NATIONAL QUALITY FORUM

Memo

June 4-5, 2018

To: Consensus Standards Approval Committee (CSAC)

From: Patient Experience and Function Project Team

Re: Patient Experience and Function, Fall 2017 Cycle

CSAC Action Required

The CSAC will review recommendations from the Patient Experience and Function Standing Committee at its June 4-5, 2018 meeting and vote on whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, recommended measures, themes identified, and responses to the public and member comments. The following documents accompany this memo:

1. **Patient Experience and Function, Fall 2017 draft report**. The draft report has been updated to reflect the changes made following the Standing Committee's discussion of public and member comments. The complete draft report and supplemental materials are available on the project webpage.
2. **Comment Table**. Staff has identified themes within the comments received. This table lists 28 comments received during the post-meeting comment period and the NQF and Standing Committee responses.

Background

Ensuring that all patients and family members are engaged partners in healthcare is one of the core priorities of the National Quality Strategy and NQF. The current healthcare system lacks necessary measures to support the new paradigm in which patients are empowered to participate actively in their own care. In this new healthcare paradigm, high-quality performance measures are essential to provide insight on how providers are responding to the needs and preferences of patients and families, and how healthcare organizations can create effective care practices that support positive patient experience and improved function.

Patient Experience and Function is a newly formed NQF measure topic area encompassing many of the measures previously assigned to the Person- and Family-Centered Care and Care Coordination topic areas. Measures included in this portfolio assess patient function and experience of care as they relate to health-related quality of life and the many factors that affect it, including communication, care coordination, transitions of care, and use of health information technology.

The 24-member Patient Experience and Function Standing Committee has been charged with overseeing the NQF patient experience and function measure portfolio, evaluating both newly submitted and previously endorsed measures against NQF's measure evaluation criteria,

identifying gaps in the measurement portfolio, providing feedback on how the portfolio should evolve, and serving on any ad hoc or expedited projects in its designated topic areas.

On January 31, 2018, the Patient Experience and Function Standing Committee evaluated four newly submitted measures and one measure undergoing maintenance review. The Standing Committee recommended one measure submitted for maintenance review for endorsement and did not recommend the four newly submitted measures for endorsement.

Draft Report

The Patient Experience and Function fall 2017 draft report presents the results of the evaluation of five measures considered under the Consensus Development Process (CDP). One is recommended for endorsement, and four were not recommended.

The measures were evaluated against the 2017 version of the measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	1	4	5
Measures recommended for endorsement	1	0	1
Measures recommended for inactive endorsement with reserve status	0	0	0
Measures withdrawn from consideration	0	0	0
Reasons for not recommending	N/A	Scientific Acceptability – 3[a]	3

CSAC Action Required

Pursuant to the CDP, the CSAC is asked to consider endorsement of one candidate consensus measure.

Measure Recommended for Endorsement

- 1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey Version 2.0 (American College of Surgeons)

Overall Suitability for Endorsement: Yes-18; No-0

[a] The Committee voted to stop the evaluation of measure 3326, citing similarities to failed measures 3319 and 3324.

Measures Not Recommended

(See Appendix B for the Committee's votes and rationale)

- 3319 Long Term Services and Supports (LTSS) Comprehensive Assessment and Update (CMS)
- 3324 Long Term Services and Supports (LTSS) Comprehensive Care Plan and Update (CMS)
- 3325 Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner (CMS)
- 3326 Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge (CMS)

Comments and Their Disposition

NQF received 28 comments from 10 organizations (including 7 member organizations) and individuals pertaining to the draft report and to the measures under consideration.

A table of comments submitted during the comment period, with the responses to each comment and the actions taken by the Standing Committee and measure developers, is posted to the Patient Experience and Function project webpage.

Comment Themes and Committee Responses

Comments about specific measure specifications and rationale were forwarded to the developers, who were invited to respond.

The Standing Committee reviewed all of the submitted comments (general and measure specific) and developer responses. Committee members focused their discussion on measures or topic areas with the most significant and recurring issues.

Themed Comments

Theme 1 – Standardized Data Elements

One general comment in the memo related to Overarching Project Themes and Discussion and suggested that most health plans do not use the Office of the National Coordinator (ONC) certified technology and therefore do not have structured data elements to map to standard coding language. To the extent that health plans adopt ONC eLTSS certified technology, it will become easier to construct the four LTSS measures submitted for NQF's consideration during the fall 2017 cycle.

Committee Response

The PEF Standing Committee agrees that the electronic Long-Term Services and Supports (eLTSS) initiative supported by the Office of the National Coordinator for Health Information Technology (ONC) is critical in facilitating and promoting the adoption of standardized data elements to support the development of reliable and valid performance measures.

Theme 2 – NQF Measure Evaluation Criteria

One comment was directed to NQF staff and raised concerns about the evaluation process, noting that the Committee did not formally vote on MLTSS measures #3326 *Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge* and had concerns about the measure passing the importance and scientific acceptability criteria. The commenter was concerned that the measure was not fully assessed against the criteria as per NQF's standard process.

NQF Response

Due to the nature of the four MLTSS measures (as a set of very similar measures that build on each other), the Committee's discussion of the measures overlapped and crossed; therefore, many of the issues with measure #3326, as you note, had been discussed by the time this measure was up for review. Staff summaries of measure discussions are slotted into the appropriate section in the report, rather than written out chronologically, so a discussion may appear at a later point in Appendix A than it did in the actual discussion. The MLTSS measures were all tested in the same way and were assessed by the Committee to have similar reliability and validity issues, so the issues with the reliability and validity of 3326 were discussed during earlier sections. In addition, because this measure builds on assessment and care plan processes measured in #3319 and #3324 (in order to be re-assessed, an assessment must have taken place; in order for a care plan to be updated, there must be a care plan in place), the Committee agreed there was no point to formally evaluating the measure based on the related measures not passing. NQF committees often receive measure sets, or related groups of measures, and it is within a committee's purview to request a measure vote may be "carried" across similar measures: a measure can pass or fail criteria using this method.

Measure-Specific Comments

1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey Version 2.0

Two comments were received on this measure during the post-meeting commenting period. One comment expressed general support for the measure's endorsement and does not require a response. The other comment also expressed support for the measure's endorsement, but noted concern over the ability of survey tools for patient satisfaction to measure performance, particularly for surgeons. The commenter also questioned the validity of survey tools for patient satisfaction given that "collection of data is frequently so far removed from the actual patient interaction."

Measure Steward/Developer Response

We greatly appreciate the sentiments expressed by AANS. Indeed, these sentiments were among the reasons why the CAHPS Surgical Care Survey was developed. We believe this measure represents a step in the right direction to move towards meaningful, patient-centered surgical care. Future iterations of this measure are in development, and we look forward to continued AANS support.

3319 Long Term Services and Supports (LTSS) Comprehensive Assessment and Update

Fifteen comments were received on this measure during the post-meeting comment period. Five comments raised concerns with the measure that related to evidence, face-to-face encounters, data availability, and stratification; these comments supported the Committee's decision not to recommend. NQF staff forwarded these five comments to the developer for responses (below). Thirteen of the comments were from the developer in response to the draft report and relate to details from the discussion on the measure. NQF staff have responded to these comments.

Measure Steward/Developer Response

(1) We appreciate the comments regarding the measure's specification that an assessment must include a face-to-face discussion with the member in the home (unless there is documentation of a member refusing in-home assessment) and will consider potential changes to the measure in the future.

We also appreciate the suggestion to include social support as a required core element. We will consider these potential changes to the measure in the future.

Regarding data availability, the measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized measure to assess the degree to which assessments among the MLTSS enrollee population are comprehensive has precluded the collection of comparable data across plans.

Thank you for your suggestions regarding stratification on demographic characteristics. We will consider these potential changes to the measure in the future.

(2) We appreciate the comments regarding the measure's specification of the face-to-face requirement and will consider potential changes to the measure in the future.

Thank you as well for your comment regarding variation in new state MLTSS implementations; in the future, we will consider the possibility of incorporating flexibility into the measure's specified 90-day timeframe to account for new state MLTSS implementations that are not staggered.

(3) Thank you for your comments. Although there was a mix in the inter-rater reliability of both core and supplemental elements included in the two rates, the overall score-level reliability was high. Our submission documents that the inter-class correlation coefficient (ICC) (the ratio of the subject variance to the total variance) for both Rate 1 and 2 exceeded 0.9, indicating almost perfect agreement between the samples, and showing a significant association at $p<0.05$.

