MEASURE APPLICATIONS PARTNERSHIP

Further Exploration of Healthcare Quality Measurement for the Dual Eligible Beneficiary Population

INTERIM REPORT

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NATIONAL QUALITY FORUM

CONTENTS

INTRODUCTION

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for the purpose of providing input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting, performance-based payment programs, and other purposes. MAP is designed to further the National Quality Strategy (NQS) and its three-part aim of creating better care, more affordable care, and healthier people living in healthy communities. In addition, MAP seeks to facilitate alignment of performance measures across federal programs and between public- and private-sector initiatives. Further information about MAP's role, past and future efforts, and coordination with other quality initiatives is provided in Appendix A.

As one of several tasks, MAP has been charged with providing input on the use of performance measures to assess and improve the quality of care delivered to individuals who are enrolled in both Medicare and Medicaid. The so-called "dual eligible" population is notable for its heterogeneity, vulnerability, and the difficulties experienced when navigating the healthcare and supportive services systems in the community. Within the dual eligible population, particular subpopulations have especially complex and intense needs for care and supports. The costs associated with meeting these needs are often extreme and borne primarily by strained public programs. MAP has begun to consider the quality measurement challenges posed by high-need groups of dual eligible beneficiaries. This interim report reviews activities designed to identify quality problems encountered by high-need beneficiaries, measures to address them, and limitations to doing so such as gaps in available measures.

MAP's task to consider quality measurement for high-need subgroups of dual eligible beneficiaries is divided into two phases. This interim report describes the activities of the first phase, which focused on the quality of care for adults aged 18-64 with physical disabilities as well as adults aged 65 and older with functional impairments and co-occurring chronic conditions. The second phase of the work will explore issues related to quality of care within the high-need groups of beneficiaries with behavioral health needs. MAP plans to address serious mental illness, substance use, and cognitive impairments such as dementia and intellectual/developmental disabilities.

Methods

The MAP Dual Eligible Beneficiaries Workgroup is a 27-member, multistakeholder group that provides input to the MAP Coordinating Committee (see Appendix B for the workgroup roster, Appendix C for the Coordinating Committee roster). Building on past accomplishments, the workgroup convened twice to develop the contents of this report. The agendas and materials for the September 2012 web meeting and October 2012 in-person meeting can be found on the **NQF website**.

This interim report is the third in a series of reports about quality measurement for dual eligible beneficiaries that have been delivered under contract with HHS. An **October 2011 report,** *Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries*, described MAP's initial work on understanding the unique qualities of the dual eligible population, identifying deficits in quality that affect the group, defining a strategic approach to measurement, and characterizing appropriate measures. A **June 2012 report,** *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*, built on the strategic approach, presented a prioritized set of current measures, documented potential modifications to

existing measures, and considered critical gaps in measurement. Each deliverable has advanced vital concepts in measurement and provided increasingly detailed guidance for the field.

Figure 1, below, presents major milestones in MAP's ongoing effort to explore appropriate performance measurement for dual eligible beneficiaries. These activities are described in more detail throughout the report.

FIGURE 1: PAST AND FUTURE MILESTONES IN SELECTING APPROPRIATE MEASURES FOR DUAL ELIGIBLE BENEFICIARIES

FEEDBACK LOOP WITH STAKEHOLDERS USING MAP'S PRIOR RECOMMENDATIONS ON MEASUREMENT OF DUAL ELIGIBLE BENEFICIARIES

Stakeholder Experience

Beginning in 2011, HHS has requested MAP's input on measures to address healthcare quality for dual eligible beneficiaries. In its June 2012 report, *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*, MAP recommended an initial set of measures most appropriate for use with the dual eligible population. As part of its ongoing work, MAP is considering refinements to that measure set. Refinements are intended to improve the utility of the set, incorporate newly available measures to fill previously identified gaps, inform MAP's 2012 pre-rulemaking deliberations, and dovetail with MAP's ongoing analysis of measurement for high-need subgroups. In revisiting the measure set, MAP gathered important input from stakeholders that have begun to implement MAP's prior recommendations. MAP sought to create a two-way exchange with states, communities, health plans, policymakers, consumers, measure developers, and other audiences. MAP gathered formal and informal feedback from the field on its initial measure set for dual eligible beneficiaries and shared it with MAP members.

