NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership
Dual Eligible Beneficiaries Workgroup Teleconference

July 29, 2014 | 1:00 pm - 2:00 pm ET

Participant Instructions: Dial (**888) 799-0466**; Use conference ID code **75160838**
Public Participant Instructions: Dial (**855) 452-9871**; Use conference ID code **75160838**

Meeting Objectives:

- Review Coordinating Committee and public comments of the Draft 2014 MAP Dual Eligible Beneficiaries Final Report
- Finalize recommendations for the Final Report
- Prioritize future topics for workgroup consideration

1:00 pm **Welcome, Introductions, and Review of Timeline and Inputs**

Leader: Alice Lind, Chair of MAP Dual Eligible Beneficiaries Workgroup

Key Materials: Attachment 1 - Timeline

1:10 pm **Review Key/Major Themes from Public Comment**

Leader: Alice Lind and Megan Duevel Anderson, Project Manager, NQF

Key Materials: 2014 Dual Eligible Beneficiaries Final Report Draft, Attachment 2 - Public Comment Table, Attachment 4 - MAP Coordinating Committee Meeting Summary

- MAP received 38 comments from 10 organizations during the three week comment period
- All public comments will be included as an appendix in the report
- Additionally, MAP will make note of and responds to comments throughout the text of the report

Summary of Public Comment Themes

- Focus on individual beneficiary through continued emphasis on person- and family-centered care, quality of life, and direct outcomes.
- Support for conscientious approach to measurement, with attention to the burden on stakeholders overlapping or redundant efforts, and high fidelity of measurement.
- Support for exploring gap areas and potential gap-filling concepts and avenues.
- Recommendations to pursue developing feedback loops through informal interviews with stakeholders to ensure accurate representation of their voices and identify potential areas for quality measurement.
- Suggestions to further improve reports to make them more meaningful and accessible to diverse stakeholder groups.

Workgroup Discussion: Does the workgroup have any specific responses to the public comments? Please provide the staff suggestions for how to incorporate public comments in the final report.

Themes from Coordinating Committee Review (July 18)

- MAP Coordinating Committee provided overall support the report
- Suggested approaches to gathering stakeholder feedback included: Outreach to advocates involved in Medicaid systems, regional quality measurement collaboratives, and state agencies currently using and developing measures for dual beneficiaries.
- The Coordinating Committee expressed interest in potential future topics:
  - Measures for advanced illness care (e.g., IOM, end-of-life care, palliative care),
  - Further engaging the private sector and providers organization,
  - Collaborating with the Patient Centered Outcomes Research Institute,
  - Shifting to a wellness directed model of care,
  - Population management in the context of global payment, and
  - Expanding beyond the use of public and private data (e.g., vital statistics, lab and pharmacy data, etc.)

Workgroup Discussion: Opportunity for additional questions or response to the Coordinating Committee review of the report.

1:35 pm **Discussion of Potential Future Topics for Workgroup**

Leader: Alice Lind

Key Materials: Attachment 3 - Potential Future Topics List

- Potential future topics:

- Conceptual work to revisit high-leverage opportunities and explore person-centered wellness
- Additional topics on measure development and application
- Other factors related to quality of care and outcomes

Workgroup Discussion: Each member is requested to voice their first choice for the next topic of workgroup focus. Staff will conduct roll call for each person to share their priority.

1:55 pm **Opportunity for Public Comment and Review of Next Steps**

Leader: Sarah Lash, Senior Director, NQF

Key Materials: Attachment 1 - Project Timeline

2:00 pm **Adjourn**

Attachment 1: MAP Dual Eligible Beneficiaries Workgroup Project Timeline

Early phases of project in 2011-2013

- Final Report: Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries, October 2011
- Final Report: Measuring Healthcare Quality for the Dual Eligible Beneficiary Population, June 2012
- Interim Report: Further Exploration of Healthcare Quality Measurement for the Dual Eligible Beneficiary Population, December 2013
- Interim Report from the Dual Eligible Beneficiaries Workgroup, February 2014

Recent activities contributing to the forthcoming report

- Web Meeting March 17, 2014
  - Continue exploration of strategies to promote best possible quality of life among dual eligible beneficiaries
  - Discuss expectations for shared accountability related to quality of life
  - Prepare for upcoming in-person meeting
- In-Person Meeting April 10-11, 2014
  - Identify and discuss priority measure gap areas
  - Updating MAP's family of measures for dual eligible beneficiaries
  - Develop approach to engaging stakeholders in documentation of measure use and alignment
  - Formulate recommendations to HHS about use of performance measurement and other strategies to ensure high-quality care for dual eligible beneficiaries
- MAP Coordinating Committee Web Meeting July 18, 2014
  - Finalize 2014 MAP Dual Eligible Beneficiaries Workgroup Report
  - Finalize 2014 recommendations to HHS on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid
  - Receive updates on MAP Kaizen process improvement activities

Present and Future activities

- Teleconference July 29, 2014
  - Review Coordinating Committee and public comments of the Draft 2014 MAP Dual Eligible Beneficiaries Final Report
  - Finalize recommendations for the Final Report
  - Prioritize future topics for workgroup consideration
- 2014 Final Report from the MAP Dual Eligible Beneficiaries Workgroup Due August 29, 2014
  - Work will continue in 2014/2015 through web and in-person meetings