The Technical Expert Panel (TEP) voted on the potential of the measure to distinguish performance among health plans as a result of standardizing expectations regarding the key components of a high-quality, person-centered care plan. The majority of the TEP supported the measure (62 percent agreed or strongly agreed that high performance on this measure indicates that a health plan is providing higher quality care), and an even

greater proportion (69%) of the TEP agreed that performance scores on this measure will distinguish between good and poor performance in the future.

(4) We appreciate the comments regarding the measure's specification of face-to-face care plan development and will consider potential changes to the measure in the future.

Thank you for your comment regarding variation in new State MLTSS implementations; in the future, we will consider the possibility of incorporating flexibility into the measure's specified 90-day timeframe to account for new State MLTSS implementations that are not staggered.

We appreciate your comment regarding the balance between medical and non-medical/quality of life core elements specified in this measure. Over time, we anticipate that elements from the "supplemental" requirements will move to the "core" requirements as performance improves. In the meantime, the currently proposed "core" rates can fill a long-standing measurement gap while generating results that are both meaningful and usable to stakeholders.

Thank you for your comments regarding stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.

(5) We appreciate your comments about the measure's specification regarding the face-to-face LTSS Assessment in the member's home unless there is documentation of a member refusing in-home assessment.

NQF Response

(1) Thank you for your comments specific to the draft report. We agree with many of your suggested edits/revisions and will update the following pages:

- Comprehensive Assessment and Update (p.10). We agree with your revision and will update the sentence to include your recommended addition of "all core elements" to the completion of comprehensive assessments.
- Comprehensive Assessment and Update (p.10). We agree that the statement does not accurately reflect the Committee's assessment of the testing results and have revised the sentence to reflect your feedback: "However the Committee expressed concern in regards to the amount of flexibility around how the comprehensive assessment is captured, as well as the low reliability of some of the data elements, and suggested that the overall reliability was high because the performance is so low."
- Comprehensive Assessment and Update (p.10) on low performance rates. The concern of the Committee was specific to the measure not adequately distinguishing between good and poor performance in accountability programs. We agree that the overall low performance rates can indicate substantial room for improvement.

- Comprehensive Assessment and Update (p.11) on removal and/or modification or data elements. We will update the statement to: "The developer also noted that the number and mix of data elements were revised after reviewing testing results. Updated data elements reflected those that had higher frequency in testing, corresponded to elements used in plan assessment forms, and were recommended by the developer's Technical Expert Panel (TEP) members. Due to resource limitations, the measure was not retested following these modifications."

- Comprehensive Assessment and Update (p.11) on the Committee's support of further analysis and resubmission of the measure. We agree with your suggestion and have updated the statement to: "However, the Committee strongly supported further analysis and development of the measure and encouraged the developer to resubmit a version of the measure with fewer data elements that have strong reliability."

- Comprehensive Assessment and Update (p. 22).We agree with your revision and will update the sentence to: "Committee members expressed concern at the low number of comprehensive assessments completed with all nine required core elements, agreeing that comprehensive assessments are a vitally important tool and a foundation of developing a care plan and providing care."

- Comprehensive Assessment and Update (p. 22) on care plans. We appreciate your suggestion, but it was not included in the conversation or mentioned by the Committee, so we will not include it as part of the discussion.

- Comprehensive Assessment and Update (p. 22) on Committee concerns on approach to measuring assessment completion. We agree with your suggestion and will take out the last sentence.

- Comprehensive Assessment and Update (p. 22) on assessment variation. We will update the sentence to more accurately reflect your response: "Committee members asked why the measure does not ask who does the assessment, or require that assessments be done by certain types of providers. The developer explained that health plans use a variety of qualified professionals, including nurses, social workers, and other members of a care management team to perform these assessments."

- Comprehensive Assessment and Update (p. 22) on standardized assessments. We have revised the statement to: "Also in response to questions, the developer reminded the Committee that the measure focuses on the documentation of data elements, and further explained the list of standardized assessments are only suggestions."

- Comprehensive Assessment and Update (p. 23) on the Committee's concern on the reliability results. We have revised the statement to: "The Committee expressed concern in regards to the amount of flexibility around how the

comprehensive assessment is captured, as well as the low reliability of some of the data elements, and suggested that the overall reliability was high because the performance is so low."

- Comprehensive Assessment and Update (p. 23) on measure modification post-testing. We have revised the statement to reflect your input: "The developer also noted that following the low data element testing results, the measure was pared down to include data elements that had higher frequency in testing, corresponded to elements used in plan assessment forms, and were recommended by the developer's Technical Expert Panel (TEP) members."

3324 Long Term Services and Supports (LTSS) Comprehensive Care Plan and Update

Seven comments were received on this measure during the post-meeting comment period. Four comments raised concerns with the measure regarding face-to-face encounters, nonstandard data elements, stratification, and the low agreement rates found during reliability testing. The comments also included support of the Committee's decision not to recommend. These four measures were forwarded to the developer for responses (below). Three of the comments were from the developer in response to the draft report and relate to details from the discussion on the measure. NQF staff have responded to these comments.

Measure Steward/Developer Response

(1) We appreciate the comments regarding the measure's specification of face-to-face care plan development and caregiver involvement in the development of the care plan. We will consider these potential changes to the measure in the future.

Regarding data availability, the measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized measure to assess the degree to which care plan updates among the MLTSS enrollee population are comprehensive has precluded the collection of comparable data across plans.

The clarification of ""substantial update"" is included in the description of the measure. The current measure includes MLTSS plan members who had a comprehensive LTSS care plan with seven core elements (and at least four supplemental elements for rate number 2) documented within 120 days of enrollment.

Thank you for your comments regarding stratification on demographic characteristics. We will consider potential changes to the measure in the future. "

(2) We appreciate the comments regarding the measure's specification of the face-to-face requirement and will consider potential changes to the measure in the future.

(3) We appreciate your comments. The Technical Expert Panel (TEP) voted on the potential of the measure to distinguish performance among health plans as a result of standardizing expectations regarding the key components of a high-quality, person-centered care plan. The majority of the TEP supported the measure (54 percent agreed or strongly agreed that high performance on this measure indicates that a health plan is providing higher quality care), and an even greater proportion (62%) of the TEP agreed

that performance scores on this measure will distinguish between good and poor performance in the future.

Thank you for your comments regarding the measure's scientific acceptability.

(4) We appreciate the comments regarding the measure's specification of face-to-face care plan development and caregiver involvement in the development of the care plan. We will consider potential changes to the measure in the future.

Thank you for your comments regarding stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.

NQF Response

(1) Thank you for your comments specific to the draft report. We agree with many of your suggested edits/revisions and will update the following pages:

- Comprehensive Care Plan and Update (p.11) on the nature of TEP support on the measure. We will update the sentence to "The Committee noted that the majority of the measure developer's TEP supported the measure: 62 percent agreed that performance scores on the measure in the future will distinguish between good and poor performance; and 54 percent agreed or strongly agreed that high performance on this measure indicates that a health plan is providing higher quality care."
- Comprehensive Care Plan and Update (p. 11 and 12) on revising and resubmitting the measure with a smaller number of elements. We have verified this comment, and it pertains to the discussion on the measure during the web evaluation meeting on February 5, 2018.
- Comprehensive Care Plan and Update (p.25) on the Committee's concerns on evidence. We will include the following developer response to reflect your comment: "The developer addressed the Committee's concerns on provider burden with a clarification that the level of analysis for this measure is health plans, specifically those that participate in Medicaid managed long-term services and supports programs. These plans are under contract with, and paid by, states to manage care for Medicaid beneficiaries receiving LTSS. The burden for data collection would not fall to individual physicians and home health workers; these functions are performed by the health plan and health plan-paid staff."

3325 Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner

Six comments were received on this measure during the post-meeting comment period. Four of these comments raise concerns with the measure, specifically the denominator exclusions and transmission of information; and also support the Committee's decision not to recommend. These four comments were forwarded to the developer for responses. Two of the comments were from the developer in response to the draft report and are specific to details outlining the discussion on the measure. NQF staff have responded to these comments.

Measure Steward/Developer Response

(1) Thank you for your comments. Regarding the measure's denominator exclusion, the current technical specifications exclude members that have documentation of refusal to allow care plan sharing. Additionally, the specified denominator for the measure includes only MLTSS plan members with a care plan.