Medicare-Medicaid Coordination Office

The Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare & Medicaid Services (CMS) is the first among many audiences for this work. Established under the Affordable Care Act (ACA), the MMCO has many goals related to assessing and improving the quality of dual eligible beneficiaries' care. The MMCO is the primary driver of measure use for this population and is pursuing several major initiatives in partnership with states to improve the integration and coordination of Medicare and Medicaid benefits.

MMCO staff have noted the value of MAP's input as they work across CMS in pursuit of an aligned quality strategy. MAP's recommendations provide a strategic framework for proceeding with measurement of quality for dual eligible beneficiaries. For example, HHS has renewed efforts to identify a core set of measures for home- and community-based services (HCBS). This direction is consistent with MAP's June 2012 report. MMCO leadership cited "a tremendous evolution in thinking about quality measures and how we work across the agency." Informed by MAP, cross-agency collaboration in the form of activities such as an HHS Measure Policy Council (MPC) helps to leverage resources and spur progress in important areas. With cross-agency alignment in mind, the MPC will establish measures that support the NQS to be used across HHS's many programs.

In applying MAP's recommendations to programs, the MMCO is using a multi-year phased approach to implementation. This approach is designed to accommodate current limitations of measurement and the real-world feasibility of scaling up large programs. MMCO leadership noted that they have considered MAP's recommendations in concert with other stakeholders' input to ensure that the system is measuring the right things to ultimately benefit the dual eligible population and in a manner that is not overly burdensome. MMCO is paying attention to minimizing extraneous measures that will not produce improved quality.

State Agencies

State agencies implementing integrated care programs for dual eligible beneficiaries also provided important perspectives about MAP's recommendations. One Medicaid agency's leadership acknowledged that MAP's prior work provided a strong foundation for conceptualizing high-quality care in the dual eligible population as the state began to plan its integrated care demonstration. Similar to the MMCO, Medicaid agencies acknowledged the critical importance of choosing the right measures to demonstrate improvements in care. Medicaid agencies have had difficulty identifying a parsimonious measure set that is not just a large amalgamation of all measures previously in use in the state. Meaningful alignment of Medicare and Medicaid measurement is an extremely complex task that will require years of collaboration to achieve.

States' experiences in measure selection parallel MAP's findings regarding measure gaps. Measures of physical health outnumber those for mental health. Measures of physical and mental health are both far more common than any standardized measures of quality in nonmedical supportive services. States have considered how to balance the need for transparency and quality assurance with the lack of scientifically rigorous measures and will need to reach a compromise. They intend to gain experience with collecting data to support measurement in gap areas and to refine the approach over time using rapid cycle improvement models. In this way, states can serve as test beds for measure development, refinement, and later endorsement of measures.

MAP specifically sought input from the Medicaid Medical Directors Learning Network (MMDLN), a group convened under funding from the Agency for Healthcare Research and Quality (AHRQ). Discussion of MAP's findings with the MMDLN highlighted the role of data and system infrastructure in driving the selection of measures. States' Medicaid financing arrangements vary widely, and the type of data available for measurement will depend on the mix of managed care, fee-for-service, and other models. The Medicaid Medical Directors were also interested in alignment of measure requirements. The specific example cited was measurement within nursing facilities and the potential for conflicting federal and state reporting requirements.

Health Plans

Several health plans provided feedback on MAP's dual eligible beneficiaries measure set. The performance of health plans in providing care to dual eligible beneficiaries will be of intense interest as the plans seek to be included in federal/state demonstrations to integrate care for dual eligible beneficiaries. Other plans are already serving the dual eligible population as Special Needs Plans (SNPs) under existing provisions for Medicare Part C (Medicare Advantage). If standardized measures were in use across these plans, then their performance could be compared. However, as recently noted by the Government Accountability Office (GAO), comparison is not possible under current model of care requirements.[1]

Similar to feedback provided by other stakeholders, health plans emphasized the need for measure selection that aligns with existing reporting requirements. In this case, current measures reported by health plans are predominantly Healthcare Effectiveness Data and Information Set (HEDIS®) metrics developed by the National Committee for Quality Assurance (NCQA). More than 90 percent of health plans already collect 75 measures across eight domains of care for HEDIS.[2] Many health plans are also required to use Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to evaluate beneficiaries' experience of care. Health plans cautioned MAP regarding the required number and frequency of beneficiary surveys, especially in the dual eligible population, for which language barriers, mental illness, and cognitive limitations are common. Despite the barriers, MAP members are committed to capturing beneficiaries' perspectives and urge

innovation in this area to uncover workable solutions.