Attachment 2: Public Comments

Commenter Name	Commenter Organization	Question	Comment
Joe Caldwell	National Council on Aging	1) General Comments	Thank you for the opportunity to provide public comment on the National Quality Forum (NQF) Measure Applications Partnership (MAP): 2014 Report from Dual Eligible Workgroup. The National Council on Aging (NCOA) supports the work NQF has done in identifying high-priority measure gaps, including identified gaps in person-centered planning, self-determination, and community participation. We appreciate the work of NQF in highlighting work being done to attempt to fill these gaps. In particular, we acknowledge efforts to develop quality of life and consumer experience measures (e.g. National Core Indicators, Council on Quality and Leadership Personal Outcomes Measures, and Home and Community-Based Experience Survey). However, we remain deeply concerned that about the lack of any endorsed HCBS measures as states rapidly move forward with implementation of duals integration demonstrations and expansion of MLTSS programs. The path forward to endorsement of HCBS measures is unclear. We believe NQF should play a stronger leadership role in making specific recommendations to CMS about investments needed in HCBS quality measure development to expedite endorsement and guidance to states in this area. In addition, we believe there are many important domains missing from the list of priority measure gaps that reflect the paradigm of quality within HCBS. Rebalancing, self-direction, employment, family caregiver supports, and adequacy of the direct care workforce are some areas we believe deserve more attention. NCOA leads a coalition of 37 national aging and disability organizations (known as the Friday Morning Collaborative). The coalition focuses on HCBS issues and meets regularly. There is a lot of collective knowledge and expertise within the collaborative across the spectrum of individuals who are dual eligible and need long-term services and supports. We encourage you to consider us a resource and would be happy to offer additional assistance in the areas of HCBS quality measures.

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Carmella Bocchino	America's Health Insurance Plans	1) General Comments	We applaud the MAP's efforts to focus its work on performance measure development in topic areas relevant to dual eligible beneficiaries and that support quality of life outcomes. We support the high-priority measure gaps, however, we recommend adding language to recognize that as measure gaps are addressed CMS should consider including such measures in federal quality programs and retiring existing measures to minimize measurement burden. MAP should continue to recommend a parsimonious measure set that builds on existing measures (e.g. NCQA, CMS Star Ratings, etc.). Utilizing measures that have been widely accepted and that are feasible, reliable, and valid, will minimize burden of data collection and administrative costs. We also recommend that the MAP focus measurement efforts on direct outcomes measures, instead of survey measures. Survey responses are often not specific enough for health plans to translate into actionable or targeted improvements. The MAP should also consider the number and frequency of surveys currently administered to health plan members and patients when determining what types of measures are most appropriate for the Dual Eligible population. Oftentimes members and patients are unable to remember pertinent information when responding to surveys. Recall bias is particularly problematic for the elderly and those with behavioral health problems. We support MAP's efforts to improve measure alignment across the Medicare and Medicaid programs, as well as across private-sector programs. Such alignment is important for ensuring that measurement is both meaningful and manageable and for reducing the overall measurement burden. Measures also should be tested and selected based on their ability to better identify, understand, and close the disparities that exist between and within target populations. In addition, while we encourage efforts to expand measurement of vulnerable populations, the operational bandwidth required to accommodate any new efforts must be kept in mind. One specific area of opportunity is to condense a given family of measures to those most connected to meaningful outcomes and eliminating measures that represent minor variations on the same measure concept. It is also important that stakeholders have access to the complete technical specification for each measure to ensure uniform measure implementation and the comparability of performance data.
Deborah Fritz	GlaxoSmith Kline	1) General Comments	We commend MAPs efforts to improve the use of performance measures to assess and improve the quality of care delivered to this complex and vulnerable population of Dual Eligible patients. We support the approach taken to include the development of measures across the spectrum of care encompassing

Commenter Name	Commenter Organization	Question	Comment
			a holistic approach for the patient needs and outcomes. The gaps identified on page 6 of the report go well beyond the traditional clinical goals of care and represent important areas to address related to the quality of care provided to individuals. The efforts and consideration towards the harmonization of measures is also appreciated as the burden to provider organizations to meet disparate reporting requirements represents a tremendous strain on resources. We support your continued work to simplify measures recommendations across measures set where possible. Last, we applaud the diligence NQF and MAP display in maintaining a transparent and multi-stakeholder process to drive improvement in patient care.
Elizabeth Demakos	Uniform Data System for Medical Rehabilitation	1) General Comments	UDSMR welcomes the opportunity to comment on the National Quality Forum's Measure Applications Partnership: 2014 Report from the Dual Eligible Beneficiaries Workgroup Draft Report from Comment, June 13, 2014. We appreciate the work that the NQF is doing to improve the health outcomes of the dual eligible population. UDSMR was pleased to present the FIM®instrument to the Dual Eligible Workgroup and continues to maintain that the FIM®instrument and its derivatives are the best tools to measure function for this population across all venues of post-acute care.The Measures Application Partnership (MAP) has identified alignment as an important characteristic in measure selection criteria. MAP has also acknowledged that developing and testing measures is complex and time-consuming (and therefore can be costly).As you may be aware, Research Triangle Institute's (RTI's) November 2012 report, Analysis of Crosscutting Medicare Functional Status Quality Metrics Using the Continuity and Assessment Record and Evaluation (CARE) Item Set, referred to the well-respected FIM®instrument more than thirty times. One could surmise from this report that function was the only predictive measure across all settings of care. Function would not be the only measure necessary to measure quality in each venue, but it is a sound anchor that cuts across all settings of care and can be easily compared and risk-adjusted to align quality measurement. The FIM® instrument has been used for over twenty-five years in the rehabilitation industry, has been tested for reliability and validity in all venues of care, imposes a low data collection burden, and has been used in the Medicare program for inpatient rehabilitation as a payment system for over ten years. Using an instrument with a proven, successful implementation reduces the cost and time of recreating or developing new measures. FIM® instrument benefits:

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			1. It predicts outcomes. Determines a patient's expected functional improvement, identify risk factors for readmission, and predicts many outcomes. 2. It is easy to monitor and audit. The rating criteria are easily identified in the patient's chart. 3. It classifies patients with similar resource needs. The tool assigns patients to case-mix groups; it can be used to establish payment categories for like patients. 4. It enhances facilities' quality improvement initiatives. FIM® gain, length-of-stay efficiency, and community discharge rates can be used to measure quality improvement initiatives. 5. It helps clinicians and administrators manage their cases. Regional and national benchmarks available for managing care. 6. It can be used as the basis of a P4P system. Efficiency and quality metrics make an excellent starting point for a pay-for-performance initiative. 7. Reduces the data collection burden. Easier to use than other current and proposed instruments. Reducing data collection time increases time spent providing care improving efficiency and outcomes. UDSMR has offered CMS a royalty-free license for the use of the FIM® instrument for inpatient rehabilitation and is willing to do the same for other venues of care as well. UDSMR has submitted two functional change measures—Change in Mobility Score and Change in Self Care—to the NQF Person- and Family-Centered Care for endorsement. These measures are subsets of the FIM® instrument. We look forward to further discussions with NQF including the results of our research into the use of the FIM® instrument and its derivatives in acute and post-acute care, as well as assisting NQF improve the quality of health care
Lauren Agoratus	Family Voices NJ	1) General Comments	We understand that "MAP briefly considered…NQF #2065 Gastrointestinal Hemorrhage Mortality Rate (IQI #18)… found to be too narrow and would not address any gap areas" which is disappointing due to its importance as a high risk measure due to mortality rates. We urge NQF to reconsider this decision.

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Joyce Chan	Healthfirst	1) General Comments	There is significant variation among dual eligible members. We recommend that measures be tested across those elements with great variability (i.e., primary language, residence in Health Professional Shortage Areas, residence in urban vs. rural communities, etc.). In addition, we encourage MAP to ensure that all measures are able to be evaluated without undue burden to stakeholders We support MAP's recommendation to align reporting requirements and measures across programs and stakeholder groups. This alignment will better focus stakeholder efforts on improvement and reduce resource burden. It will also support collaborative efforts among stakeholders (e.g., payers and providers) as they work on improving the same measures.
Anne Cohen	Disability Health Access, LLC	1) General Comments	I appreciate NQF's efforts to organize the complex set of potential measures into a "family of Measures set," this has made a difficult task more meaningful. I encourage NQF to continue to look at additional ways to make the reports more meaningful and usable to non-academic and industry representatives. I suggest reorganizing the appendix chart to create a color coded system indicating the measures that are in the 7 topic family measures and indicating the additional family measurement areas(population health, affordable care, and person- and family-centered care) currently being finalized. I also suggest further explanation of the concept of process measures, outcome measure, composite measures, engagement/experience measures, and efficiency measure. In particular as we continue to put emphasis on person-centered measures it would be useful to also indicate if an individual measure or a family of measures fulfills that concept.
E. Clarke Ross	Consortium for Citizens with Disabilities	1) General Comments	Presentation of measures is complex and daunting. We suggest that measures be ordered into major categories (e.g., community living, prevention of chronic illness, beneficiary choice and self-direction, etc.). Color coding of measures by major category might help in the understanding and presentation. Suggest this report include language from the NQF MAP May 30, 2014 draft report - "one single term cannot apply to all individuals in all situations; in actuality, an individual with many needs may self-identify as a person, client, or patient at a single point in time....Use the word 'person' as an over-arching term to encompass the health and healthcare needs of all individuals, regardless of age, setting, or health status."

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Valerie Wilbur	SNP Alliance	1) General Comments	The SNP Alliance appreciates the thoughtful work of the Dual Eligible Work Group. We urge NQF to continue to clarify that (1) the Family of Measures is intended to serve as a set of options -- not an all-inclusive measure set mandated for all plans/providers; and (2) when several measures are included for a particular category, such as medication management or care transitions, the idea is to offer options, not for plans/providers to report all measures. This is especially important for many of the CAHPS measures which have multiple questions and which could lead to significant duplication of reporting if, for example, CAHPS, HCAHPS, and CAHPS 4.0 were all required. Data fatigue is as important a consideration for enrollees as for plans and could reduce beneficiary submission rates. We strongly support the proposed focus for the path forward on alignment, impact of measures and fit-for-purpose embodied in the two key questions raised in the Report. Current Medicare measures are biased toward average Medicare beneficiaries, not high-risk/high-need populations. There are few MA Stars measures of unique importance to duals, no system-level measures that evaluate aggregate performance across time and care settings, and few outcome measures. There are also no measures to evaluate the degree to which Medicare and Medicaid benefits and services are being integrated. The need for risk adjustment of measures for high-risk beneficiaries also is needed to better align measures and expected outcomes with population specific needs and limitations. Below are SNP Alliance priorities for the 4 areas addressed in the path forward: • High Leverage Opportunities: We would prioritize “visioning a future state for quality measurement.” For healthcare to move from a provider-based, component-driven approach to a person-centered, system-oriented approach, with priority on advancing care for frail, disabled, chronically-ill persons, it is as important for the state of quality measurement to change as for health care delivery structures to change. • Additional Measure Topics: Prioritize development of structural measures to evaluate the degree of integration of Medicare/Medicaid benefits and services, distinguishing between care integration and program integration. • Other factors: Priority should be given to advancing risk adjustment of measures within the Dual Eligible Beneficiary Family of Measures. We strongly support performance measurement and accountability. We also know that performance is affected by the complexity of medical conditions and by social determinants of health, as recognized by the NQF SES Panel. Risk adjustment or stratification of measures is critical to performance measurement and the future of specialized care for the most needy, high-risk, and costly service groups. Primary care/behavioral health integration models also critical for