We recognize that standardization of these measure elements is in progress. The measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized measure to assess the degree to which care plan updates among the MLTSS enrollee population are shared within a timely fashion with the PCP has precluded the collection of comparable data across plans.

Thank you for your comments regarding stratification on demographic characteristics. We will consider these potential changes to the measure in the future.

(2) We appreciate your comment regarding additional denominator exclusions; the specified measure's denominator only includes MLTSS plan members with a care plan. Regarding members who declined to choose a PCP, we will consider changing the measure's specification to include these potential exclusions in the future.

(3) Thank you for your comments. We would like to clarify that the Interclass Correlation Coefficient (ICC) (the ratio of the subject variance to the total variance) for the measure rate exceeded 0.9, indicating almost perfect agreement between the samples for the single data element indicating that the care plan was shared, and showing a significant association at $p<0.01$. However, the other elements in the LTSS Shared Care Plan with Primary Care Practitioner measure were assessed too infrequently among the 144 paired assessments (<30) to allow for inter-rater reliability analysis. We have updated the measure specifications to help improve reliability of certain elements.

(4) Thank you for your comments regarding additional denominator exclusions for enrollees who could not be reached, who refused to participate in the development of a comprehensive care plan, or who declined to choose a PCP. We will consider changing the measure's specification to reflect these potential exclusions in the future. We appreciate your comment about stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.

NQF Response

(1) Thank you for your comment in regards to #3325 LTSS Shared Care Plan with PCP (p. 12) on interpretation of care plans and updates. We will revise the sentence to: “The Committee suggested that the reliability issues might be attributed to inherent ambiguity in care plans, including differences in interpretation of what constitutes a care plan, or an update to a care plan, as well as the timing of a transmission. The developer noted that since the care plans may be lengthy, the numerator counts sharing important parts of the care plan when it is updated.”

(2) Thank you for your comment in regards to NQF #3325 LTSS Shared Care Plan with PCP (P.27) on reliability. We have updated the statement to reflect your feedback: "The Committee suggested that the reliability issues might be attributed to inherent ambiguity in care plans, including differences in interpretation of what constitutes a care plan, or an update to a care plan, as well as the timing of a transmission. The developer noted that since the care plans may be lengthy, the numerator counts sharing important parts of the care plan when it is updated."

3326 Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge

Four comments were received on this measure during the post-meeting comment period. Three of these comments raise concerns with the measure, agree with the Committee's decision not to recommend, and were forwarded to the developer for responses (below).

Measure Steward/Developer Response

(1) Thank you for your comments. We recognize that standardization of these measure elements is in progress. The measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized measure to assess the degree to which re-assessments/care plan updates among the MLTSS enrollee population are completed in a timely fashion has precluded the collection of comparable data across plans.

We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider this as a potential change to the measure in the future.

This measure is currently specified such that any discharges from unplanned stays at inpatient facilities should result in a re-assessment or both a re-assessment and care plan update within 30 days of discharge. A face-to-face discussion with the member must be conducted using a structured or semi-structured tool that addresses the member's health status and needs and includes at a minimum nine core elements, as specified in 3319: Long Term Services and Supports (LTSS) Comprehensive Assessment and Update. The assessment may additionally include supplemental elements. Furthermore a care plan updated to identify member needs, preferences, risks, and contains a list of the services and supports planned to meet those needs while reducing risks.

Thank you for your input regarding denominator exclusions. The stakeholders who advised us during measure development did not consider that a member could not be reached as a valid denominator exclusion; while the member was in the hospital, the plan would know where to reach them. In the future, we will revisit the possibility of adding member refusal of care planning as a denominator exclusion.

Thank you for your comments regarding caregiver involvement, and stratification on demographic characteristics. We will consider these as potential changes to the measure in the future.

(2) Thank you for your comment regarding access to non-aligned dually-eligible enrollees' data; in the future, we will consider potential changes to the measure's specified timeframe to account for plans' access to the required data elements.

We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider this as a potential change to the measure in the future.

The measure excludes MLTSS plan members who refused to participate in an assessment or development of a comprehensive LTSS care plan. We appreciate your comments regarding excluding members who could not be contacted and will consider this as a potential change to the measure specifications in the future. Thank you for your comment regarding access to non-aligned dually-eligible enrollees' data; in the future, we will consider potential changes to the measure's specified timeframe to account for plans' access to the required data elements.

We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider this as a potential change to the measure in the future.

The measure excludes MLTSS plan members who refused to participate in an assessment or development of a comprehensive LTSS care plan. We appreciate your comments regarding excluding members who could not be contacted and will consider this as a potential change to the measure specifications in the future.

(3) Thank you for your comment regarding access to non-aligned dually-eligible enrollees' data; in the future, we will consider potential changes to the measure's specified timeframe to account for plans' access to the required data elements.

We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider potential changes to the measure in the future.

Thank you for your input regarding additional denominator exclusions for enrollees who could not be reached or who refuse care planning; we will take this into consideration.

Regarding caregiver involvement, we appreciate your suggestion to document the availability of informal caregivers separately from documentation of such caregivers' involvement. We will consider this potential change to the measure specification.

We also appreciate your comment about stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.

Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. Two NQF members provided their expression of support. Appendix C details the expression of support.

Appendix A: CSAC Checklist

The table below lists the key considerations to inform the CSAC's review of the measures submitted for endorsement consideration.

Key Consideration	Yes/No	Notes
Were there any process concerns raised during the CDP project? If so, briefly explain.	Yes	NQF received one post-evaluation public comment that raised concerns about the evaluation process, noting that the Committee did not formally vote on measure #3326 Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge, but had concerns about the measure passing the importance and scientific acceptability criteria. The commenter was concerned that the measure was not fully assessed against the criteria per NQF's standard process. NQF shared the following response: "*Thank you for your comment and concern. Due to the nature of the four LTSS measures (as a set of very similar measures that build on each other), the Committee's discussion of the measures overlapped and crossed; therefore, many of the issues with the measure, as you note, had been discussed by the time this measure was up for review. Staff summaries of measure discussions are slotted into the appropriate section in the report, rather than written out chronologically, so a discussion may appear at a later point in Appendix A than it did in the actual discussion. The MLTSS measures were all tested in the same way and were assessed by the Committee to have similar reliability and validity issues, so the issues with the reliability and validity of 3326 were discussed during earlier sections. In addition, because this measure builds on assessment and care plan processes measured in #3319 and #3324 (in order to be re-assessed, an assessment must have taken place; in order for a care plan to be updated, there must be a care plan in place), the Committee agreed there was no point to formally evaluating the measure based on the related measures not passing. NQF committees often receive measure sets, or related groups of measures, and it is within a committee's purview to request a measure vote may be "carried" across similar measures: a measure can pass or fail criteria using this method."*

Key Consideration	Yes/No	Notes
Did the Standing Committee receive requests for reconsideration? If so, briefly explain.	No	
Did the Standing Committee overturn any of the Scientific Methods Panel's ratings of Scientific Acceptability? If so, state the measure and why the measure was overturned.	No	
If a recommended measure is a related and/or competing measure, was a rationale provided for the Standing Committee's recommendation? If not, briefly explain.	Yes	Measure 1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey Version 2.0 is related to eight additional CAHPS measures. NQF staff presented all related measures to the Committee during the post-comment call. The Committee discussed alignment across all measures and noted no concerns for the measure's endorsement. The Committee noted the need for the alignment of domains within the various CAHPS measures and agreed to further discuss in future Committee work.
Were any measurement gap areas addressed? If so, identify the areas.	No	
Are there additional concerns that require CSAC discussion? If so, briefly explain.	No	

Appendix B: Measures Not Recommended for Endorsement

The table below lists the Committee's vote and rationale for measures not recommended for endorsement.

