a national membership organization dedicated to improving policy and practice of Medicare Advantage Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). The Alliance represents 31 Managed Care Organizations that collectively operate 266 SNPs (141 D-SNPs, 79 C-SNPs and 46 I-SNPs) in 39 States and the District of Columbia.

Member organizations also operate 29 MMPs that operate in all nine states currently in the capitated Financial Alignment Initiative. All D-SNPs exclusively enroll dually eligible beneficiaries and two-thirds of SNP Alliance members operate plans certified as Fully Integrated Dually Eligible Special Needs Plans (FIDESNPs). In addition, a large proportion of beneficiaries enrolled in I-SNPs and C-SNPs also are dually eligible.

The Alliance is very supportive of NQF's efforts to improve performance measurement and the quality of care for dual eligible beneficiaries. We are pleased to be represented on the MAP Dual Eligible Beneficiaries Workgroup and to submit the following comments on the draft report.

While we agree that individual measures recommended for inclusion in the 2015 Family of Dual Eligible Beneficiaries measures have merit, it is not entirely clear to us how a number of the new additions align with priority measure gaps. While we understand that measures to fill these gaps may not yet be available, we are concerned that expanding the family with available measures in the meantime may have negative consequences relative to the goals of parsimony and alignment.

We concur with the MAP's identification of the measure gaps identified on p. 18 and the importance of measure development in these areas. In fact, the gaps are sufficiently large that gap filling activity may be more important than trying to make fit measures that are less than adequate in measuring the quality of dual eligible beneficiaries' care. The SNP Alliance encourages the MAP to continue and expand its efforts in this area, establishing linkages with other NQF projects and, to the greatest extent possible, with measure development initiatives underway within CMS, NCQA and elsewhere to further progress.

We also believe that more effort must be given to moving more aggressively toward use of outcome measures. Survey measures are inherently subjective and subjective to recall, which does not appropriately capture true quality or quality improvement. It is also difficult for a number of key subgroups of dual beneficiaries, particularly those with cognitive, developmental, or various levels of frailty and/or confusion, to complete self-report surveys. Moreover, comparison of findings between plans that serve a high percentage of these subgroups with those that do not can easily misrepresent quality comparisons.

In addition, we have these specific comments on new additions to the dual eligible family:

1) While we appreciate the importance of understanding the experience of individuals with serious mental illness, we are concerned that problems related to inadequate diagnosis of mental illness may compromise the meaningfulness of these measures. Also, we would appreciate an explanation of how these measures are intended to be used alongside similar measures for broader populations.

2) Lastly, we are particularly supportive of adding measures to the family that focus on care coordination. Among the new measures for 2015, these include the measures related to medication reconciliation and follow-up post discharge from emergency department. We simply want to reiterate the importance of maintaining principles of parsimony as new measures are introduced to the set of reporting requirements.

Comments on Person- and Family-Centered Care

America's Health Insurance Plans

Carmella Bocchino

We agree with the two pronged approach NQF is taking in terms of measure alignment and the advancement of person and family-centered care.

Center for Medicare Advocacy, Inc.

Kata Kertesz

The Center for Medicare Advocacy (Center) appreciates the opportunity to comment on the draft report.

The Center, founded in 1986, is a national, non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality healthcare. We draw upon our direct experience with thousands of individuals and their families to educate policymakers about how their decisions affect the lives of real people. Additionally, we provide legal representation to ensure that beneficiaries receive the health care benefits to which they are legally entitled, and to the quality health care coverage and services they need.

We applaud the draft report's focus on person- and family- centered care. We agree that "[i]t supports health and well-being by being consistent with, respectful of, and responsive to an individual's priorities, goals, needs, and values" (page 19). We therefore underscore again the importance of not adjusting for socioeconomic status until it is definitively established through data collection that such risk adjustment would not harm dually eligible beneficiaries by providing lower quality care. For such complex patients, person- centered care includes addressing the diverse needs of the population. For example, having translators available, longer hours available for scheduling appointments, and other similar interventions that target the needs of this population and lead to improved, person-centered care. We are encouraged by the inclusion of CareOregon in the report, as an example of a plan successfully employing such interventions.

Community Catalyst

Renee Hodin

Community Catalyst is pleased that the draft report acknowledges the need to move quickly toward a more person- and family-centered approach to delivering healthcare services and long-term services and supports. We believe it is essential to seek feedback directly from beneficiaries about their goals, experiences, level of activation and perspective, as well as to get this information from a beneficiary's caregivers (if applicable): This is a critical undergirding of achieving the triple aim and should be a top priority of all health plans. Our experience is that the consumers are more than eager to share their experiences and are able to define what quality means to them and their family. There is value in gaining beneficiary perspective to understand the challenges and barriers to the implementation of the Financial Alignment Initiative.

Thisis too often missed overlooked by looking at satisfaction data. To do this, measures will need to be standardized but allow for variation.

We also urge NQF to include organizational capacity, incentives and preparation and training of the workforce to the definition of quality for LTSS.

Consortium for Citizens with Disabilities

E. Clarke Ross

American Association on Health and Disability (AAHD): as with recent NQF MAP reports to CMS on persons dually eligible, we respectfully ask NQF to again reference the National Core Indicators and Personal Outcome Measures as possible and ovation models for addressing the whole person in an individualized manner.

Florida Hospital

John Hood

AHS strongly supports the stratification of measures to better understand the impact of disparities in dual eligible populations. While we understand that the inclusion of sociodemographic factors and risk adjustment are controversial, it strikes us that the MAP has clearly acknowledged the necessity to consider these factors when determining which comparative measures are meaningful. It is our view that a disciplined approach to sociodemographic risk adjustment will not mask disparities but will, in fact, allow for more meaningful comparisons. This is especially important for providers who treat high levels of patients at risk due to their sociodemographic status. We agree that national averages penalize entities that serve higher proportions of dual eligible beneficiaries and other beneficiaries with high risk sociodemographic factors. We think it makes more sense to perform peer group comparisons rather than nationwide comparisons in order to avoid masking what is happening to beneficiaries who are dual eligible or face sociodemographic risk factors. Hospitals that treat patients with high risk factors may have low scores despite high quality of care because their base population is not as healthy as hospitals that primarily treat patients with low risk factors. Peer group comparisons will permit meaningful performance evaluations. For instance, urban core hospitals should be compared to other urban core hospitals and not to suburban hospitals because these facilities see different types of patients both in terms of clinical and sociodemographic risk.

We strongly support the sharing of specialized care models designed to meet needs of dual eligible populations and other at risk groups to produce better outcomes. It is our view that there should be a provider-accessible repository hosted by the NQF or the Centers for Disease Control and Prevention (CDC). This repository should contain information on the different population groups being addressed, the resources available in the community, the outcomes of the approach and their applicability for other communities.

Henry Ford Hospital

David Nerenz

Improved care coordination is a cornerstone of the new dual-eligible managed care plans, with a stated goal of improving the quality of care and access to care for dual-eligibles. Kenneth Thorpe, PhD, has previously identified key design features of effective care coordination models; he defined these activities as providing the foundation for cost savings and improved health outcomes for dual eligibles. These design elements include:

- Coordination of care for all covered Medicare and Medicaid services utilizing a team based approach and a capitated payment from Medicare and Medicaid
- Approaches that provide a “whole” person focus on preventing disease and managing acute and mental health services tailored to the needs of dually eligible beneficiaries over age 65 and those under 65 with disabilities who reside in the community and in institutions.
- Medical advice from a care coordinator available 24/7
- Assessment of patient risk and development of an individualized care plan
- Medication management, adherence and reconciliation
- Transitional care
- Regular contact with enrollees

- Centralized health records
- Close integration of the care coordination function and primary care (and specialist) physicians

We encourage MAP to develop performance measures that will help determine the effectiveness of care coordination activities on the cost and quality of care including rates and cost of: hospitalizations and hospital readmissions within 30 days; nursing home admissions; Emergency Department use; and outpatient visits, in addition to the effective use of medications to achieve targeted health outcomes, including medication reconciliation at all points along the continuum.