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			duals, given the prevalence of behavioral health diagnoses among duals.
Valerie Wilbur	SNP Alliance	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	• We support identification of a new HIV-AIDS screening measure and inclusion of NQF #2079 as compliance with medical visits strongly influences morbidity and mortality. We strongly recommend adding NQF #2082 and NQF #2083. Viral load suppression and antiretroviral therapy can help prevent HIV from advancing to AIDS, assess the risk of disease progression and help guide initiation of therapy. These two measures were included in a set core indicators recommended by HHS and are consistent with the Institute of Medicine's recommendations for monitoring HIV services and those developed by the NQF and the NCQA. Another indicator on the HHS list that we strongly support is Retention in HIV Medical Care. • We strongly support MAP's objective to align measures across programs. More emphasis is needed on aligning metric selection, definitions, and oversight requirements for Medicare and Medicaid in measuring performance of the same service or function for plans and providers. • We agree that current measures fail to capture the complex array of conditions at play in chronically ill persons' lives over time or to respond to the systemic nature of chronic illness care as a condition evolves over time and across settings. Current measures focus on specific interventions, health professionals and points in time. We also support greater focus social issues that affect health outcomes in vulnerable populations and recommend that the Dual Work Group build on the work of the SES Risk Adjustment Panel by (1) reviewing the Dual Family of Measures to determine which should be adjusted or stratified for SES impacts; (2) identifying a "core group" of measures from the Dual Family that are particularly relevant in accounting for SES factors; and (3) identifying SES measurement gaps. • We urge the Dual Work Group to evaluate the validity and reliability of self-reported data from persons with behavioral, mental health or cognitive impairment diagnoses. • We support the development of Care Planning and Assessment measures, but recommend that they cover the full continuum of primary, acute, and long-term care services. Separate assessments and care planning for primary, acute and long-term care services fails to recognize the interdependence among the many unique service providers caring for individuals with complex medical problems covered by separate benefit programs. An integrated approach to assessment and care planning is needed to maximize financial and clinical outcomes and minimize the potential for adverse outcomes during care transitions. An integrated process also is consistent with the goal of patient centeredness since it reduces the burden of multiple assessments for the beneficiary and multiple meetings for family caregivers. • We agree that for persons with complex care needs, a face-to-face, in-home assessment is ideal, but

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			not necessary for all beneficiaries and is inconsistent with telehealth trends. For those without complex health problems whose conditions are stable, a telephonic or mailed assessment may be appropriate and could increase the number of assessments performed as well as family/guardian participation in care planning. We suggest consideration of risk-stratifying in-home, telephonic and mail assessments by patient needs and preferences. • We suggest the following modifications to the proposed measures: (1) for all measures refer to "beneficiaries," not MLTSS beneficiaries; (2) add medication review to the core group of domains in the Assessment Composite measure; (3) change "shared" care plan to "common" care plan that is jointly developed among relevant providers and add a "care coordination" function that assesses provider collaboration around a common care plan; and (4) transmit the common care plan to relevant providers and health professionals. We urge NCQA to put the measures out for public comment before finalizing.
Joe Caldwell	National Council on Aging	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	On page 8, of the report, we recommend striking the following sentence, "It might be preferable to directly question the people involved in the care-planning process to gauge their experience, but this would be burdensome and subjective." The perspectives of consumers and family members are essential and the most valid way to assess true person-centeredness.

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Carmella Bocchino	America's Health Insurance Plans	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	NCQA is developing measures for Managed Long Term Services and Supports, and we recommend considering adding these to the Family of Measures once fully specified and tested. We also offer the following measure specific comments: 0022: This measure may result in the under-treatment of pain and depression in the elderly and thus should be monitored. Also, we recommend assessing whether high-risk medications are being appropriately prescribed. 0027: Health plan use of this measure is dependent upon state-specific Medicaid benefits. Smoking and tobacco use cessation is not a benefit in some states thus this measure is only useful for in-state comparisons. 0028, 0111, & 0710: It is unclear how data for these measures will be collected and from what sources. CMS must provide additional specifications to ensure standardized data collection. 0228: Given the numerous surveys (CTM-3 and HCAHPS) used to measure patient satisfaction with care transitions, we are concerned with the additional burden on members self-reporting care experience and its potential impact on the other surveys being used. 0554: Data for this measure can be difficult for plans to collect if pharmacy benefits information is unavailable due to carve-outs thus requiring burdensome sampling and chart review. 0573: Screening members for HIV is important, but barriers exist in transferring STD and HIV screening data among providers, health plans, and ASOs. The primary barrier is privacy restrictions requiring health plans to obtain consent before providing this information to others making it difficult to report complete data. We recommend excluding this measure or reporting by clinicians in the aggregate. 0709: For conditions such as CHF and COPD, health plans would be assessed based on an individual's health status progression, even though deterioration in health status is expected. This measure does not consider psychosocial determinants of health that impact the Dual Eligible population and is more appropriate for commercial and Medicare populations.