Legend: Y = Yes; N = No; H = High; M = Moderate; L = Low; I = Insufficient

Measure	Voting Results	Standing Committee Rationale
3319 Long Term Services and Supports (LTSS) Comprehensive Assessment and Update (CMS)	**Evidence** H-1; M-13; L-5; I-0 **Gap** H-15; M-4; L-0; I-0 **Reliability** H-0; M-6; L-13; I-0 **Validity** N/A **Feasibility** N/A **Usability and Use** *Use* N/A *Usability* N/A	This measure did not meet the Reliability subcriterion. The Committee expressed concern in regards to low reliability results for both data element and score level testing. The Committee suggested that low reliability of data elements coupled with low performance rates overall may be an indication that the measure may not adequately distinguish between good and poor performance in accountability programs. The Committee strongly supported further analysis and development of the measure and encouraged the developer to resubmit a simpler version of the measure with additional testing information.
3324 Long Term Services and Supports (LTSS) Comprehensive Care Plan and Update (CMS)	**Evidence** H-0; M-13; L-2; I-4 **Gap** H-6; M-13; L-0; I-0 **Reliability** H-0; M-11; L-7; I-1 **Validity** H-0; M-6; L-12; I-1 **Feasibility** N/A **Usability and Use** *Use* N/A *Usability* N/A	This measure did not meet the Validity subcriterion. The measure relied on face validity rather than empirical validity testing. The Committee noted that the majority of the measure developer's technical expert panel (TEP) supported the measure but not an overwhelming number (54 percent agreed or strongly agreed that high performance on this measure indicates that a health plan is providing higher quality care). Committee members suggested that validity could be improved with more precisely defined and/or standardized data elements. Committee members encouraged the developer to conduct additional testing and bring the measure back in the future for re-review, and/or resubmit the measure with a smaller number of elements that had higher reliability and validity.

Measure	Voting Results	Standing Committee Rationale
3325 Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner (CMS)	**Evidence** H-0; M-13; L-2; I-2 **Gap** H-4; M-13; L-0; I-0 **Reliability** H-0; M-4; L-11; I-2 **Validity** N/A **Feasibility** N/A **Usability and Use** *Use* N/A *Usability* N/A	This measure did not meet the Reliability subcriterion. The Committee expressed concerns with the variability of the reliability score, noting low agreement on the data element scores. Additionally, because these measures are considered in early development in terms of data standardization and data collection, the Committee expressed concerns about excess burden for the provider.
3326 Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge (CMS)	The Committee voted to stop the evaluation of measure 3326 citing similarities to failed measures 3324 and 3325.	Based on similar reliability and validity concerns, the Committee elected not to continue the evaluation of this measure after a short discussion and vote to continue the evaluation of this measure. Committee members reiterated the need for measures in this topic area, but agreed the four submitted measures in the LTSS set are not ready for NQF endorsement.

Appendix C: NQF Member Expression of Support Results

Two NQF members provided their expression of support. One out of five measures under consideration received support from NQF members. Results for each measure are provided below.

NQF #1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey Version 2.0 (American College of Surgeons)

Member Council	Support	Do Not Support	Total
Health Professional	1	0	1

NQF #3319 Long Term Services and Supports (LTSS) Comprehensive Assessment and Update (CMS)

Member Council	Support	Do Not Support	Total
Health Plan	0	1	1
Health Professional	0	1	1

NQF #3324 Long Term Services and Supports (LTSS) Comprehensive Care Plan and Update (CMS)

Member Council	Support	Do Not Support	Total
Health Plan	0	1	1
Health Professional	0	1	1

NQF #3325 Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner (CMS)

Member Council	Support	Do Not Support	Total
Health Plan	0	1	1
Health Professional	0	1	1

Appendix D: Details of Measure Evaluation

Recommended Measures

1741 Consumer Assessment of Healthcare Providers and Systems (CAHPS)® Surgical Care Survey Version 2.0 (American College of Surgeons, Division of Advocacy and Health Policy): Recommended

Submission

Description: The following 6 composites and 1 single-item measure are generated from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surgical Care Survey. Each measure is used to assess a particular domain of surgical care quality from the patient's perspective.

Measure 1: Information to help you prepare for surgery (2 items)

Measure 2: How well surgeon communicates with patients before surgery (4 items)

Measure 3: Surgeon's attentiveness on day of surgery (2 items)

Measure 4: Information to help you recover from surgery (4 items)

Measure 5: How well surgeon communicates with patients after surgery (4 items)

Measure 6: Helpful, courteous, and respectful staff at surgeon's office (2 items)

Measure 7: Rating of surgeon (1 item)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surgical Care Survey (S-CAHPS) is a standardized survey instrument that asks patients about their experience before, during and after surgery received from providers and their staff in both inpatient and outpatient (or ambulatory) settings. S-CAHPS is administered to adult patients (age 18 and over) that had an operation as defined by CPT codes (90 day globals) within 3 to 6 months prior to the start of the survey.

The S-CAHPS expands on the CAHPS Clinician & Group Survey (CG-CAHPS), which focuses on primary and specialty medical care, by incorporating domains that are relevant to surgical care, such as sufficient communication to obtain informed consent, anesthesia care, and post-operative follow-up and care coordination. Other questions ask patients to report on their experiences with office staff during visits and to rate the surgeon.

The S-CAHPS survey is sponsored by the American College of Surgeons (ACS). The survey was approved as a CAHPS product in early 2010 and the Agency for Healthcare Research and Quality (AHRQ) released version 1.0 of the survey in the spring of 2010. The S-CAHPS survey Version 2.0 was subsequently endorsed by NQF in June 2012 (NQF #1741). 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/cg/about/index.html. Surgeons may customize the S-CAHPS survey by adding survey items that are specific to their patients and practice. However, the core survey must be used in its entirety in order to be comparable with other S-CAHPS data. The S-CAHPS survey is available in English and Spanish.

The 6 composite measures are made up of the following items:

The 1 single item measure (Measure 7) is (Q35): Using any number from 0 to 10, where 0 is the worst surgeon possible and 10 is the best surgeon possible, what number would you use to rate all your care from this surgeon?

Measure 1: Information to help you prepare for surgery (2 items)

Q3. Before your surgery, did anyone in this surgeon's office give you all the information you needed about your surgery?

Q4. Before your surgery, did anyone in this surgeon's office give you easy to understand instructions about getting ready for your surgery?

Measure 2: How well surgeon communicates with patients before surgery (4 items)

Q9. During your office visits before your surgery, did this surgeon listen carefully to you?

Q10. During your office visits before your surgery, did this surgeon spend enough time with you?

Q11. During your office visits before your surgery, did this surgeon encourage you to ask questions?

Q12. During your office visits before your surgery, did this surgeon show respect for what you had to say?

Measure 3: Surgeon's attentiveness on day of surgery (2 items)

Q15. After you arrived at the hospital or surgical facility, did this surgeon visit you before your surgery?

Q17. Before you left the hospital or surgical facility, did this surgeon discuss the outcome of your surgery with you?

Measure 4: Information to help you recover from surgery (4 items)

Q26. Did anyone in this surgeon's office explain what to expect during your recovery period?

Q27. Did anyone in this surgeon's office warn you about any signs or symptoms that would need immediate medical attention during your recovery period?

Q28. Did anyone in this surgeon's office give you easy to understand instructions about what to do during your recovery period?

Q29. Did this surgeon make sure you were physically comfortable or had enough pain relief after you left the hospital or surgical facility where you had your surgery?

Measure 5: How well surgeon communicates with patients after surgery (4 items)

Q31. After your surgery, did this surgeon listen carefully to you?

Q32. After your surgery, did this surgeon spend enough time with you?

Q33. After your surgery, did this surgeon encourage you to ask questions?

Q34. After your surgery, did this surgeon show respect for what you had to say?

Measure 6: Helpful, courteous, and respectful staff at surgeon's office (2 items)

Q36. During these visits, were clerks and receptionists at this surgeon's office as helpful as you thought they should be?

Q37. During these visits, did clerks and receptionists at this surgeon's office treat you with courtesy and respect?

Numerator Statement: We recommend that S-CAHPS Survey items and composites be calculated using a top-box scoring method. The top box score refers to the percentage of patients whose responses indicated excellent performance for a given measure. This approach is

a kind of categorical scoring because the emphasis is on the score for a specific category of responses.

The top box numerator for the Overall Rating of Surgeon is the number of respondents who answered 9 or 10 for the item, with 10 indicating “Best provider possible”.

For more information on the calculation of reporting measures, see What´s Available for the CAHPS Surgical Care Survey: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/surgical/about/whats-available-surgical-care-survey.pdf

Also see Patient Experience Measures from the CAHPS Surgical Care Survey Document 409 obtained by going to: https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html

Also, for more information on the calculation of reporting measures, see How to Report Results of the CAHPS Clinician & Group Survey, available at https://cahps.ahrq.gov/surveys-guidance/cg/cgkit/HowtoReportResultsofCGCAHPS080610FINAL.pdf.