The SNP Alliance

Richard Bringewatt

The SNP Alliance is pleased to respond to the National Quality Forum's request for comment on the draft report titled, Advancing Person-Centered Care for Dual Eligible Beneficiaries through Performance Measurement: 2015 Recommendations from the Measure Applications Partnership.

The SNP Alliance is a national membership organization dedicated to improving policy and practice of Medicare Advantage Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). The Alliance represents 31 Managed Care Organizations that collectively operate 266 SNPs (141 D-SNPs, 79 C-SNPs and 46 I-SNPs) in 39 States and the District of Columbia.

Member organizations also operate 29 MMPs that operate in all nine states currently in the capitated Financial Alignment Initiative. All D-SNPs exclusively enroll dually eligible beneficiaries and two-thirds of SNP Alliance members operate plans certified as Fully Integrated Dually Eligible Special Needs Plans (FIDESNPs). In addition, a large proportion of beneficiaries enrolled in I-SNPs and C-SNPs also are dually eligible.

The Alliance is very supportive of NQF's efforts to improve performance measurement and the quality of care for dual eligible beneficiaries. We are pleased to be represented on the MAP Dual Eligible Beneficiaries Workgroup and to submit the following comments on the draft report.

The SNP Alliance applauds the report's emphasis on advancing person- and family-centered care. We agree that consumers and, as appropriate, their caregivers should be active participants in the assessment of their needs, in care planning and in the delivery of their care.

Further, health care plans and providers have a responsibility to empower and activate consumers by motivating, encouraging and coaching individuals toward this end. Currently, performance measurement systems do not recognize this dynamic. We encourage NQF and the MAP Dual Eligible Beneficiaries Workgroup to consider how the performance measurement system should be adapted toward this end.

In addition, we believe it is important to make a distinction between concepts of person-centeredness and care network performance. The former is focused primarily on ensuring that consumers are empowered to assume a greater role in the ongoing management of their care and where clinical interventions are modified to more fully account for individual interests, needs and concerns. The latter is focused more on enabling care providers who serve many of the same people, either at the same time or in sequence to one another, to optimize their collective performance around the total array of services needed by any one person, as his/her needs evolve over time and across care settings. Both concepts are important but issues of critical importance to advancing collective partnerships or care integration do not always get adequate attention when subsumed under "person-centered care" discussions.

APPENDIX E:

MAP Dual Eligible Beneficiaries Family of Measures (2015 Update)

The family of measures for Dual Eligible Beneficiaries is a group of the best available measures to address the unique needs of the dual eligible beneficiary population. The family of measures functions like a menu that stakeholders can consult to select subsets of measures that best suit the needs of particular programs. The current family of measures was selected based on the MAP Measure Selection Criteria (Appendix C) and refined over time. Additional details about each measure are available on the NQF Quality Positioning System (QPS). The family of measures is also available in the spreadsheet accompanying this report on the project page.

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0004 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) *National Committee for Quality Assurance (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.	Administrative Claims, Electronic Clinical Data	Health Plan, Integrated Delivery System	
0005 Endorsed CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child *Agency for Healthcare Research and Quality (AHRQ)*	Patient Reported Outcome	The Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS) is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months. The survey includes standardized questionnaires for adults and children. All questionnaires can be used in both primary care and specialty care settings. The adult survey is administered to patients aged 18 and over. The child survey is administered to the parents or guardians of pediatric patients under the age of 18. Patients who have had at least one visit during the past 12-months are eligible to be surveyed.	Patient Reported Data/ Survey	Clinician: Group/ Practice, Clinician: Individual	One commenter expressed difficulty taking action based on the results of surveys

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0006 Endorsed Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial) *AHRQ*	Patient Reported Outcome	The CAHPS Health Plan Survey is a standardized survey instrument which asks enrollees to report on their experiences accessing care and health plan information, and the quality of care received by physicians. HP-CAHPS Version 4.0 was endorsed by NQF in July 2007 (NQF #0006). The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at https://cahps.ahrq.gov/surveys-guidance/hp/index.html.	Patient Reported Data/ Survey	Health Plan	One commenter expressed difficulty taking action based on the results of surveys
0007 Endorsement Removed NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H) *NCQA*	Patient Reported Outcome	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 2. Health Promotion and Education item 3. Coordination of Care item	Patient Reported Data/ Survey	Clinician: Group/ Practice, Individual, Health Plan, Integrated Delivery System, Population: National, Regional, State	One commenter expressed difficulty taking action based on the results of surveys
0008 Endorsed Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) *AHRQ*	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	Survey: Patient Reported Data/ Survey	Health Plan	One commenter expressed difficulty taking action based on the results of surveys
0018 Endorsed Controlling High Blood Pressure (CBP) *NCQA*	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 during the measurement year based on the following criteria: • Patients 18–59 years of age whose BP was <140/90 mm Hg. • Patients 60–85 years of age with a diagnosis of diabetes whose BP was <140/ 90 mm Hg. • Patients 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. A single rate is reported and is the sum of all three groups.	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0022 Endorsed Use of High-Risk Medications in the Elderly (DAE) *NCQA*	Process	There are two rates for this measure: • The percentage of patients 65 years of age and older who received at least one high-risk medication. • The percentage of patients 65 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	Administrative Claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System	None
0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation (MSC) *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 patients 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 patients 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 patients 18 years of age and older who were current smokers or tobacco users who discussed or were provided smoking cessation methods or strategies during the measurement year.	Patient Reported Data/ Survey	Health Plan, Integrated Delivery System	None
0028 Endorsed Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention *AMA-PCPI*	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	Administrative Claims, Electronic Clinical Data, Electronic Health Record, Registry, Paper Medical Records	Clinician: Group/ Practice, Individual, Team	None
0032 Endorsed Cervical Cancer Screening (CCS) *NCQA*	Process	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21–64 who had cervical cytology performed every 3 years. • Women age 30–64 who had cervical cytology/ human papillomavirus (HPV) co-testing performed every 5 years.	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0034 Endorsed Colorectal Cancer Screening (COL) *NCQA*	Process	The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.	Administrative Claims, Electronic Clinical Data: Imaging/ Diagnostic Study, Laboratory, Paper Medical Records	Health Plan, Integrated Delivery System	None
0043 Endorsed Pneumococcal Vaccination Status for Older Adults (PNU) *NCQA*	Process	Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination.	Patient Reported Data/ Survey	Health Plan, Integrated Delivery System	None
0097 Endorsed Medication Reconciliation *NCQA*	Process	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	Clinician: Group/ Practice, Clinician: Individual	One commenter recommended office visits within 10-14 days after discharge in vulnerable populations
0101 Endorsed Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls *NCQA*	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 of age and older who were screened for future fall risk at least once within 12 months B) Falls: Risk Assessment: Percentage of patients aged 65 years of age and older with a history of falls who had a risk assessment for falls completed within 12 months C) Plan of Care for Falls: Percentage of patients aged 65 years of age and older with a history of falls who had a plan of care for falls documented within 12 months.	Administrative Claims, Electronic Clinical Data	Clinician: Group/ Practice, Clinician: Individual	None
0104 Endorsed Adult Major Depressive Disorder (MDD): Suicide Risk Assessment *AMA-PCPI*	Process	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	Electronic Clinical Data: Electronic Health Record, Registry	Clinician: Group/ Practice, Individual, Team	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0105 Endorsed Antidepressant Medication Management (AMM) *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).	Administrative Claims, Electronic Clinical Data: Electronic Clinical Data, Pharmacy	Health Plan, Integrated Delivery System	None
0166 Endorsed HCAHPS *Centers for Medicare & Medicaid Services (CMS)*	Outcome	HCAHPS (NQF #0166) is a 32-item survey instrument that produces 11 publicly reported measures: 7 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information and care transition); and 4 single-item measures (cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of hospital)	Patient Reported Data/ Survey	Facility	One commenter expressed difficulty taking action based on the results of surveys
0176 Endorsed Improvement in management of oral medications *CMS*	Outcome	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.	Electronic Clinical Data	Facility	None
0201 Endorsement Removed[a] Pressure Ulcer Prevalence (hospital acquired) *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.	Electronic Clinical Data, Other, Paper Medical Records	Clinician: Team, Facility	None
0202 Endorsed Falls with Injury *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.	Electronic Clinical Data, Other, Paper Medical Records	Clinician: Team	None