MAP's dual eligible beneficiaries core measure set contains many measures that are not designed to be collected and analyzed at the health plan level. Health plans identified this limitation and expressed concern that some measures might be incorrectly attributed to them. Others noted that the feasibility of sharing and collecting measurement data across entities can be limited by lack of interoperability, carve-outs to subcontractors, and confidentiality requirements. Finally, health plans emphasized the need to be given clear and complete technical specifications for each measure to ensure consistency in reporting and the validity of results.

Consumers

Consumer advocates also provided their perspectives on MAP's dual eligible beneficiaries measure set. Vital to any person-centered framework is the concept of self-determination, further emphasized by commenters in this context. Self-determination is defined by the Council on Quality and Leadership (CQL) as a combination of skills, knowledge, and beliefs that enable a person to engage in goal-directed, self-regulated autonomous behavior and understanding of one's strengths and limitations together with a belief in oneself as capable and effective.[3]

MAP members questioned the utility of measures with narrowly defined denominator populations, concerned that individuals with complex needs and significant disabilities would be excluded. They noted that measures should be as inclusive of age, clinical condition, setting of care, and level of analysis as possible, which would improve the ability to use a single measure horizontally (across programs) and vertically (across the continuum of care). This perspective is important to MAP but also extends to related health reform efforts such as accountable care organizations and medical homes.

Measures should reflect the aspects of care that are important to dual eligible beneficiaries and their families. Identifying and implementing an appropriate mix of measures will take time, and MAP members noted that current measures are not sufficient to reflect the diverse needs and experiences of the full dual eligible population. In particular, new methods must be developed to gather information from individuals with cognitive impairments and/or physical disabilities who may have difficulties responding to surveys without a proxy present. MAP members shared the model practice of third-party independent consumer and family monitoring teams currently operating in four states. These teams directly assess beneficiaries' experience with publicly provided services and supports.

MAP Response to Stakeholder Feedback on Measurement

As highlighted by stakeholders, system infrastructure, alignment with other reporting programs, assignment of accountability, and measure gaps continue to pose barriers to effective performance measurement. Easy remedies for these long-standing problems are not available, but MAP can offer further specificity regarding its prior recommendations to minimize confusion.

MAP's Core Measure Set for Dual Eligible Beneficiaries published in June 2012, and future versions of that set, should be viewed as a menu of available measure options. In compiling the measures, MAP did not intend to imply that all of them should be applied within a single program. The set is multi-purpose. Different components of the health system have different roles, and only a portion of the measure set is applicable to each type of care setting or level of analysis. Users of measures should choose a subset of measures that are relevant to them. For example, a large hospital system would select the measures for acute care that are designed to be analyzed at the facility or system level. Alternatively, a program enrolling only older adults would use measures that are designed to be used in that age group.

The concept of fit-for-purpose is particularly important when applying MAP's recommended measures. A measure is typically designed for one or more specific purposes; these should match its intended use in a program. The data source on which a measure is based is a contributing factor. For example, measures specified for use in home health care generally rely on the standard assessment performed with all patients at the start and end of the care episode. This assessment instrument, the Home Health Care Outcome & Assessment Information Set (OASIS), helps home health agencies determine individuals' needs, develop a plan of care, and assess progress over the course of treatment. Data from this assessment are not readily available to other parts of the system, so it is not possible to use the measure more broadly unless comparable sources of information can be identified.

Identifying measures for potential inclusion in a measurement program requires careful review of all available information. A measure's title cannot communicate all relevant details, such as the numerator and denominator populations included in the analysis. Program implementers should also estimate the potential impact of exclusions, like beneficiaries' ages or co-occurring conditions, on the size of the denominator population of interest. NQF and measure stewards can provide more detailed information than is practical to include within reports. NQF's online **Quality Positioning System** (QPS) tool provides useful information about endorsed measures, including descriptions, numerator and denominator statements, steward contact information, and historical changes.