Denominator Statement: The measure’s denominator is the number of survey respondents. The target population for the survey is adult patients (age 18 and over) who had a major surgery as defined by Common Procedural Terminology (CPT) codes (90 day globals) within 3 to 6 months prior to the start of the survey.

Results will typically be compiled over a 12-month period.

For more information on the calculation of reporting measures, see Patient Experience Measures from the CAHPS Surgical Care Survey, available at https://www.ahrq.gov/cahps/surveys-guidance/surgical/instructions/get-surg-care-survey-instruct.html.

Exclusions: The following are excluded when constructing the sampling frame:

- Surgical patients whose procedure was greater than 6 months or less than 3 months prior to the start of the survey.

- Surgical patients younger than 18 years old.

- Surgical patients who are institutionalized (put in the care of a specialized institution) or deceased.

Adjustment/Stratification: If survey users want to combine data for reporting from different sampling strata, they will need to create a text file that identifies the strata and indicates which ones are being combined and the identifier of the entity obtained by combining them.

See pages 18-19 of the Instructions for Analyzing Data available at https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/2015-Instructions-for-Analyzing-Data-from-CAHPS-Surveys.pdf.

Level of Analysis: Clinician : Group/Practice

Setting of Care: Inpatient/Hospital, Other, Outpatient Services

Type of Measure: Outcome: PRO-PM

Data Source: Instrument-Based Data

Measure Steward: American College of Surgeons, Division of Advocacy and Health Policy

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Y-17**; **N-1**; 1b. Performance Gap: **H-3**; **M-13**; **L-2**; **I-0;**

Rationale:

- The Committee supported the measure's inclusion of both pre-operative and post-operative responses in the survey instrument, noting that capturing the full episode is critical.
- The Committee inquired about feedback and criticisms that the developer has received from clinicians regarding use of the measure. The developer noted that clinicians have been key supporters of the measure. The developer also discussed use of the broader H-CAHPS survey, which is often used instead of S-CAHPS; however, many surgeons prefer the use of the surgery-specific survey. The developer noted that providers were generally supportive of the measure and appreciated the feedback it provides. Committee members echoed the preference for S-CAHPS from a patient perspective, noting experiences when they wished to provide feedback to a specific surgeon, but were instead administered the more general H-CAHPS survey.
- The Committee noted the measure's lack of risk adjustment and disparities data and agreed that the measure presents an opportunity to further examine racial and other types of disparities in experience of care. The developer explained that collecting and using disparities data is a priority and noted that they have recently received a grant from the Agency for Healthcare Research and Quality (AHRQ) to explore further integration of disparities data collection and analysis.
- The developer also discussed a recent move to aggregated patient-reported outcome data in an effort to further examine disparities more meaningfully.
- The Committee noted that the S-CAHPS assesses a process of communication rather than the quality of communication. The developer agreed that quality of the communication is important and explained they are developing a series of measures that focus on an entire episode of care including key elements specific to surgical phases. NCQA is developing sets of measures that link key process of surgical care to surgical outcomes and patient experience. These new measure sets will capture whether the surgical goals were acknowledge and understood by the patient before surgery and whether they were attained. The developer emphasized the importance of capturing the full episode of care and all of those associated with that care (physicians, nurses, patients, pre- and post-op teams, etc.) in order to capture the patient's full experience. The Committee supported this initiative and suggested that any future measures should consider whether the patient had accurate expectations of possible temporary side effects following surgery.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-4**; **M-14**; **L-0**; **I-0** 2b. Validity: **H-3**; **M-15**; **L-0**; **I-0**

Rationale:

- The Committee discussed the measure's use of top-box scoring and questioned the method's ability to reflect the presence of poor performance. For instance, the measure could report that 90% of surgeons receive a 9 or 10, but would fail to reflect that the other 10% received an average score of one. The developer stated that users of the measure can calculate means or other statistics for quality improvement initiatives.
- The Committee noted the lack of both social and clinical risk adjustment and/or stratification. The measure does include the standard CAHPS case mix adjustment, but the Committee agreed that there is an opportunity to push the measure further in accounting for social determinants of health.
- The Committee asked for clarification around exclusions of patients who are not able to communicate, such as those arriving for emergency surgery. The denominator excludes emergency surgery patients, as they will not have undergone the processes of care leading up to surgery, which are an important part of this measure.

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3. Feasibility: H-6; M-10; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- Committee members raised potential feasibility problems; one member noted that the low response rate of the S-CAHPS and H-CAHPS could raise issues regarding the measure's representativeness of the population of patients seen at sites or by providers; another member noted that the data for the measure are derived from patient responses to a 47-question survey and recommended using an electronic option to reduce survey burden for patients with access to a computer and increase data accuracy and response rates.
- A Committee member stated general concern over the feasibility of all Patient-Report Outcome Measures (PROMs), but noted that the use of multiple modalities for data collection and lower burden electronic options for collection will continue to minimize the issue. Ultimately, the Committee agreed the measure met the feasibility criteria.

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4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-17; No Pass-0** 4b. Usability: **H-12; M-5; L-1; I-0**

Rationale:

- The Committee asked whether the developer had considered any real-time data collection in order to allow providers to immediately intervene if a patient reports confusion or sub-par communication. The developer responded that hospitals are working to implement real-time feedback loops for their own quality improvement efforts, but that the process is not currently involved in quality measurement.

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5. Related and Competing Measures

Related:

- 0005 : CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child
- 0006: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)
- 0166: HCAHPS
- 0258: CAHPS In-Center Hemodialysis Survey
- 0517: CAHPS Home Health Care Survey (experience with care)
- 2651: CAHPS Hospice Survey (experience with care)
- 2548: Child Hospital CAHPS (HCAHPS)
- 2967: CAHPS Home- and Community-Based Services Measures

Standing Committee Recommendation for Endorsement: **Y-18**; **N-0**

6. Public and Member Comment

NQF received two comments on this measure during the post-meeting commenting period. One comment expressed general support for the measure's endorsement and did not require a response. The other comment also expressed support for the measure's endorsement, but noted concern over the ability of survey tools for patient satisfaction to measure performance, particularly for surgeons. The commenter also questioned the validity of survey tools for patient satisfaction given that "collection of data is frequently so far removed from the actual patient interaction."

> Developer Response: We greatly appreciate the sentiments expressed by AANS. Indeed, these sentiments were among the reasons why the CAHPS Surgical Care Survey was developed. We believe this measure represents a step in the right direction to move towards meaningful, patient-centered surgical care. Future iterations of this measure are in development, and we look forward to continued AANS support.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Appeals

Measures Not Recommended

3319 Long Term Services and Supports (LTSS) Comprehensive Assessment and Update (CMS): Not Recommended

Submission

Description: This measure assesses the percentage of Managed Long Term Services and Support (MLTSS) plan enrollees who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core and supplemental elements. This measure has two rates:

Rate 1: Percent of MLTSS plan enrollees with documentation of a comprehensive LTSS assessment including nine (9) core elements within 90 days of enrollment or at least annually.

Rate 2: Percent of MLTSS plan enrollees with documentation of a comprehensive LTSS assessment including nine (9) core elements AND at least twelve (12) supplemental elements within 90 days of enrollment or at least annually.

Numerator Statement: The measure has two rates. The numerators for the two rates are as follows:

Rate 1: MLTSS plan enrollees who had either of the following:

- A comprehensive LTSS assessment completed within 90 days of enrollment for new enrollees, with nine (9) core elements documented, or
- A comprehensive LTSS assessment completed at least once during the measurement year for all other enrollees (established enrollees), with nine (9) core elements documented.
- Rate 2: MLTSS plan enrollees who had either of the following:
- A comprehensive LTSS assessment completed within 90 days of enrollment for new enrollees, with nine (9) core and at least twelve (12) supplemental elements documented, or
- A comprehensive LTSS assessment completed at least once during the measurement year for all other enrollees (established enrollees) with nine (9) core and at least twelve (12) supplemental elements documented.

Note: Initial assessment should be completed within 90 days of enrollment, and updated annually thereafter.

Denominator Statement: Medicaid MLTSS plan enrollees age 18 years and older.

Note: For individuals who have multiple distinct continuous enrollment periods during the measurement year, plans should look at the assessment completed in the last continuous enrollment period of 120 days or greater during the measurement year. This denominator is aligned with the denominator of a paired measure, LTSS Comprehensive Care Plan and Update, to allow MLTSS plans to use a single sample for assessing both measures.