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			1626: Data for this measure cannot be obtained using the administrative claims reporting method and health plans will have to conduct burdensome chart reviews; often this material is not included in the chart but may be retained by the family. It would also be helpful to understand the Committee's reasoning for including this measure, as we question its value to the measure family. 1927: This measure requires annual screening and resource use that is not predicated upon evidence based medicine. Annual screening has not demonstrated better outcomes. 2111: It is challenging to influence and educate providers on the overuse of anti-psychotics among persons with dementia. We recommend excluding this measure. 2091 & 2092: It would be helpful to understand the Committee's reasoning for including these measures, as we question their value to the measure family.
Mary Kennedy	Association for Community Affiliated Plans	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	(1/2)The Association for Community Affiliated Plans (ACAP) is an association of 58 nonprofit and community-based Safety Net Health Plans (SNHPs) located in 24 states. Our member plans provide coverage to over 12 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans and Medicare-Medicaid Plans for dually-eligible individuals.Overview. We appreciated the update to the Family of Measures and, as in previous comments, urge parsimony as new measures are considered. We support your exclusion of measures deemed to be too narrow as narrow measures can lead to an unwarranted and counter-productive proliferation of measures.NQF #2158-Payment Standardized Medicare Spending per BeneficiaryWe believe there should be risk adjustment and/or stratification where necessary for duals eligibles, SES markers, and health status. We were surprised at your recommendation to include the measure before these factors are developed.Promote Cross-Program Alignment across State and Private-Sector Programs In addition to alignment across Medicare and Medicaid, we urge that you also look at reporting requirements for the Exchange's Qualified Health Plans. Measurement Gap We appreciate that you are looking at measurement gaps and look forward to NQF's upcoming work on care coordination and Alzheimer's disease and other dementias. We urge that NQF focus on evidence-

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			based outcome measures over process measures. We especially support the inclusion of the optimal functioning measure as this is one of the most important factors in assessing the care received by the dual eligible population. MLTSS Measures There must be an accommodation in measures for people who actively refuse care assessment. We also ask that those people for whom the state does not have a current contact address or phone number, be excluded from the 90 day contact measure. We note that many care management systems are not standardized and it would be difficult to pull data from those systems. We urge NQF to support measures which use standardized, administrative data. We welcomed the discussion of new survey instruments. These measurements should be stratified and not have the biases inherent in current CAHPS tools. Research Priorities for PCORI We suggest that PCORI considers a measure that would assess the readiness of institutionalized individuals to return to their community. The current assessments focus on entry to care especially if institutional care is used. The Duals demonstrations have a goal to re-balance care towards use of community based MLTSS. Dual eligible individuals are a key group for research on socioeconomic status in healthcare

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Deborah Fritz	GlaxoSmith Kline	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	We commend the hard work and effort put forth by the multi-stakeholder committee dedicated to improving the care of the Dual Eligible patients. The set of proposed measures is robust in many ways including addressing preventative measures of smoking cessation, cancer screenings, fall prevention, mental health and medication use evaluations. The inclusion of these measures is to be commended. The inclusion of several immunization measures is applauded including 0043 Pneumonia vaccination status for older adults, 0682 Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine, and 1659 Influenza Immunization. Additionally, we offer for consideration the following Immunization measures: 0041 Influenza Immunization – This measure provides an immunization measure for all patients seen for a visit during the flu season, not just those admitted to an in-patient facility 0399 and 0400 Paired Measure Hepatitis C: Hepatitis B Vaccination with high risk chronic conditions An observed gap within the Dual Eligible Family of Measures is around high-prevalent chronic diseases to this population. While a few measures do address chronic disease states including 0018 Controlling High Blood Pressure and 0729 Optimal Diabetes Care, measures for many of the most prevalent chronic disease states are absent. While not an exhaustive list of highly prevalent chronic diseases in this patient population, we offer the following measures for consideration for inclusion representing prevalent respiratory chronic disease states: COPD 0091 COPD: Spirometry Evaluation 0102 COPD: Inhaled Bronchodilatory therapy 1825 COPD: Management of Poorly Controlled COPD Asthma 1800 Asthma Medication Ratio 1799 Medication Management for People with Asthma 0047 Pharmacologic Therapy for Persistent Asthma 0548 Respiratory – Suboptimal Control of Asthma

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Lauren Agoratus	Family Voices NJ	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	We understand that NQF is collaborating with CMS and Mathematica to develop 6 measures for MLTSS (Managed Long Term Services and Supports) including: • Assessment Composite which requires in-home assessment with the following components within 90 days of enrollment which we support. • Care Plan Composite which requires documentation of a care plan developed face-to-face within 30 days of completed assessment which we also support. • Shared Care Plan in which the care plan was transmitted to key long-term services and supports providers and the primary care provider within 30 days of development. We would hope this would even be done within 7 days for continuity of care. Other key measures we support include Assessment Update, Care Plan Update, and Reassessment and Care Plan Update After Discharge and we look forward to details on these.

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E. Clarke Ross	Consortium for Citizens with Disabilities	2) Updates to Family of Measures for Dual Eligible Beneficiaries and Measure Gaps	Recommend deleting from this report - UDSMR FIM. They made a brief telephone presentation to the workgroup. They provided no measures. They provided no data. They provided no outcomes. They also expressed an attitude - why is NQF doing this work when the UDSMR FIM exists and no changes are needed. Inclusion of USSMR FIM at this point in time is premature. UDSMR FIM could be cited in the list of future topics for the workgroup to consider. Recommend adding to the report - Council on Quality and Leadership (CQL) Personal Outcome Measures (POM). They made an in-person meeting presentation. They provided their measures. The provided their data. They provided outcomes. CQL POM has been included in previous NQF reports and should be recognized again. Add to the future topics for workgroup consideration - CMS-AHRQ pilot Medicaid home and community-based services personal experience approach. Delighted to see the stated need for the authentic beneficiary experience into the quality measurement process. The observation that directly asking people involved is "burdensome and subjective" was made by some workgroup members but was not a decision or consensus of the workgroup. Current use of National Core Indicators, Council on Quality and Leadership Personal Outcome Measures, and CMS HCBS personal experience approach affirm that such approaches are not automatically "burdensome and subjective." ADA, particularly the Supreme Court Olmstead decision, requires a person centered planning that begins with the authentic beneficiary experience. We affirm the high priority measure gaps and affirm the report's observation that resources be devoted to research activities for these activities, especially non-clinical processes and person-centered outcomes. We affirm the observation that the field do more to address the social issues that affect health outcomes of vulnerable populations. We agree with the observation that discussions revealed tensions and differences of opinion as to whether the NCQA measures are sufficiently consumer-oriented. We believe that the current NCQA work is "not" sufficiently consumer-oriented.