A phased approach for measure selection and implementation is appropriate for multiple reasons. First, not all measures are ready for immediate use in the dual eligible population as they are currently designed. MAP noted many modifications it would like to see before measures are used to evaluate the care of vulnerable beneficiaries of all ages. Premature use may have negative unintended consequences. Second, measures for dual eligible beneficiaries are likely to be applied to newly merged data and newly launched initiatives. States, communities, and small health plans lacking measurement experience may benefit from starting with a moderate number of measures and gradually adding more, and more sophisticated, measures. Finally, the mix of measure types can be adjusted over time. An initial focus on structure and process measures, if that is all that can be expected, can be modified to include more cost and outcome measures over time.

Parsimony is one of MAP's guiding principles. Ideally, a set should include the smallest possible number of measures to achieve a program's desired objectives. This minimizes the resources required to report and analyze measures. When possible, program implementers should leverage data already being collected for other purposes. Using the same measures across multiple programs achieves alignment, enables comparisons, and reduces data collection burden. However, using too few measures will leave stakeholders with an unclear picture of results and insufficient information upon which to base quality improvement efforts.

Measurement is one component of a larger strategy to improve the quality of care that dual eligible beneficiaries receive and to achieve the better health outcomes that are the ultimate goal. Measures can provide valuable information and promote accountability, but they are most effective when used together with policy analysis, program evaluation, beneficiary outreach and engagement, provider education, and myriad other quality improvement tools. These additional tools are especially important when considering determinants of health that are outside the healthcare delivery system, such as transportation, housing, and the built environment.

Effect of Dual Eligible Beneficiaries Perspective on MAP Pre-Rulemaking Input

MAP's recommendations regarding measures for dual eligible beneficiaries are incorporated into MAP's annual pre-rulemaking process. The role of pre-rulemaking, derived from statutory authority in the ACA, is an important innovation in the regulatory process. MAP examines an extensive list of measures under consideration by HHS for inclusion in the following year's rules for performance measurement programs. In addition to the stakeholder feedback noted above, MAP reflected on the previous year of experience promoting the use of measures for dual eligible beneficiaries. The MAP Coordinating Committee and the MAP Clinician, Hospital, and PAC/LTC Workgroups responded by supporting several measures across a range of programs. Specifically, 12 measures from the Dual Eligible Beneficiaries Core Set are now proposed or finalized in two or more HHS programs. An additional 6 measures from the set are proposed or finalized in one HHS program. This uptake of MAP's recommendations demonstrates success in increasing the use of measures that are meaningful for the care of dual eligible beneficiaries.

Because most federal measurement programs reviewed by MAP are targeted toward single settings of care or types of services, the population-centered approach of this work relates to all of the programs to some degree. Currently, none of these programs is dedicated to measuring the care experience for dual eligible beneficiaries. Only Medicare Advantage Special Needs Plans that specifically enroll this population (D-SNPs) are able to readily measure the quality of care being delivered to dual eligible beneficiaries. However, D-SNPs enroll fewer than 10 percent of dual eligible beneficiaries, and the outcomes they achieve cannot be generalized to other programs. Further, measures for SNPs are not currently under MAP's pre-rulemaking purview. Expanding the use of measures that are relevant to dual eligible beneficiaries' unique needs requires such measures to be added to many other existing programs.

MAP also considered new issues and enhancements in the process that would optimize the utility of information about the needs of dual eligible beneficiaries in the 2012/2013 pre-rulemaking cycle. During MAP's current 2012/2013 pre-rulemaking cycle, the Dual Eligible Beneficiaries Workgroup encouraged other MAP workgroups to use the Evolving Core Set of Measures for Dual Eligible Beneficiaries to identify and recommend measures relevant to this population.

Additional Opportunities Related to Federal Programs

Some federal programs present further opportunities for understanding the quality of care received by dual eligible beneficiaries. Medicare programs in which dual eligible beneficiaries comprise a large share of patients include those for End Stage Renal Disease (ESRD). The ESRD Quality Initiative promotes improvement through public reporting of measure results on the Dialysis Facility Compare website and through performance-based payment incentives. ESRD programs have a long history of performance measurement linked with public reporting, and the relatively large number of dual eligible beneficiaries receiving ESRD care presents a unique opportunity to explore stratification of measure results.