[a] NQF #0201 Pressure ulcer prevalence (hospital acquired) endorsement was removed after the MAP Dual Eligible Beneficiaries Workgroup met to complete the 2015 update to the family of measures. This measure will be considered by the Workgroup during a future update to the family of measures.

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0228 Endorsed 3-Item Care Transition Measure (CTM-3) *University of Colorado*	Patient-Reported Outcome	The CTM-3 is a hospital level measure of performance that reports the average patient reported quality of preparation for self-care response among adult patients discharged from general acute care hospitals within the past 30 days.	Patient Reported Data/ Survey	Facility	None
0326 Endorsed Advance Care Plan *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.	Administrative Claims, Electronic Clinical Data	Clinician: Group/ Practice, Individual	None
0418 Endorsed Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan *CMS*	Process	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	Administrative Claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Individual, Team, Population: Community, County or City, National, Regional, State	None
0419 Endorsed Documentation of Current Medications in the Medical Record *CMS*	Process	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known 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	Clinician: Individual, Population: National	None
0420 Endorsed Pain Assessment and Follow-Up *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	Administrative Claims, Electronic Clinical Data, Electronic Health Record	Clinician: Individual	None
0421 Endorsed Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up *CMS*	Process	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25	Administrative Claims, Electronic Clinical Data: Electronic Health Record, Registry, Paper Medical Records	Clinician: Group/ Practice, Individual, Population: County or City, National, Regional, State	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0553 Endorsed Care for Older Adults (COA) – Medication Review *NCQA*	Process	Percentage of adults 66 years and older who had a medication review during the measurement year; a review of all a patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System	None
0554 Endorsed Medication Reconciliation Post-Discharge (MRP) *NCQA*	Process	The percentage of discharges during the first 11 months of the measurement year (e.g., January 1–December 1) for patients 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System	None
0557 Endorsed HBIPS-6 Post Discharge Continuing Care Plan Created *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).	Electronic Clinical Data, Paper Medical Records	Facility, Population: National	None
0558 Endorsed HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider upon Discharge *The Joint Commission*	Process	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a complete post discharge continuing care plan, all the components of which are transmitted to the next level of care provider upon discharge. 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-6: Post Discharge Continuing Care Plan Created) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-6 (Post Discharge Continuing Care Plan Created).	Electronic Clinical Data, Paper Medical Records	Facility, Population: National	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0576 Endorsed Follow-Up After Hospitalization for Mental Illness (FUH) *NCQA*	Process	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the patient received follow-up within 30 days of discharge • The percentage of discharges for which the patient received follow-up within 7 days of discharge.	Administrative Claims, Electronic Clinical Data	Health Plan, Integrated Delivery System	One commenter recommended office visits within 10-14 days after discharge in vulnerable populations
0640 Endorsed HBIPS-2 Hours of Physical Restraint Use *The Joint Commission*	Process	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint. 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-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.	Electronic Clinical Data, Paper Medical Records	Facility, Population: National	One commenter expressed concerns about the consistency of documentation in the medical record
0641 Endorsed HBIPS-3 Hours of Seclusion Use *The Joint Commission*	Process	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion. 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-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.	Electronic Clinical Data, Paper Medical Records	Facility, Population: National	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0646 Endorsed Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) *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	Administrative Claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System	None
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) *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	Administrative Claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System	None
0648 Endorsed Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) *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	Administrative Claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System	None
0649 Endorsed Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/ Self Care] or Home Health Care) *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	Administrative Claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Integrated Delivery System	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0674 Endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) *CMS*	Outcome	This measure is based on data from all target MDS 3.0 assessments of long-stay nursing home residents (OBRA, PPS or discharge). It reports the percentage of residents who experience one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) in the last quarter (3-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	Electronic Clinical Data	Facility, Population: National	None
0682 Endorsed Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay) *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.	Electronic Clinical Data	Facility, Population: National	None
0692 Endorsed Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument *AHRQ*	Patient Engagement/ Experience	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.	Other, Survey: Patient Reported Data/ Survey	Facility	One commenter expressed difficulty taking action based on the results of surveys

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0709 Endorsed Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year *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	Administrative Claims, Electronic Clinical Data: Pharmacy	Clinician: Group/ Practice, Health Plan, Population: County or City, National, Regional, State	None
0710 Endorsed Depression Remission at Twelve Months *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.	Electronic Clinical Data, Electronic Health Record, Registry, Paper Medical Records	Clinician: Group/ Practice, Facility	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
0712 Endorsed Depression Utilization of the PHQ-9 Tool *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).	Electronic Clinical Data, Electronic Health Record, Registry, Paper Medical Records	Clinician: Group/ Practice, Facility	None
0729 Endorsed Optimal Diabetes Care *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.	Electronic Clinical Data, Electronic Health Record, Registry, Paper Medical Records	Clinician: Group/ Practice, Integrated Delivery System	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
1626 Endorsed Patients Admitted to ICU who Have Care Preferences Documented *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.	Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Health Plan, Integrated Delivery System	None
1659 Endorsed Influenza Immunization *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.	Administrative Claims, Paper Medical Records	Facility, Population: National, Regional, State	None
1768 Endorsed Plan All-Cause Readmissions (PCR) *NCQA*	Process	For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned 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* (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission *An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).	Patient Reported Data/ Survey	Health Plan, Integrated Delivery System	None
1789 Endorsed Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) *CMS*	Outcome	The measure estimates a hospital-level risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge. The measure reports a single summary risk-standardized readmission rate (RSRR), derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on 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-level standardized risk ratios (SRR) for each of these five specialty cohorts. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Admissions for planned procedures that are not accompanied by an acute diagnosis do not count as readmissions in the measure outcome. The target population is patients 18 and over. CMS annually reports the measure for patients who are 65 years or older and are enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals.	Administrative Claims	Facility	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
1902 Endorsed Clinicians/ Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy *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, stratifiers). Two composites can be calculated from the item set: 1) Communication to improve health literacy (5 items), and 2) Communication about medicines (3 items)	Patient Reported Data/ Survey	Clinician: Group/ Practice, Individual	None
1909 Endorsed Medical Home System Survey (MHSS) *NCQA*	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	Administrative Claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Imaging/ Diagnostic Study, Laboratory, Pharmacy, Registry, Healthcare Provider Survey, Management Data, Other, Paper Medical Records, Patient Reported Data/ Survey	Clinician: Group/ Practice, Individual	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
1927 Endorsed Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications *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.	Administrative Claims, Electronic Clinical Data, Pharmacy	Health Plan, Integrated Delivery System, Population: State	None
1932 Endorsed Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) *NCQA*	Process	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Administrative Claims, Electronic Clinical Data, Laboratory, Pharmacy	Health Plan, Integrated Delivery System, Population: State	None
2079 Endorsed HIV Medical Visit Frequency *Health Resources and Services Administration - 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.	Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Facility	None
2091 Endorsed Persistent Indicators of Dementia without a Diagnosis—Long Stay *American Medical Directors Association*	Process	Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.	Electronic Clinical Data	Facility	None
2092 Endorsed Persistent Indicators of Dementia without a Diagnosis—Short Stay *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.	Electronic Clinical Data	Facility	None