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Valerie Wilbur	SNP Alliance	3) Strategies to Support Improved Quality of Life Outcomes	• The SNP Alliance strongly supports movement toward improving quality of life measurement. While we see a strong relationship between quality of life and the four areas identified as the focus for performance measurement, we're not ready to say these are THE vehicles for addressing this issue. We share a strong sense of caution that researchers and public administrators should not get ahead of their clear thinking by implementing new measures in this area too quickly. • We agree that the beneficiary should be the primary team member and final arbiter of the care plan and goals. We support advancing motivational interviewing skills as discussed at the Dual Work Group meeting to help clarify which goals are most important to consumers as part of the shared decision making process. We also believe that a single health professional should be accountable for health care oversight on the delivery side. The professional may change as a person's condition evolves. • We fully agree that providers need to be trained and compensated for providing navigation services as part of the shared decision making process. MAP should consider recommending that the provisions in the recent federal SRG legislation (S. 2110) that would have established CPT codes for care coordination be sufficiently broad to encompass these activities.
Carmella Bocchino	America's Health Insurance Plans	3) Strategies to Support Improved Quality of Life Outcomes	We are supportive of the four domains for measurement of quality of life; however, measurement in this area must demonstrate a cost benefit so that it does not add to the total cost of care and to the cost of achieving good health and well-being. In addition, the strategies to improve and assess the quality of life outcomes should focus on all determinants of health and drive accountability for results beyond the health care system. Targeting a broad set of drivers (care and non-care related) that contribute to patient reported outcomes and quality of life will be critical, as the health care sector oftentimes is seen wholly accountable when other contributors exist.
Lauren Agoratus	Family Voices NJ	3) Strategies to Support Improved Quality of Life Outcomes	We also urge inclusion of the perspectives of consumers – both adults and parents of dual eligible youth – and organizations representing families of consumers (especially youth) in development of the measures. The MAP membership appears to be very heavily weighted toward adults.

Commenter Name	Commenter Organization	Question	Comment
Joe Caldwell	National Council on Aging	4) Approach to Constructing a Stakeholder Feedback Loop	On page 18, “Table 2: Potential Topics for Future Consideration by MAP,” we recommend the following: We applaud a focus on “wellness-directed model over a disease-focused model.” We recommend inclusion self-management of chronic conditions and health promotion for individuals with disabilities. (Fourth bullet in first section)We also support the consideration of interim measures in non-medical domains. We recommend a specific focus on HCBS measures because of the pressing need for measure. We recommend greater consultation with national aging and disability consumer organizations and coalitions about HCBS interim measures (Fifth bullet in first section).In addition, we also recommend greater consultation with national aging and disability consumer organizations and coalitions about measure gaps.We support the consideration of employment and workforce outcomes. However, recommend a specific focus on measures for the direct care workforce providing HCBS as well as measures to support family caregivers.
Carmella Bocchino	America's Health Insurance Plans	4) Approach to Constructing a Stakeholder Feedback Loop	We support the MAP’s recommendation to align reporting requirements and measures across programs and stakeholder groups. Alignment will focus resources, help achieve improved outcomes, and reduce measurement "noise" or redundant reporting requirements.
Lauren Agoratus	Family Voices NJ	4) Approach to Constructing a Stakeholder Feedback Loop	Regarding Table 2: Potential Topics for Future Consideration by MAP, we strongly support person-centered wellness. The Affordable Care Act focuses on shared decision-making and the importance of prevention/wellness, particularly the pediatric Bright Futures guidelines endorsed by the American Academy of Pediatrics. Under “Other factors related to quality of care” we strongly support “Primary care/behavioral health integrations models” as resulting in best outcomes. The National Alliance for Mental Illness has an initiative “Integrating Mental Health in Pediatric Primary Care” which has a study on efficacy, and materials for providers and families, at http://www.nami.org/Template.cfm?Section=child_and_teen_support&Template=/ContentManagement/ContentDisplay.cfm&ContentID=120673. Regarding “Appendix D: Current Family of Measures for Dual Eligible Beneficiaries,” we continue to support the endorsed measures. These include: 0005 CAHPS Clinician/Group Surveys - (Adult Primary Care, Pediatric Care, and Specialist Care Surveys) The consumer satisfaction surveys are good measures of quality of care.