Exclusions: Exclude enrollees in the denominator who were enrolled in the plan prior to September 1 of the year prior to the measurement year (i.e., established enrollees) who left the plan for more than 45 days between January 1 and December 31 of the measurement year.

Exclude enrollees who could not be reached for a comprehensive assessment or who refused a comprehensive assessment.

Adjustment/Stratification: Not Applicable, no stratification.

Level of Analysis: Health Plan

Setting of Care: Home Care, Other

Type of Measure: Process

Data Source: Management Data, Other, Paper Medical Records

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

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STANDING COMMITTEE MEETING [01/31/2018]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-1**; **M-13**; **L-5**; **I-0**; 1b. Performance Gap: **H-15**; **M-4**; **L-0**; **I-0**

Rationale:

- The Committee agreed this measure covers a critical topic for managed care and has the potential to move the field forward. Committee members expressed shock at the low number of comprehensive assessments completed with all nine required core elements, agreeing that comprehensive assessments are a vitally important tool and a foundation of developing a care plan and providing care. A Committee member noted that care plans should be influenced by a patient's goals and resources, and that patients need to see how these assessments influence their care plan.
- Committee members discussed the very low rates of performance (0.0%-25.5% for rate one, nine core elements documented, and 0.0-21.% for rate two, nine core elements and twelve supplemental elements documented), and questioned whether that demonstrates a true gap in care, or whether it is a sign the measure is not looking at the right components of an assessment. The Committee also raised concerns about the process of measuring the documentation of an assessment rather than measuring whether something was done.
- The developer explained that measurement requires documentation, and that documentation is also key to good care coordination and ensuring that a care plan will include all needs. There are documentation problems with these assessments, leading to a lack of knowledge on whether something was assessed and nothing was found, or whether it was not assessed.
- While the developer collected race and ethnicity information, results were not analyzed or reported due to the lack of data; Committee members flagged cognitive impairment as another area to assess for disparities. In response to a question from the Committee, the developer explained that current reporting rates are too low to assess disparities, but they would like to do so in the future when more data are available.

2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-6**; **L-13**; **I-0** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X**

Rationale:

- Committee members asked why the measure does not ask who does the assessment, or require that assessments be done by certain types of providers, and the developer explained that health plans use a variety of qualified professionals, including nurses, social workers, and other members of a care management team to perform these assessments. Also in response to questions, the developer reminded the Committee that the measure focuses on the documentation of data elements, and further explained the list of standardized assessments are only suggestions; however, Committee members did note the lack of standardization may be influencing the low reliability.
- The Committee expressed concern in regards to the amount of flexibility around how the comprehensive assessment is captured, as well as the low reliability of some of the data elements, and suggested that the overall reliability was high because the performance is so low. The Committee suggested that low reliability of data elements coupled with low performance rates overall may be an indication that the measure may not adequately distinguish between good and poor performance in accountability programs. The developer responded that several state Medicaid agencies have adopted LTSS standardized data elements to support reporting and to improve data element reliability, but that there remains great variation in performance and lack of standard data elements across the nation.
- The developer also attributed low reliability scores to the lack of standardization in documentation, lack of documentation of negative responses during an assessment, and a large performance gap.
- The developer also noted that following the low data element testing results, the measure was pared down to include data elements that had higher frequency in testing, corresponded to elements used in plan assessment forms, and were recommended by the developers Technical Expert Panel (TEP) members. Due to resource limitations, the measure was not retested following these modifications. The measure is currently under consideration for inclusion in HEDIS and, if included, the developer will monitor reliability through HEDIS auditing.
- While the measure did not pass the reliability criterion, the Committee strongly supported further analysis and development and encouraged the developer to resubmit the measure with additional testing information.

Standing Committee Recommendation for Endorsement: **Did Not Pass Reliability**

6. Public and Member Comment

Fifteen comments were received on this measure during the post-meeting comment period. Five comments raised concerns with the measure that related to evidence, face-to-face

encounters, data availability and stratification; these comments supported the Committee's decision not to recommend. NQF staff forwarded these five comments to the developer for responses (below). Thirteen of the comments were from the developer in response to the draft report and relate to details from the discussion on the measure. NQF staff responded to these comments.

Developer Responses: (1) We appreciate the comments regarding the measure's specification that an assessment must include a face-to-face discussion with the member in the home (unless there is documentation of a member refusing in-home assessment) and will consider potential changes to the measure in the future.

We also appreciate the suggestion to include social support as a required core element. We will consider these potential changes to the measure in the future.

Regarding data availability, the measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized measure to assess the degree to which assessments among the MLTSS enrollee population are comprehensive has precluded the collection of comparable data across plans.

Thank you for your suggestions regarding stratification on demographic characteristics. We will consider these potential changes to the measure in the future.

(2) We appreciate the comments regarding the measure's specification of the face-to-face requirement and will consider potential changes to the measure in the future.

Thank you as well for your comment regarding variation in new state MLTSS implementations; in the future, we will consider the possibility of incorporating flexibility into the measure's specified 90-day timeframe to account for new state MLTSS implementations that are not staggered.

(3) Thank you for your comments. Although there was a mix in the inter-rater reliability of both core and supplemental elements included in the two rates, the overall score-level reliability was high. Our submission documents that the inter-class correlation coefficient (ICC) (the ratio of the subject variance to the total variance) for both Rate 1 and 2 exceeded 0.9, indicating almost perfect agreement between the samples, and showing a significant association at $p<0.05$.

The Technical Expert Panel (TEP) voted on the potential of the measure to distinguish performance among health plans as a result of standardizing expectations regarding the key components of a high-quality, person-centered care plan. The majority of the TEP supported the measure (62 percent agreed or strongly agreed that high performance on this measure indicates that a health plan is providing higher quality care), and an even greater proportion (69%) of the TEP agreed that performance scores on this measure will distinguish between good and poor performance in the future.

(4) We appreciate the comments regarding the measure's specification of face-to-face care plan development and will consider potential changes to the measure in the future.

Thank you for your comment regarding variation in new State MLTSS implementations; in the future, we will consider the possibility of incorporating flexibility into the measure's specified 90-day timeframe to account for new State MLTSS implementations that are not staggered.

We appreciate your comment regarding the balance between medical and non-medical/quality of life core elements specified in this measure. Over time, we anticipate that elements from the "supplemental" requirements will move to the "core" requirements as performance improves. In the meantime, the currently proposed "core" rates can fill a long-standing measurement gap while generating results that are both meaningful and usable to stakeholders.

Thank you for your comments regarding stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.

(5) We appreciate your comments about the measure's specification regarding the face-to-face LTSS Assessment in the member's home unless there is documentation of a member refusing in-home assessment.

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7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Appeals

3324 Long Term Services and Supports (LTSS) Comprehensive Care Plan and Update (CMS): Not Recommended

Submission

Description: This measure assesses the percentage of Managed Long Term Services and Support (MLTSS) plan enrollees who have documentation of a comprehensive care plan in a specified timeframe that includes documentation of core domains. The measure has two rates:

Rate 1: Percent of MLTSS plan enrollees with a comprehensive LTSS care plan including seven (7) core elements documented within 120 days of enrollment or at least annually.

Rate 2: Percent of MLTSS plan enrollees with a comprehensive LTSS care plan including seven (7) core elements and at least four (4) supplemental elements documented within 120 days of enrollment or at least annually.

Numerator Statement: The measure has two rates. The numerators for the two rates are as follows:

Rate 1: MLTSS plan enrollees who had either of the following:

- A comprehensive LTSS care plan completed within 120 days of enrollment for new enrollees, with seven (7) core elements documented, or

- A comprehensive LTSS care plan completed at least once during the measurement year for all other enrollees (established enrollees) with all seven (7) core elements documented.

Rate 2: MLTSS plan enrollees who had either of the following:

- A comprehensive LTSS care plan completed within 120 days of enrollment for new enrollees, with seven (7) core elements and at least four (4) supplemental elements documented, or

- A comprehensive LTSS care plan completed at least once during the measurement year for all other enrollees (established enrollees) with seven (7) core elements and at least four (4) supplemental elements documented.

Note: Initial care plan should be developed within 120 days of enrollment (allows for 90 days to complete assessment and 30 days to complete care plan), and updated annually thereafter.