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
2111 Endorsed Antipsychotic Use in Persons with Dementia *Pharmacy Quality Alliance*	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.	Administrative Claims	Health Plan	None
2152 Endorsed Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling *AMA-PCPI*	Process	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user	Electronic Clinical Data: Electronic Health Record, Registry	Clinician: Group/ Practice, Individual, Team	None
2158 Endorsed Payment-Standardized Medicare Spending Per Beneficiary (MSPB) *CMS*	Cost/ Resource Use - Per episode	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.	Administrative Claims	Facility	None
2380 Endorsed Rehospitalization During the First 30 Days of Home Health *CMS*	Outcome	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay were admitted to an acute care hospital during the 30 days following the start of the home health stay.	Administrative Claims	Facility	None
2456 Endorsed Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient *Brigham and Women´s Hospital*	Outcome	This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult patient. The time frame is the hospitalization period. At the time of admission, the admission orders are compared to the preadmission medication list (PAML) compiled by trained pharmacist (i.e., the gold standard) to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This process is repeated at the time of discharge where the discharge medication list is compared to the PAML and medications ordered during the hospitalization.	Electronic Clinical Data, Electronic Health Record, Pharmacy, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/Survey	Facility	One commenter supported the inclusion of this care coordination measure

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
2502 Endorsed All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs) *CMS*	Outcome	This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) discharged from an Inpatient Rehabilitation Facility (IRF) who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital (LTCH), within 30 days of an IRF discharge. The measure is based on data for 24 months of IRF discharges to non-hospital post-acute levels of care or to the community.	Administrative Claims, Other	Facility	None
2505 Endorsed Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health *CMS*	Outcome	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay used an emergency department but were not admitted to an acute care hospital during the 30 days following the start of the home health stay.	Administrative Claims	Facility	None
2510 Endorsed Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) *CMS*	Outcome	This measure estimates the risk-standardized rate of all-cause, unplanned, hospital readmissions for patients who have been admitted to a Skilled Nursing Facility (SNF) (Medicare fee-for-service [FFS] beneficiaries) within 30 days of discharge from their prior proximal hospitalization. The prior proximal hospitalization is defined as an admission to an IPPS, CAH, or a psychiatric hospital. The measure is based on data for 12 months of SNF admissions.	Administrative Claims, Other	Outcome	None
2512 Endorsed All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs) *CMS*	Outcome	This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) discharged from a Long-Term Care Hospital (LTCH) who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital (LTCH), within 30 days of an LTCH discharge. The measure is based on data for 24 months of LTCH discharges to non-hospital post-acute levels of care or to the community.	Administrative Claims, Other	Facility	None
2597 Endorsed Substance Use Screening and Intervention Composite *American Society of Addiction Medicine*	Composite	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record	Clinician: Group/ Practice, Clinician: Individual	Three commenters supported the addition of measures addressing behavioral health

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
2599 Endorsed Alcohol Screening and Follow-up for People with Serious Mental Illness *NCQA*	Process	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI).	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Health Plan	Three commenters supported the addition of measures addressing behavioral health
2600 Endorsed Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence *NCQA*	Process	The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported. Rate 1: The percentage of patients 18 years and older with a diagnosis of serious mental illness who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Rate 2: The percentage of adults 18 years and older with a diagnosis of alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention NQF #0028). This measure is currently stewarded by the AMA-PCPI and used in the Physician Quality Reporting System.	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Health Plan	Two commenters supported the addition of measures addressing management of comorbidities for people with SMI
2601 Endorsed Body Mass Index Screening and Follow-Up for People with Serious Mental Illness *NCQA*	Process	The percentage of patients 18 years and older with a serious mental illness who received a screening for body mass index and follow-up for those people who were identified as obese (a body mass index greater than or equal to 30 kg/m2). Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care & Screening: Body Mass Index: Screening and Follow-Up NQF #0421). It is currently stewarded by CMS and used in the Physician Quality Reporting System.	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Health Plan	Two commenters supported the addition of measures addressing management of comorbidities for people with SMI

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
2602 Endorsed Controlling High Blood Pressure for People with Serious Mental Illness *NCQA*	Outcome	The percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0018: Controlling High Blood Pressure). It was originally endorsed in 2009 and is owned and stewarded by NCQA. The specifications for the existing measure (Controlling High Blood Pressure NQF #0018) have been updated based on 2013 JNC-8 guideline. NCQA will submit the revised specification for Controlling High Blood Pressure NQF #0018 in the 4th quarter 2014 during NQF's scheduled measure update period. This measure uses the new specification to be consistent with the current guideline.	Administrative Claims, Electronic Clinical Data, Paper Medical Records	Health Plan	Two commenters supported the addition of measures addressing management of comorbidities for people with SMI
2603 Endorsed Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing *NCQA*	Process	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0057: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing). This measure is endorsed by NQF and is stewarded by NCQA.	Administrative Claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Pharmacy, Paper Medical Records	Health Plan	Two commenters supported the addition of measures addressing management of comorbidities for people with SMI
2604 Endorsed Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy *NCQA*	Process	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0062: Comprehensive Diabetes Care: Medical Attention for Nephropathy). It is endorsed by NQF and is stewarded by NCQA.	Administrative Claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Pharmacy, Paper Medical Records	Health Plan	Two commenters supported the addition of measures addressing management of comorbidities for people with SMI

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
2605 Endorsed Follow-Up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence *NCQA*	Process	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported: • The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge. • The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge. • The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge. • The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.	Administrative Claims	Health Plan, Population: State	One commenter supported the addition of measures of post-discharge follow-up One commenter expressed concerns about the potential for skewed data due to increased labeling of patients in the ED as 'outpatients' but who are receiving essentially the same care as inpatients.
2606 Endorsed Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg) *NCQA*	Outcome	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading during the measurement year is <140/90 mm Hg. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0061: Comprehensive Diabetes Care: Blood Pressure Control <140/90 mm Hg) which is endorsed by NQF and is stewarded by NCQA.	Administrative Claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan	Two commenters supported the addition of measures addressing management of comorbidities for people with SMI
2607 Endorsed Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) *NCQA*	Outcome	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control >9.0%). This measure is endorsed by NQF and is stewarded by NCQA.	Administrative Claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Pharmacy, Paper Medical Records	Health Plan	Two commenters supported the addition of measures addressing management of comorbidities for people with SMI