Commenter Name	Commenter Organization	Question	Comment
			0097 Medication Reconciliation This is important as the primary cause of medical errors resulting in increased morbidity and rehospitalization. 0101 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls This is an important safety measure to prevent injury and improve outcomes. 0201 Pressure ulcer prevalence (hospital acquired) Again, this is another measure that prevents injury and promotes better outcomes. 0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) The use of health information technology will decrease medical errors, and prevent emergency room use and hospitalization. 1768 Plan All-Cause Readmissions This measure is important in examining inappropriate early discharge as well as preventable hospital acquired conditions. 1902 Clinicians/ Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy We strongly support this as the single largest barrier to healthcare access.
Anne Cohen	Disability Health Access, LLC	4) Approach to Constructing a Stakeholder Feedback Loop	It's critical for NQF to engage stakeholders that represent consumer voices. In order to do this I suggest creating a short usable and meaningful document that explains why different categories (family measures) are critical to ensure quality care for Dual Eligibles. I also encourage having an annual call with these consumer groups explaining NQF's mission and to seek feedback on the Family of Measures categories. NQF may also consider conducting interviews with Dual Eligible consumers, health plans, providers and state officials in pilot states to share the efforts of the workgroup and to identify possible quality areas that would indicate measurement gaps.
E. Clarke Ross	Consortium for Citizens with Disabilities	4) Approach to Constructing a Stakeholder Feedback Loop	We appreciate the identification of employment as a future topic of consideration We recommend that the workgroup further consider the application of the concept of "dignity of risk."

Commenter Name	Commenter Organization	Question	Comment
Valerie Wilbur	SNP Alliance	4) Approach to Constructing a Stakeholder Feedback Loop	1. We strongly support the focus on alignment, impact of measures and fit-for-purpose as well as the focus on the 4 areas identified on page 17 of the report – identification of measures that are widely used, that have contributed to significant positive impact on quality, that are not functioning as intended, and that are a poor fit for a program's goals. We would support a specific recommendation that in the case of poor fit, the measure be discontinued. The SNP Alliance is particularly interested in addressing alignment requirements between Medicare and Medicaid and among SNPs, MMPs, general MA plans, and managed care and fee-for-service providers serving a similar population segment. 2. We request that MAP gather feedback from SNPs, MMPs, consumers, family caregivers, providers and state Medicaid and related entities. Since 85-100% of SNP and MMP enrollment, respectively, is composed of duals, the perspectives of these plans and their state partners is critical. Consumers should weigh in on which measures are most important to them and should address the burden produced by multiple consumer surveys. Providers should be polled on measure "fit-for-purpose" relative to the populations they serve and about the increasing reporting burden and what they recommend to reduce this burden relative to serving duals. NQF also should consider how to ensure accurate representation across consumers, recognizing the inherent bias of surveys toward healthier respondents, including having better recall of information such as procedures performed and satisfaction measures. Some plans, including the dual demos, have Consumer Advisory Committees that could serve as a source of information. Providers and plans also could help provide access to consumer input. 3. Additional measure refinement should include: (1) Measures related to social determinants of health such as health literacy, homeless and substance abuse; (2) Identification of additional behavioral health measures; (3) Examining and documenting the validity and reliability of self-report measures for persons with intellectual and/or cognitive impairments; and identifying alternative data collection methods, including clear rules for the use of proxy reporting, and the need for further risk adjustment of measures. (4) Modifications to the MA Star rating system that could include exclusion of selected irrelevant measures for specific dual subsets; addition of dual-relevant measures; allocation of greater weight to the Star measures most relevant to enrolled beneficiaries; and establishment of different cut points for Star rating thresholds for duals. (5) Identifying "core measures" within the Family of Measures of particular relevance to specific dual subsets. 4. These issues would be relevant to MAP, CMS, consumers and family caregivers; state Medicaid and related agencies with responsibilities related to the dual population; to SNPs and Medicare-Medicaid Plans; and to providers.

Attachment 3: Potential Future Topics List

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

Attachment 4 - MAP Coordinating Committee Meeting Summary

Measure Applications Partnership
MAP Coordinating Committee Web Meeting

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

The National Quality Forum (NQF) convened a web meeting of the Measure Applications Partnership (MAP) Coordinating Committee on Friday, July 18, 2014. An online archive of the meeting is available by clicking here.

Welcome and Review of Meeting Objectives

Session was led by George Isham and Beth McGlynn, MAP Coordinating Committee Co-Chairs, with additional presentation by Sarah Lash, Senior Director, NQF.

Following opening remarks from Ms. Lash, Drs. Isham and McGlynn reviewed the following meeting objectives:

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

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

Session was led by Harold Pincus, MAP Medicaid Task Force Chair, with additional presentation by Elizabeth Carey, Project Manager, NQF.

Ms. Carey provided background information on the Medicaid enrollee population as well as the Medicaid Adult Core Set. Ms. Carey's presentation included CMS' three-part goal for the Medicaid Adult Core Set ("Adult Core Set"), the number of measures in the set mapped to the National Quality Strategy Priorities and major clinical conditions, and the number of states reporting each measure.

Dr. Pincus discussed the themes from the MAP Medicaid Task Force's review of the Adult Core Set:

- Value of considering states' experiences during the Task Force's discussion and decisionmaking process;
- Importance of the measure set remaining stable to enable states to gain experience and build capacity for reporting; and,

- Support for the majority of the measures in the Adult Core Set for continued use in the program.

Dr. Pincus presented three measures recommended for phased addition to the Adult Core Set (#0059, #1799, and #0647) and one measure the task force recommended for removal due to its retirement from HEDIS following guideline changes (#0063).

Requesting guidance from the Coordinating Committee, Dr. Pincus presented two measures the task force conditionally supported for continued use in the Adult Core Set:

- NQF# 2371 Annual Monitoring for Patients on Persistent Medications
- NQF# 1768 Plan All Cause Readmission

The Adult Core Set currently contains NQF# 2371. This measure had NQF endorsement removed at one point in time, but has now been updated and gained the approval of the NQF Safety Standing Committee. The task force conditionally supported the continued use of this measure if its endorsement is renewed but considered it to be narrowly designed. Focusing on a single point in time, condition, or prescription fails to reflect the overall quality of medication management. The Medicaid Task Force noted a preference for the inclusion of a measure of adherence or shared decision-making about medication choices, and suggested further review of additional medication management measures. In public comment prior to the Coordinating Committee meeting, the Pharmacy Quality Alliance (PQA) suggested NQF# 0541 Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category as it is an adherence measure.