Denominator Statement: Medicaid MLTSS enrollees age 18 years and older.

Note: For individuals who have multiple distinct continuous enrollment periods during the measurement year, plans should look at the care plan completed in the last continuous enrollment period of 120 days or greater during the measurement year. This denominator is aligned with the denominator of a paired measure, LTSS Comprehensive Assessment and Update, to allow MLTSS plans to use a single sample for assessing both measures.

Exclusions: Exclude enrollees in the denominator who were enrolled in the plan prior to September 1 of the year prior to the measurement year (i.e. established enrollees) and who left the plan for more than 45 days between January 1 and December 31 of the measurement year. These are enrollees who may have left the plan before their annual care plan update was conducted.

Exclude enrollees who could not be reached for development of a comprehensive care plan or who refused to participate in development of a comprehensive care plan. Enrollees who refuse care planning are excluded from the requirement of having goals and preferences documented and enrollee signature.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan

Setting of Care: Home Care, Other

Type of Measure: Process

Data Source: Management Data, Other, Paper Medical Records

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

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STANDING COMMITTEE MEETING [01/31/2018]

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0**; **M-13**; **L-2**; **I-4**; 1b. Performance Gap: **H-6**; **M-13**; **L-0**; **I-0;**

<u>Rationale</u>:

- The Committee noted that the formal evidence base for care coordination is still immature, thus making it difficult, if not impossible, for the developer to provide a robust evidence base. There is also no agreement on what elements are most

important to include in a care plan, but the developer explained this measure is intended to help with that standardization.

- The Committee did note some concerns about burden on providers for a measure with limited evidence.
- The developer addressed the Committee's concerns on provider burden with a clarification that the level of analysis for this measure is health plans, specifically those that participate in Medicaid managed long-term services and supports programs. These plans are under contract with, and paid by, states to manage care for Medicaid beneficiaries receiving LTSS. The burden for data collection would not fall to individual physicians and home health workers; these functions are performed by the health plan and health plan-paid staff.
- Despite these concerns, the literature demonstrates enough of a connection between the process and downstream outcomes, particularly the link between documenting preferences and outcomes, that the measure passed the evidence criterion.
- In addition, the Committee agreed there is a large opportunity for improvement in care based on the performance data analysis (0.0-2.4% have documentation of the seven core elements, or the core elements and four supplemental elements), although they did raise some concerns that the gap may be at least partly attributable to the wide variation in care planning.
- Noting that measure 3319 *LTSS Comprehensive Assessment and Update* was supposed to be the foundation of the set of measures and was not recommended, the Committee was concerned and questioned whether the first measure not passing affected the ability of the Committee to recommend the other measures. Committee members noted this was a "chicken and egg" situation, with more data needed in order to standardize care, but these measures are intended to help collect the data needed to standardize care.

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2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-11**; **L-7**; **I-1 (consensus not reached)** 2b. Validity: **H-0**; **M-6**; **L-12**; **I-1**

<u>Rationale</u>:

- The Committee noted that the reliability was variable, with some rates highly reliable and others less reliable; reliability issues were specific to key data elements, which raised concerns from the Committee, but overall the reliability for the performance score was moderate.
- The measure relies on face validity, rather than empirical validity testing. The Committee raised concerns with these results and noted that the majority of the measure developer's TEP supported the measure but not an overwhelming number (54% agreed or strongly agreed that high performance on this measure indicates that a health plan is providing higher quality care).
- Committee members suggested that validity could be improved with more precisely defined and/or standardized data elements. The developer explained that it thought the validity was low because so many entities were reporting zero.

- The measure did not pass Validity, a must-pass criterion, therefore Committee members did not recommend the measure for endorsement. The Committee, however, strongly encouraged the developer to conduct some additional testing and resubmit the measure in the future for re-review, and/or resubmit the measure with a smaller number of elements that had higher reliability and validity.

Standing Committee Recommendation for Endorsement: **Did Not Pass Validity**

Rationale:

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6. Public and Member Comment

Seven comments were received on this measure during the post-meeting comment period. Four comments raised concerns with the measure regarding face-to-face encounters, nonstandardized data, stratification, and the low agreement rates found during reliability testing. The comments also included support of the Committee's decision not to recommend. These four measures were forwarded to the developer for responses (below). Three of the comments were from the developer in response to the draft report and relate to details from the discussion on the measure. NQF staff responded to these comments.

> **Developer Responses**: **(1)** We appreciate the comments regarding the measure's specification of face-to-face care plan development and caregiver involvement in the development of the care plan. We will consider these potential changes to the measure in the future.
>
> Regarding data availability, the measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized measure to assess the degree to which care plan updates among the MLTSS enrollee population are comprehensive has precluded the collection of comparable data across plans.
>
> The clarification of ""substantial update"" is included in the description of the measure. The current measure includes MLTSS plan members who had a comprehensive LTSS care plan with seven core elements (and at least four supplemental elements for rate number 2) documented within 120 days of enrollment.
>
> Thank you for your comments regarding stratification on demographic characteristics. We will consider potential changes to the measure in the future. "
>
> **(2)** We appreciate the comments regarding the measure's specification of the face-to-face requirement and will consider potential changes to the measure in the future.
>
> **(3)** We appreciate your comments. The Technical Expert Panel (TEP) voted on the potential of the measure to distinguish performance among health plans as a result of standardizing expectations regarding the key components of a high-quality, person-centered care plan. The majority of the TEP supported the measure (54 percent agreed or strongly agreed that high performance on this measure indicates that a health plan is providing higher quality care), and an even greater proportion (62%) of the TEP agreed

that performance scores on this measure will distinguish between good and poor performance in the future.

Thank you for your comments regarding the measure's scientific acceptability.

(4) We appreciate the comments regarding the measure's specification of face-to-face care plan development and caregiver involvement in the development of the care plan. We will consider potential changes to the measure in the future.

Thank you for your comments regarding stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.

3325 Long Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner (CMS): Not Recommended

Submission

Description: This measure assesses the percentage of Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees with a care plan for whom all or part of the care plan was transmitted to the primary care practitioner (PCP) within 30 days of the care plan's development or update.

Numerator Statement: Medicaid MLTSS enrollees who have a care plan (or part of a care plan) that was transmitted to their PCP within 30 days of the care plan's development or update date.

Denominator Statement: Medicaid MLTSS enrollees age 18 years and older who had a care plan developed or updated in the measurement year.

Exclusions: Exclude enrollees in the denominator who were not enrolled in an MLTSS plan for at least 30 days after a care plan´s development or update date. These are enrollees who may have left the plan before it was shared with the PCP.

Exclude enrollees for whom there is documentation of enrollee refusal to allow care plan sharing.

Adjustment/Stratification: Not Applicable, no stratification.

Level of Analysis: Health Plan

Setting of Care: Home Care, Other

Type of Measure: Process

Data Source: Management Data, Other, Paper Medical Records

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

STANDING COMMITTEE MEETING [01/31/2018]

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-0**; **M-13**; **L-2**; **I-2**; 1b. Performance Gap: **H-4**; **M-13**; **L-0**; **I-0;**

Rationale:

- The Committee noted concerns on the evidence base for this measure similar to concerns on measures 3319 and 3324, but agreed that despite the lack of systematic review or graded evidence, there is existing evidence linking improved communication to better outcomes.
- In addition, the Committee agreed there is significant opportunity for improvement in care: performance ranged from 0.0-23.4% for having a care plan shared within 30 days, and 69.6% of enrollees had no documentation of a care plan shared with an eligible provider.

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2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-4**; **L-11**; **I-2** 2b. Validity: **H-X**; **M-X**; **L-X**; **I-X**

Rationale:

- The Committee expressed concerns with the variability of the reliability score, noting low agreement on the data element scores. The Committee suggested that the reliability issues might be attributed to inherent ambiguity in care plans, including differences in interpretation of what constitutes a care plan, or an update to a care plan, as well as the timing of a transmission. The developer noted that since the care plans may be lengthy, the numerator counts sharing important parts of the care plan when it is updated. Additionally, because this measure is considered in early development in terms of data standardization and data collection, the Committee expressed concerns about excess burden for the provider. The Standing Committee agreed the measure did not pass the Reliability criterion—a must-pass criterion.