NQF Measure #, Endorsement, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis	Public Comments Received
2608 Endorsed Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%) *NCQA*	Outcome	The percentage of patients 18-75 years of age with a serious mental and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is <8.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0575: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0). This measure is endorsed by NQF and is currently stewarded by NCQA.	Administrative Claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Pharmacy, Paper Medical Records	Health Plan	Two commenters supported the addition of measures addressing management of comorbidities for people with SMI
2609 Endorsed Diabetes Care for People with Serious Mental Illness: Eye Exam *NCQA*	Process	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had an eye exam during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0055: Comprehensive Diabetes Care: Eye Exam). This measure is endorsed by NQF and is stewarded by NCQA.	Administrative Claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan	Two commenters supported the addition of measures addressing management of comorbidities for people with SMI

Measures for Use in Subgroups

To address the complexity and heterogeneity of dual eligible population, MAP considered the use of measures from the family for specific subgroups in the 2012 report: **Further Exploration of Healthcare Quality Measurement for the Dual Eligible Beneficiary Population** and **2014 Interim Report from the MAP Dual Eligible Beneficiaries Workgroup**. MAP considered organizational schemata based on age, functional status, and clinical diagnoses, ultimately combining these factors to produce four high-need groups:

- Adults ages 18-64 with physical or sensory disabilities
- Medically complex adults age 65 and older with functional limitations and co-occurring chronic conditions
- Beneficiaries with serious mental illness (SMI) and/or substance use disorders
- Beneficiaries with cognitive impairment (e.g., dementia, intellectual/developmental disability)

Notably, these subgroups and appropriate measures overlap significantly. However, it can be helpful for stakeholders to view the family of measures from a lens focused on specific populations of interest. The **spreadsheet** with the current family of measures accompanying this report includes a tab that enables filtering by these subgroups. It is posted to the **project page**.

Subgroup: Adults Ages 18-64 with Physical or Sensory Disabilities

0005 CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)

0006 CAHPS Health Plan Survey v 4.0 - Adult Questionnaire

0007 NCQA Supplemental Items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)

0018 Controlling High Blood Pressure

0027	Medical Assistance With Smoking and Tobacco Use Cessation (MSC)
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
0032	Cervical Cancer Screening
0034	Colorectal Cancer Screening
0097	Medication Reconciliation
0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
0166	HCAHPS
0176	Improvement in Management of Oral Medications
0201	Pressure Ulcer Prevalence (hospital acquired)
0202	Falls with Injury
0228	3-Item Care Transition Measure (CTM-3)
0326	Advance Care Plan
0419	Documentation of Current Medications in the Medical Record
0420	Pain Assessment and Follow-Up
0421	Adult Weight Screening and Follow-Up
0554	Medication Reconciliation Post-Discharge (MRP)
0646	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
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)
0648	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
0649	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
0709	Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year
0729	Optimal Diabetes Care
1626	Patients Admitted to ICU who Have Care Preferences Documented
1659	Influenza Immunization
1768	Plan All-Cause Readmissions (PCR)
1789	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)
1902	Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy
1909	Medical Home System Survey (MHSS)
2079	HIV Medical Visit Frequency
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
2158	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)
2380	Rehospitalization During the First 30 Days of Home Health
2456	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
2502	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)
2505	Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health
2510	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
2512	All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs)

Subgroup: Medically Complex Adults Age 65 and Older with Functional Limitations and Co-occurring Chronic Conditions

0005 CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)

0006 CAHPS Health Plan Survey v 4.0 - Adult Questionnaire

0007 NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)

0018 Controlling High Blood Pressure

0022 Use of High-Risk Medications in the Elderly (DAE)

0027 Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

0043 Pneumonia Vaccination Status for Older Adults

0097 Medication Reconciliation

0101 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls

0166 HCAHPS

0176 Improvement in Management of Oral Medications

0201 Pressure Ulcer Prevalence (hospital acquired)

0202 Falls with Injury

0228 3-Item Care Transition Measure (CTM-3)

0326 Advance Care Plan

0419 Documentation of Current Medications in the Medical Record

0420 Pain Assessment and Follow-Up

0421 Adult Weight Screening and Follow-Up

0553 Care for Older Adults (COA) – Medication Review

0554 Medication Reconciliation Post-Discharge (MRP)

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

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)

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

0674 Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

0682 Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)

0692 Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument

0709 Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year.

0729 Optimal Diabetes Care

1626 Patients Admitted to ICU who Have Care Preferences Documented

1659 Influenza Immunization

1768 Plan All-Cause Readmissions (PCR)

1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy

1909 Medical Home System Survey (MHSS)

2079 HIV Medical Visit Frequency

2091 Persistent Indicators of Dementia without a Diagnosis—Long Stay

2092 Persistent Indicators of Dementia without a Diagnosis—Short Stay

2111 Antipsychotic Use in Persons with Dementia

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB)

2380 Rehospitalization During the First 30 Days of Home Health

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

2502 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)

2505 Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health

2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)

2512 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs)

Subgroup: Beneficiaries with Serious Mental Illness (SMI) And/Or Substance Use Disorders

0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

0005 CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)

0006 CAHPS Health Plan Survey v 4.0 - Adult Questionnaire

0007 NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)

0008 Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)

0018 Controlling High Blood Pressure

0027 Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

0097 Medication Reconciliation

0104 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

0105 Antidepressant Medication Management

0166 HCAHPS

0176 Improvement in management of oral medications

0228 3-Item Care Transition Measure (CTM-3)

0326 Advance Care Plan

0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

0419 Documentation of Current Medications in the Medical Record

0420 Pain Assessment and Follow-Up

0421 Adult Weight Screening and Follow-Up

0554 Medication Reconciliation Post-Discharge (MRP)

0557 HBIPS-6 Post Discharge Continuing Care Plan Created

0558 HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider upon Discharge

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

0640 HBIPS-2 Hours of Physical Restraint Use

0641 HBIPS-3 Hours of Seclusion Use

0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

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)

0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

0709 Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year.

0710 Depression Remission at Twelve Months

0712 Depression Utilization of the PHQ-9 Tool

0729 Optimal Diabetes Care

1626 Patients Admitted to ICU who Have Care Preferences Documented

1659 Influenza Immunization

1768 Plan All-Cause Readmissions (PCR)

1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy

1909 Medical Home System Survey (MHSS)

1927 Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications

1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB)

0104 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

2380 Rehospitalization During the First 30 Days of Home Health

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

2502 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)

2505 Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health

2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)

2512 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs)

2597 Substance Use Screening and Intervention Composite

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness

2602 Controlling High Blood Pressure for People with Serious Mental Illness

2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing

2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy

2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence

2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)

2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)

2609 Diabetes Care for People with Serious Mental Illness: Eye Exam

Subgroup: Beneficiaries with Cognitive Impairment (e.g., Dementia, Intellectual/Developmental Disability)

0005 CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)

0006 CAHPS Health Plan Survey v 4.0 - Adult Questionnaire

0007 NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)

0018 Controlling High Blood Pressure

0027 Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

0032 Cervical Cancer Screening

0034 Colorectal Cancer Screening

0097 Medication Reconciliation

0166 HCAHPS

0176 Improvement in Management of Oral Medications

0228 3-Item Care Transition Measure (CTM-3)

0326 Advance Care Plan

0419 Documentation of Current Medications in the Medical Record

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0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

0649 Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

0674 Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

0682 Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)

0692 Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument

0709 Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year.