The Coordinating Committee supported the inclusion of a broader measure of medication management, and several committee members supported PQA's suggestion of #0541 as a possible alternative or additional measure for inclusion in the measure set. The Coordinating Committee noted that #2371 and #0541 measure different topics. Therefore, MAP supports the continued use of the annual monitoring measure due to its safety focus, but recommended the inclusion of the adherence measure as it is closely tied to healthcare outcomes. If it is only possible for CMS to include one of the medication measures, MAP expressed a slight preference for #0541.

Dr. Pincus then described that the Adult Core Set currently contains NQF #1768, a measure of readmissions at the health plan level of analysis. The task force conditionally supported this measure for continued inclusion to maintain stability in the measure set, noting that it needs a Medicaid-specific risk adjustment methodology. In response to the possibility of considering another measure of all-cause readmissions calculated at the facility level of analysis, NQF# 1789 Hospital-Wide All-Cause Unplanned Readmission Measure, CMS should consider fit-for-purpose in determining which measure is preferred for use.

Similar to the Coordinating Committee's discussion of the medication measures, MAP supported the inclusion of both measures, if possible, as both may provide valuable information for different purposes. The Coordinating Committee recommended that the measure that is most

actionable and best lends itself to national standardization, stratification, and the ability to make valid comparisons be selected by CMS.

2014 MAP Report from the Dual Eligible Beneficiaries Workgroup

Session was led by Alice Lind, MAP Dual Eligible Beneficiaries Workgroup chair with additional presentation by Megan Duevel Anderson, Project Manager, NQF.

Ms. Lind discussed the key themes from the MAP Dual Eligible Beneficiaries Workgroup's draft report:

- Maintaining the Family of Measures
- Supporting improved quality of life outcomes
- Gathering stakeholder experience

Ms. Lind's presentation also discussed high priority measures gaps that persist for the dual beneficiary population. The workgroup continued to call for measures related to person-centered care planning, coordination, addressing psychosocial needs, and community integration. Ms. Anderson presented on the approach for gathering stakeholder feedback that focused two areas: measure alignment and impact.

Coordinating Committee discussion first focused on the structure and types of information collected in the proposed feedback loop. Coordinating Committee members suggested reaching out to advocates involved in Medicaid systems, regional quality measurement collaboratives, and state agencies currently using and developing measures for dual eligible beneficiaries.

The Coordinating Committee then provided feedback on potential future topics for the Dual Eligible Beneficiaries Workgroup including: measures for advanced illness care, possibilities for collaborating with the Patient Centered Outcomes Research Institute (PCORI), shifting to a wellness-directed model of care as it relates to population health management and new payment models, and expanding the use of diverse data sources for measurement (e.g., vital statistics, lab and pharmacy data).

Opportunity for Public Comment

One public commenter suggested reaching out to patient and consumer advocacy organizations such as Families USA, Family Voices/Family-to-Family Health Information Centers, and the National Health Law Program for greater involvement in the MAP Dual Eligible Beneficiaries Workgroup work.

MAP Continuous Improvement – Updates

Session was led by Rob Saunders, Senior Director, NQF. Dr. Saunders provided an update on the efforts to improve the MAP pre-rulemaking process, including streamlining deliverables by separating measure input from guidance on programs and policy, simplifying meeting materials for committee deliberations, and extending public comment windows and making comments available for MAP discussions

Summary and Next Steps

Session was led by Dr. Isham, who concluded the meeting with a brief discussion of next steps:

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

MAP COORDINATING COMMITTEE MEMBERS IN ATTENDANCE

George Isham, Co-Chair
Elizabeth McGlynn, Co-Chair
Steven Brotman, AdvaMed
Andrea Caballero, Catalyst for Payment Reform (substitute)
Marshall Chin, Subject Matter Expert: Disparities
Maureen Dailey, American Nurses Association (substitute)
Shari Davidson, National Business Group on Health
Christopher M. Dezii, Pharmaceutical Research and Manufacturers of America (PhRMA)
Nancy Foster, American Hospital Association (substitute)
Foster Gesten, National Association of Medicaid Directors
Kate Goodrich, Centers for Medicare & Medicaid Services (CMS)
Tom Granatir, American Board of Medical Specialties (substitute)
Aparna Higgins, America's Health Insurance Plans
Gail Hunt, National Alliance for Caregiving
Gail Janes, Centers for Disease Control and Prevention (CDC)
Chip Kahn, Federation of American Hospitals
William Kramer, Pacific Business Group on Health
Sam Lin, American Medical Group Association
Lisa McGiffert, Consumers Union
Elizabeth Mitchell, Maine Health Management Coalition
Frank Opelka, American College of Surgeons
Peggy O'Kane, National Committee for Quality Assurance
Harold Pincus, Subject Matter Expert and Chair, MAP Medicaid Task Force
Carol Raphael, Subject Matter Expert
Marissa Schlaifer, Academy of Managed Care Pharmacy
Gerry Shea, AFL-CIO
Alison Shippy, National Partnership for Women and Families
Carl Sirio, American Medical Association
Margaret VanAmringe, The Joint Commission (substitute)
Nancy Wilson, Agency for Healthcare Research and Quality (AHRQ)