Standing Committee Recommendation for Endorsement: **Did Not Pass Reliability**

Rationale:

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6. Public and Member Comment

NQF received six comment on this measure during the post-meeting comment period. Four of these comments raise concerns with the measure, specifically the denominator exclusions and transmission of information; and also support the Committee's decision not to recommend. These four comments were forwarded to the developer for responses. Two of the comments were from the developer in response to the draft report and are specific to details outlining the discussion on the measure. These comments have been responded to by NQF staff.

> **Developer Responses**: **(1)** Thank you for your comments. Regarding the measure's denominator exclusion, the current technical specifications exclude members that have documentation of refusal to allow care plan sharing. Additionally, the specified denominator for the measure includes only MLTSS plan members with a care plan.

We recognize that standardization of these measure elements is in progress. The measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized measure to assess the degree to which care plan updates among the MLTSS enrollee population are shared within a timely fashion with the PCP has precluded the collection of comparable data across plans.

Thank you for your comments regarding stratification on demographic characteristics. We will consider these potential changes to the measure in the future.

(2) We appreciate your comment regarding additional denominator exclusions; the specified measure's denominator only includes MLTSS plan members with a care plan. Regarding members who declined to choose a PCP, we will consider changing the measure's specification to include these potential exclusions in the future.

(3) Thank you for your comments. We would like to clarify that the Interclass Correlation Coefficient (ICC) (the ratio of the subject variance to the total variance) for the measure rate exceeded 0.9, indicating almost perfect agreement between the samples for the single data element indicating that the care plan was shared, and showing a significant association at $p<0.01$. However, the other elements in the LTSS Shared Care Plan with Primary Care Practitioner measure were assessed too infrequently among the 144 paired assessments (<30) to allow for inter-rater reliability analysis. We have updated the measure specifications to help improve reliability of certain elements.

(4) Thank you for your comments regarding additional denominator exclusions for enrollees who could not be reached, who refused to participate in the development of a comprehensive care plan, or who declined to choose a PCP. We will consider changing the measure's specification to reflect these potential exclusions in the future. We appreciate your comment about stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.

3326 Long Term Services and Supports (LTSS) Re-Assessment/Care Plan Update after Inpatient Discharge (CMS): Not Recommended

Submission

Description: The measure has two rates:

Rate 1 (LTSS Re-Assessment after Inpatient Discharge Rate): The percentage of discharges from inpatient facilities in the measurement year for Medicaid Managed Long Term Services and Supports (MLTSS) Plan enrollees resulting in a LTSS re-assessment within 30 days of discharge.

Rate 2 (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate): The percentage of discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment and care plan update within 30 days of discharge.

Numerator Statement: The measure has two rates. The numerators for the two rates are as follows:

Rate 1 (LTSS Re-Assessment after Inpatient Discharge Rate): Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment within 30 days of discharge.

Rate 2 (LTSS Re-Assessment and Care Plan Update after Inpatient Discharge Rate): Discharges from inpatient facilities in the measurement year for MLTSS plan enrollees resulting in a LTSS re-assessment and care plan update within 30 days of discharge.

Denominator Statement: Acute and non-acute inpatient facility discharges for Medicaid MLTSS enrollees age 18 years and older. The denominator is based on discharges, not enrollees. Enrollees may appear more than once in a sample.

Exclusions: For Rate 2, enrollees who refuse care planning are excluded.

For both rates:

- Pregnancy-related or other perinatal hospital discharges are excluded.

- Enrollees who refuse re-assessment are excluded.

- Exclude planned hospital admissions from the measure denominator. A hospital stay is considered planned if it meets any of the following criteria:

- Hospital stays with a principal diagnosis of pregnancy or condition originating in the perinatal period are

- A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).

- A principal diagnosis of rehabilitation (Rehabilitation Value Set).

- An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set).

- A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Adjustment/Stratification: Not Applicable

Level of Analysis: Health Plan

Setting of Care: Home Care, Other

Type of Measure: Process

Data Source: Claims, Management Data, Other, Paper Medical Records

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

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STANDING COMMITTEE MEETING [01/31/2018]

1. Importance to Measure and Report: The measure does not meet the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-X**; **M-X**; **L-X**; **I-X**; 1b. Performance Gap: **H-X**; **M-X**; **L-X**; **I-X**

Rationale:

- This measure is related to the other LTSS measures, 3319, 3324, and 3325. Based on similar reliability and validity concerns, the Committee elected not to continue the

evaluation of this measure after a short discussion and vote to continue the evaluation of this measure; seven committee members voted to continue evaluation and ten voted not to continue evaluation.

- Additionally, Committee members noted that the evidence is still in a nascent stage for this work but also felt that there is a large enough performance gap to necessitate continued work on these kinds of measures. Committee members reiterated the need for measures in this topic area, but agreed the four submitted measures in the LTSS set are not ready for NQF endorsement. Since the Committee did not evaluate this measure against NQF's criteria, they did not vote on the recommendation for endorsement.

Standing Committee Recommendation for Endorsement: **The Committee did not formally evaluate this measure due to reliability and validity concerns.**

Rationale:

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6. Public and Member Comment

Four comments were received on this measure during the post-meeting comment period. Three of these comments raise concerns with the measure, agree with the Committee's decision not to recommend, and were forwarded to the developer for responses (below). In addition, one comment was directed to NQF staff and raised concerns about the evaluation process, noting that the Committee did not formally vote on the measure but had concerns about the measure passing the importance and scientific acceptability criteria. The commenter was concerned that the measure was not fully assessed against the criteria as per NQF's standard process.

> **Developer Responses: (1)** Thank you for your comments. We recognize that standardization of these measure elements is in progress. The measure was developed in part to help propel the process of standardizing reporting and data collection systems forward. To date, the lack of a standardized measure to assess the degree to which re-assessments/care plan updates among the MLTSS enrollee population are completed in a timely fashion has precluded the collection of comparable data across plans.
>
> We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider this as a potential change to the measure in the future.
>
> This measure is currently specified such that any discharges from unplanned stays at inpatient facilities should result in a re-assessment or both a re-assessment and care plan update within 30 days of discharge. A face-to-face discussion with the member must be conducted using a structured or semi-structured tool that addresses the member's health status and needs and includes at a minimum nine core elements, as specified in 3319: Long Term Services and Supports (LTSS) Comprehensive Assessment and Update. The assessment may additionally include supplemental elements. Furthermore a care plan updated to identify member needs, preferences, risks, and

contains a list of the services and supports planned to meet those needs while reducing risks.

Thank you for your input regarding denominator exclusions. The stakeholders who advised us during measure development did not consider that a member could not be reached as a valid denominator exclusion; while the member was in the hospital, the plan would know where to reach them. In the future, we will revisit the possibility of adding member refusal of care planning as a denominator exclusion.

Thank you for your comments regarding caregiver involvement, and stratification on demographic characteristics. We will consider these as potential changes to the measure in the future.

(2) Thank you for your comment regarding access to non-aligned dually-eligible enrollees' data; in the future, we will consider potential changes to the measure's specified timeframe to account for plans' access to the required data elements.

We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider this as a potential change to the measure in the future.

The measure excludes MLTSS plan members who refused to participate in an assessment or development of a comprehensive LTSS care plan. We appreciate your comments regarding excluding members who could not be contacted and will consider this as a potential change to the measure specifications in the future. Thank you for your comment regarding access to non-aligned dually-eligible enrollees' data; in the future, we will consider potential changes to the measure's specified timeframe to account for plans' access to the required data elements.

We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider this as a potential change to the measure in the future.

The measure excludes MLTSS plan members who refused to participate in an assessment or development of a comprehensive LTSS care plan. We appreciate your comments regarding excluding members who could not be contacted and will consider this as a potential change to the measure specifications in the future.

(3) Thank you for your comment regarding access to non-aligned dually-eligible enrollees' data; in the future, we will consider potential changes to the measure's specified timeframe to account for plans' access to the required data elements.

We appreciate the comment that this measure should be clarified to capture a re-assessment by the MLTSS health plan upon discharge to the member's place of residence. We will consider potential changes to the measure in the future.

Thank you for your input regarding additional denominator exclusions for enrollees who could not be reached or who refuse care planning; we will take this into consideration.

Regarding caregiver involvement, we appreciate your suggestion to document the availability of informal caregivers separately from documentation of such caregivers' involvement. We will consider this potential change to the measure specification.

We also appreciate your comment about stratification on additional demographic characteristics; we will consider this potential change to the measure in the future as rates increase.