0729 Optimal Diabetes Care

1626 Patients Admitted to ICU who Have Care Preferences Documented

1659 Influenza Immunization

1768 Plan All-Cause Readmissions (PCR)

1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

1902 Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy

1909 Medical Home System Survey (MHSS)

2091 Persistent Indicators of Dementia without a Diagnosis—Long Stay

2092 Persistent Indicators of Dementia without a Diagnosis—Short Stay

2111 Antipsychotic Use in Persons with Dementia

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

2158 Payment-Standardized Medicare Spending Per Beneficiary (MSPB)

2380 Rehospitalization During the First 30 Days of Home Health

2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

2502 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)

2505 Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health

2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)

2512 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs)

APPENDIX F:

List of Programs Included in the Alignment Analysis

- CMMI Priority Measures for Monitoring and Evaluation
- CMS Medicaid Adult Core Set
- CMS Health Home Measure Set
- Health Insurance Exchange Quality Rating System
- CMS Medicare Shared Savings Program (ACOs)
- CMS Hospital Inpatient Quality Reporting
- CMS Hospital Value-Based Purchasing
- CMS Inpatient Psychiatric Facility Quality Reporting
- CMS Nursing Home Quality Initiative and Nursing Home Compare
- CMS Long-Term Care Hospital Quality Reporting
- CMS Home Health Quality Reporting
- CMS Meaningful Use – for Eligible Professionals
- CMS Physician Quality Reporting System (PQRS)
- CMS Physician Value-Based Payment Modifier
- NCQA HEDIS Physician or Health Plan Measures
- CMS Medicare Part C & D Ratings
- Comprehensive Primary Care Initiative
- SIM Population Level Measures
- Joint Commission Accountability Measures
- Oregon CCO
- Vermont ACO
- Washington State Measures
- Maine ACO Payment Measures
- Most Frequently Used Measures from Phase 1 Buying Value Analysis
- Aligning Forces for Quality Communities
- California Capitated State Financial Alignment Demonstration
- Illinois Capitated State Financial Alignment Demonstration
- Massachusetts Capitated State Financial Alignment Demonstration
- Michigan Capitated State Financial Alignment Demonstration
- New York Capitated State Financial Alignment Demonstration
- Ohio Capitated State Financial Alignment Demonstration
- South Carolina Capitated State Financial Alignment Demonstration
- Texas Capitated State Financial Alignment Demonstration
- Virginia Capitated State Financial Alignment Demonstration
- Colorado Fee For Service State Financial Alignment Demonstration
- Washington Fee For Service State Financial Alignment Demonstration
- Minnesota Integrated/ Coordinated Medicare and Medicaid ICSP MSCHO
- Minnesota Integrated/ Coordinated Medicare and Medicaid ICSP SNBC

APPENDIX G:

Potential Gap-Filling Measure Concepts

Potential Gap-Filling Measure Concepts from Stakeholder Interviews

NQF staff conducted semi-structured phone interviews to collect feedback about the utility of measures from the Dual Eligible Beneficiaries Family of Measures. The interviews also explored measure gap areas and promising development activities. MAP noted a variety of interesting measure ideas or concepts from the feedback-loop conversations with groups that use and influence measures. This appendix includes select potential measure concepts for consideration and further development in areas of HCBS, consumer experience, and shared decisionmaking/beneficiary sense of control/autonomy.

Home and Community-Based Services (HCBS)

- Delivery of services in HCBS settings
- How many people a plan is serving over time in the community versus in an institution
- How many people move out of an institution into the community
- Number and portion of beneficiaries receiving care in the community
- Total expenditures and percent long-term supports and services expenditures
- Number of people who do not return to an LTSS setting in a year
- Increase in authorization of personal care services

Consumer Experience

- Emergency department use in the last six months
- Courtesy and respect
- Helpfulness of office staff
- Access to interpreters
- Relationship with care manager, such as “do you know your case manager by name?”

Shared Decisionmaking / Beneficiary Sense of Control / Autonomy

- How would you rate your healthcare in the last year
- How would you rate your overall health
- How would you rate your emotional health
- How would you rate the impact of your personal problems on your health
- Access to technology

Potential Gap-Filling Measure Concepts from Alignment Analysis

NQF used research performed by Bailitt Health Purchasing on behalf of **Buying Value** while conducting its analysis of alignment. In addition to identifying current state and regional measure sets, Buying Value noted that many states are using their own “homegrown” measures. MAP explored these state-specific measures to see if any showed promise for further development, testing, and wider use to fill gaps in current measures. Potential gap-filling measures are listed in Table G1.

TABLE G1. POTENTIAL GAP-FILLING MEASURES FROM ALIGNMENT ANALYSIS

Measure Name	Program Using "Homegrown" Measure	Gap Area
% of hospitalized patients who have clinical, telephonic or face-to-face follow-up interaction with the care team within 2 days of discharge during the measurement month.	Massachusetts Person-Centered Medical Home	Care Coordination
% of patients in the Highest Risk Registry who have documented contact/ interaction with the care manager at least once during the measurement period.	Massachusetts Person-Centered Medical Home	Care Coordination
% of patients listed in the practice's Highest Risk Registry during the measurement month who have a care plan that has been developed by the care manager with patient input and in collaboration with the care team.	Massachusetts Person-Centered Medical Home	Care Coordination
% of patients who have been seen in the emergency room with a documented chronic illness problem, who have clinical telephonic or face-to-face follow-up interaction with the care team within 2 days of the ER visit during the measurement month.	Massachusetts Person-Centered Medical Home	Care Coordination
Percentage of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within 72 hours of discharge and performed medication reconciliation with input from PCP. (Report will be cumulative for first year, starting with 1/ 1/ 2012, and will be a rolling 12-months thereafter.)	Unknown	Care Coordination
Cost of Care: Per Member Per Month rolling annual cost total and by service category - Inpatient (Behavioral vs. Medical), Outpatient, Pharmacy, others. Reported quarterly.	Unknown	Cost
Cost Savings from Improved Chronic Care Coordination and Management	Unknown	Cost
Estimate of Cost Savings (NOTE: This is from Medicaid's perspective, the State needs CMS's assistance in determining Medicare's cost savings for Medicare-Medicaid members in a Health Home program.)	Unknown	Cost
Generic Dispensing Rate	Unknown	Cost
Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider	Texas - CMS Delivery System Reform Incentive Program	Cost
Improvement in disparate health outcomes for target population, including identification of the disparity gap	Texas - CMS Delivery System Reform Incentive Program	Cost
Medicaid Spending within Global Cap	Unknown	Cost

Measure Name	Program Using "Homegrown" Measure	Gap Area
Percent of High Cost/ High Need Cases in Health Home programs	Unknown	Cost
New dementia thyroid and B12 tests	Unknown	Dementia
Medical Treatment Needs Among Chronic Disease Patients: Percentage of chronic disease patients with improved disease controls status following dental treatment	Texas - CMS Delivery System Reform Incentive Program	Oral Health
Urgent Dental Care Need in Older Adults: Proportion of older adults aged 65 and older with urgent dental care needs	Texas - CMS Delivery System Reform Incentive Program	Oral Health
Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity	Texas - CMS Delivery System Reform Incentive Program	Disparities
Advance Directives Determination (Do Not Resuscitate)	Unknown	Palliative Care
Disruptive/ Intense Daily Pain (*A low rate is desirable)	New York Department of Health	Functional Status
Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	Texas - CMS Delivery System Reform Incentive Program	Behavioral Health
Mental Health Statistic Improvement Program (MHSIP) survey	Substance Abuse and Mental Health Services Administration National Outcome Measures (NOMS)	Behavioral Health
Reduction in Polypsychopharmacology: Identified Engaged CMP Members with up to a seventeen percent polypsychopharmacologic reduction over baseline	Massachusetts Behavioral Health Partnership	Polypharmacy
Functional status assessment for complex chronic conditions (ONC 106) - Percentage of patients with two or more high impact conditions who completed initial and follow-up (patient-reported) functional status assessments	Texas - CMS Delivery System Reform Incentive Program	Quality of Life
Improve patient satisfaction and/ or quality of life scores in target population with identified disparity	Texas - CMS Delivery System Reform Incentive Program	Quality of Life
Improvement in Participant Health-Related Quality of Life (Increase in "Healthy Days"): At least a 35% survey response rate and a relative increase in "Healthy Days" of up to five percent over baseline (using survey module from The World Health Organization Quality of Life Assessment (HQROL-4))	Massachusetts Behavioral Health Partnership	Quality of Life
Quality of Life survey that assesses the outcomes of appropriate and sufficient integrated care. State agency will determine or develop the survey tools and may require other measures of quality of life	MassHealth Duals Project	Quality of Life

Measure Name	Program Using "Homegrown" Measure	Gap Area
% of patients 18- 50 years of age who were identified as having persistent asthma with a documented patient action plan during the measurement period	Massachusetts Person-Centered Medical Home	Goal-Directed Care
% of patients 18-75 years of age with diabetes (type 1 or type 2) with a documented self-management goal during the measurement period	Massachusetts Person-Centered Medical Home	Goal-Directed Care
% of patients age 18 and older with a diagnosis of COPD, with documented self-management goal during the measurement period	Massachusetts Person-Centered Medical Home	Goal-Directed Care
% of patients age 18 years and older with a diagnosis of CAD, with patient action plan documented during the measurement period	Massachusetts Person-Centered Medical Home	Goal-Directed Care
% of patients age 18 years and older with a diagnosis of CHF with documented patient action plan during the measurement period	Massachusetts Person-Centered Medical Home	Goal-Directed Care
% of patients age 18 years and older with a diagnosis of hypertension, with documented self-management goal during the measurement period	Massachusetts Person-Centered Medical Home	Goal-Directed Care
% of patients in the Highest Risk Registry who have a documented self-management goal during the measurement period.	Massachusetts Person-Centered Medical Home	Goal-Directed Care
% of patients with a diagnosis of depression with a documented self-management goal during the measurement period	Massachusetts Person-Centered Medical Home	Goal-Directed Care
% of patients with one documented self-management goal during the measurement period (this measure is included in the set of measures for every targeted disease/ condition patient population)	Massachusetts Person-Centered Medical Home	Goal-Directed Care
Diabetes: Percent of Patients with a Self-Management Goal Documented Within the Past 12 Months	Institute for Healthcare Improvement	Goal-Directed Care
Self-management plan or asthma action plan	Health Resources and Services Administration	Goal-Directed Care
% adult HH enrollees employed during previous 12 months	Unknown	Social Determinants

APPENDIX H:

Categorization of the Family of Measures by Use in the Financial Alignment Initiative

TABLE H1. MEASURES IN USE IN STATE DEMONSTRATIONS

NQF Measure #	NQF Measure Title
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
0006	CAHPS Health Plan Survey v 4.0 - Adult questionnaire
0007	NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)
0008	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)
0018	Controlling High Blood Pressure
0022	Use of High-Risk Medications in the Elderly (DAE)
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
0032	Cervical Cancer Screening
0034	Colorectal Cancer Screening
0097	Medication Reconciliation
0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
0105	Antidepressant Medication Management
0166	HCAHPS
0201	Pressure Ulcer Prevalence (hospital acquired)
0202	Falls with Injury
0228	3-Item Care Transition Measure (CTM-3)
0326	Advance Care Plan
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
0420	Pain Assessment and Follow-Up
0421	Adult Weight Screening and Follow-Up
0553	Care for Older Adults (COA) – Medication Review
0554	Medication Reconciliation Post-Discharge (MRP)
0576	Follow-Up After Hospitalization for Mental Illness (FUH)
0640	HBIPS-2 Hours of Physical Restraint Use
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)
0648	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)
0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
0692	Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument
1768	Plan All-Cause Readmissions (PCR)
1927	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

TABLE H2. MEASURES NOT USED IN ANY STATE DEMONSTRATIONS, WITH POTENTIAL JUSTIFICATION

NQF Measure #	NQF Measure Title	Potential Reason(s) Measure Not Selected
0005	CAHPS Clinician/ Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)	Individual clinician level of analysis; state financial alignment demonstrations are generally based on health plan or state level of analysis
0027	Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	Difficult to collect data since it is based on consumer survey
0043	Pneumonia vaccination status for older adults	Difficult to collect data since it is based on consumer survey
0111	Bipolar Disorder: Appraisal for Risk of Suicide	Clinician level of analysis; state financial alignment demonstrations are generally based on health plan or state level of analysis
0176	Improvement in Management of Oral Medications	Facility level of analysis (home health agency); state financial alignment demonstrations are generally based on health plan or state level of analysis
0419	Documentation of Current Medications in the Medical Record	Clinician level of analysis; state financial alignment demonstrations are generally based on health plan or state level of analysis
0557	HBIPS-6 Post discharge Continuing Care Plan Created	Facility level of analysis (inpatient psychiatric care); state financial alignment demonstrations are generally based on health plan or state level of analysis
0558	HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider upon Discharge	Facility level of analysis (inpatient psychiatric care); state financial alignment demonstrations are generally based on health plan or state level of analysis; generally difficult to collect data regarding care coordination between two unrelated providers
0641	HBIPS-3 Hours of Seclusion Use	Facility level of analysis (inpatient psychiatric care); state financial alignment demonstrations are generally based on health plan or state level of analysis
0646	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)	Facility level of analysis (hospital); state financial alignment demonstrations are generally based on health plan or state level of analysis
0649	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/ Self Care] or Home Health Care)	Facility level of analysis (hospital); state financial alignment demonstrations are generally based on health plan or state level of analysis
0682	Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)	Facility level of analysis (nursing facility); state financial alignment demonstrations are generally based on health plan or state level of analysis
0709	Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year.	Clinician level of analysis; state financial alignment demonstrations are generally based on health plan or state level of analysis

NQF Measure #	NQF Measure Title	Potential Reason(s) Measure Not Selected
0710	Depression Remission at Twelve Months	Clinician level of analysis; state financial alignment demonstrations are generally based on health plan or state level of analysis
0712	Depression Utilization of the PHQ-9 Tool	Clinician level of analysis; state financial alignment demonstrations are generally based on health plan or state level of analysis
0729	Optimal Diabetes Care	Clinician level of analysis; state financial alignment demonstrations are generally based on health plan or state level of analysis
1626	Patients Admitted to ICU who Have Care Preferences Documented	Facility level of analysis (hospital); state financial alignment demonstrations are generally based on health plan or state level of analysis
1659	Influenza Immunization	Facility level of analysis (hospital); state financial alignment demonstrations are generally based on health plan or state level of analysis
1789	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Facility level of analysis (hospital); state financial alignment demonstrations are generally based on health plan or state level of analysis. Risk adjustment model for this measure has been controversial and is not yet resolved.
1902	Clinicians/ Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	Clinician level of analysis; state financial alignment demonstrations are generally based on health plan or state level of analysis; difficult and expensive to collect survey data from consumers
1909	Medical Home System Survey (MHSS)	This measure is a complex composite of six domains, each containing multiple elements and factors. It is designed for use in outpatient primary care practices pursuing certification as medical homes.
2079	HIV Medical Visit Frequency	Clinician level of analysis; state financial alignment demonstrations are generally based on health plan or state level of analysis. Measure was first endorsed in 2013 and more time may be needed for uptake in programs.
2091	Persistent Indicators of Dementia without a Diagnosis—Long Stay	Facility level of analysis (nursing facility); state financial alignment demonstrations are generally based on health plan or state level of analysis. Measure was first endorsed in 2013 and more time may be needed for uptake in programs.
2092	Persistent Indicators of Dementia without a Diagnosis—Short Stay	Facility level of analysis (nursing facility); state financial alignment demonstrations are generally based on health plan or state level of analysis. Measure was first endorsed in 2013 and more time may be needed for uptake in programs.
2158	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	Facility level of analysis (hospital); state financial alignment demonstrations are generally based on health plan or state level of analysis. Measure was first endorsed in 2013 and more time may be needed for uptake in programs.

TABLE H3. MEASURES NOT USED IN ANY STATE DEMONSTRATIONS, WITH UNKNOWN JUSTIFICATION

NQF Measure #	NQF Measure Title	Potential Reason(s) Measure Not Selected
2111	Antipsychotic Use in Persons with Dementia	This measure is relatively new, having gained NQF endorsement for the first time in 2013. However, there are no obvious reasons for excluding it from use. It is a claims-based measure designed for the health plan level of analysis.

APPENDIX I:

Measure-Specific Feedback from Interview Participants

In an initial effort to address the lack of information about the use of performance measures, NQF staff collected feedback about the performance and utility of measures from the Dual Eligible Beneficiaries Family of Measures. Staff gathered information from representatives of multiple stakeholder groups representing the interests of the Medicare-Medicaid dually eligible and other vulnerable populations.

Eight organizations not currently represented among MAP members participated: three health plan organizations, two consumer advocacy groups, one state program, and two companies supporting measurement in the industry. This table summarizes the measure-specific feedback from the eight organizations that participated in the semi-structured phone interviews.

TABLE I1. MEASURE–SPECIFIC FEEDBACK FROM INTERVIEW PARTICIPANTS

NQF#	Title	Participant Perspectives
Multiple	Consumer Assessment of Health Providers and Systems (CAHPS®)	One stakeholder described difficulty in affecting CAHPS results, that only large-scale changes will produce a difference in the measure results. One participant shared that measure results are received at the contract level, but that additional information about performance for specific populations such as dual beneficiaries would be beneficial. However, this would increase the cost of measurement. Two participants noted the importance of CAHPS but limitations of this and other consumer survey instruments to collect beneficiary perspectives. Specifically, that they cannot achieve reliable results from beneficiaries with limited English proficiency and the number of languages offered does not reflect the populations served. Additional adaptations are needed for individuals with intellectual or developmental disabilities. Two participants expressed concerns regarding the impact of recall bias on results. Self-reported rates of clinical care such as timing and location of influenza vaccination are believed to be difficult for individuals to accurately recall. Similarly, surveyed individuals may not readily identify what care or services are in question, and may confuse a home health worker with a nurse or a health plan representative with a clinic staff member. One participant warned of the low response rates, especially among beneficiaries under age 65 and individuals with behavioral health or mental health diagnoses who may be difficult to contact by mail.
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	One stakeholder noted that this is a very difficult measure, though the topic is clearly important.

NQF#	Title	Participant Perspectives
0018	Controlling High Blood Pressure	Two stakeholders noted this is a good measure and there are disparities in blood pressure outcomes among at-risk populations, but they can be addressed. Multiple stakeholders expressed concern about the use of measures of tight control in the elderly and frail populations, that these may not be appropriate targets or achievable by providers.
0022	Use of High-Risk Medications in the Elderly (DAE)	Three stakeholders noted the significant number of dual eligible beneficiaries who are elderly with multiple medical and behavioral or mental health diagnoses and therefore may need to be on multiple high-risk medications. Participants recommended additional exclusions, including antipsychotic and anticonvulsive medications. One plan noted making improvements on this measure has not been a priority because of the population characteristics, though the topic is part of education to providers.
0027	Medical Assistance with Smoking and Tobacco Use Cessation	Two participants noted the problematic rates of tobacco use and its importance as a public health issue. One participant described challenges with providers who are reluctant to offer treatment because they do not know what is covered by a plan; education from one plan is insufficient because plans offer different benefits.
0032	Cervical Cancer Screening	One stakeholder noted the importance of this measure and the potential unintended consequences of overuse outside of clinical practice guidelines. Another participant described difference in rates achieved within the behavioral health population and ongoing effort to improve it by connecting with beneficiaries.
0034	Colorectal Cancer Screening	One stakeholder noted this was an important and good measure with suspected disparities specifically in the Latino population. Another participant described difference in rates achieved within the behavioral health population and ongoing effort to improve it by connecting with beneficiaries.
0097	Medication Reconciliation	Three stakeholders emphasized the importance of medication reconciliation in the population. One participant shared the need for very deliberate efforts to communicate the reason for the medication and instructions, as well as the need for improved health literacy. One participant described reproducible results of medication reconciliation as impossible to get because of the lack of common definition. As a result this measure is viewed by this stakeholder as unsuitable to make comparisons.
0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	One participant noted the importance of falls in the population and the successful use of the measure to drive change relative to other measures.
0105	Antidepressant Medication Management	One participant noted this measure is not of high quality and to look for new measures in development.

NQF#	Title	Participant Perspectives
0326	Advance Care Plan	One stakeholder described a large program to increase the number of members with advance directives, but that this was not being measured or reported. Another participant shared the preference of providers to create advanced care plans over advanced directives.
0553	Care for Older Adults (COA) – Medication Review	One participant described challenges using this measure because it does not recognize ongoing care. It is better suited for use with new patients. Providers would not necessarily need to complete every aspect in every visit.
0554	Medication Reconciliation Post-Discharge (MRP)	One participant described this measure as difficult to collect because of the lack of data infrastructure. Some best practices for addressing this issue are to use a high-touch model of care, hot-spotting, and in-home evaluations.
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	One participant described this measure as helpful to spur and gauge improvement; ongoing challenges to achieving 7-day follow-up; and new partnerships with facilities, health agencies, community organizations, and providers. Changes that improve performance include involvement of a case manager and connection to supports and services already in the community, including nutritional assistance and transportation services.
0648	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	One stakeholder described transition of care measures as confusing because of the varying requirements by settings. One participant questioned the attribution of discharge and planning to health plans rather than hospitals because of the overall ability to influence the results.
0649	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	One stakeholder described transition of care measures as confusing because of the varying requirements by settings. One participant questioned the attribution of discharge and planning to health plans rather than hospitals because of the overall ability to influence the results.
1768	Plan All-Cause Readmissions (PCR)	One participant described this measure as plan-specific and relevant, as well as helpful to plans for examining performance and improvement.

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NATIONAL QUALITY FORUM
1030 15TH STREET, NW, SUITE 800
WASHINGTON, DC 20005

www.qualityforum.org