Stratification is a method used to examine the results associated with distinct groups within a broader population. Risk factors such as race, gender, and dual eligibility status can be associated with differences in clinical outcomes. Examining quality data stratified by such factors can be useful in understanding differences between groups, helping practitioners understand and address disparities.

MAP considered the use of stratification in the ESRD program. The current state of measurement

does not allow measure results for dual eligible beneficiaries to be compared to those for other ESRD patients, so it is not currently known if their experiences are better, worse, or the same as other patients. Even the basic demographics of dual eligible beneficiaries receiving ESRD care are not well understood. After discussion of the pros and cons that included input from the ESRD provider community, MAP concluded that the first step in exploring the feasibility of stratification of ESRD measures would be for CMS to analyze the composition of the dual eligible beneficiary population receiving ESRD care and, in the context of measure development, explore whether other risk factors present in the group would confound stratification of the measures.

In preparation for pre-rulemaking deliberations, MAP also explored application of measures in federal programs specific to clinicians and hospitals, making recommendations to enhance uptake and alignment of measures relevant to dual eligible beneficiaries. Although MAP did not have access to HHS' list of measures under consideration at the time of the meetings on which this report is based, members discussed possible measures to add to several major payment programs in the abstract. These activities will be more fully described in MAP's forthcoming report on the results of the 2012/2013 pre-rulemaking cycle.

MAP's discussions were wide-ranging, yet the importance of quality measurement in long-term supports and services (LTSS) was a regular theme. Dual eligible beneficiaries with disabling conditions rely on Medicaid to provide LTSS, a factor that sets them apart from people with disabilities that have more personal resources. MAP members suggested that the timeliness, adequacy, responsiveness, and person-centeredness of LTSS contribute more, and more directly, to one's quality of life than do many other issues MAP has considered. MAP re-emphasized its previous recommendation that measure development, testing, and standardization is needed in the LTSS field, particularly Medicaid HCBS.

EVOLVING CORE MEASURE SET FOR DUAL ELIGIBLE BENEFICIARIES

MAP previously published a Core Measure Set for assessing the quality of care provided to the dual eligible population in its report, *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*. Since that time, the state of quality measurement has continued to evolve. In addition, MAP was able to gather feedback on end-users' experiences in applying the set to programs, as described previously. MAP considered additions and deletions from the measures based on three general factors:

- Stakeholder feedback, including Medicaid/ State perspectives;
- Progress made on newly endorsed measures to fill measure gaps; and
- Other changes in endorsement status (e.g., endorsement removed, change in time-limited endorsement, placed on reserve status because further improvement is not possible or expected).

After deliberations, MAP reached general agreement on changes to the set of measures presented in Table 1. These changes are intended to fine-tune the set, now referred to as the Evolving Core Measure Set for Dual Eligible Beneficiaries to distinguish it from previous versions. The first column provides the name of each measure, its assigned number if it has been endorsed, and its current NQF-endorsement status. An asterisk (*) following the measure name and gold shading denote a new addition to the set since it was first published in June 2012. The second column notes the data source or sources from which the measure was derived. The third column describes the sites in the continuum of care to which a measure can be applied, such as a pharmacy, acute care hospital, or outpatient behavioral health services. The fourth column lists the levels at which a measure can be attributed, such as an individual clinician, a health plan, or a regional population. The setting of care and level of analysis are not interchangeable. Finally, the fifth column identifies a small number of high-priority measures that MAP has designated as part of its Starter Set, a group of measures most ready for implementation in the dual eligible population as they are currently specified. Additional details about the measures such as descriptions, measure stewards, and MAP's additional considerations for their use are provided in Appendix D. MAP's rationale for changes to the Evolving Core Measure Set is provided following the table.

TABLE 1: EVOLVING CORE MEASURE SET FOR EVALUATING THE CARE OF DUAL ELIGIBLE BENEFICIARIES

Measure Name, NQF Number, and Status	Data Source	Setting(s) of Care	Level(s) of Analysis	Starter Set?
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment *0004 Endorsed*	Administrative Claims, Electronic Clinical Data: Electronic Health Record (EHR), Paper Medical Records	Ambulatory Care: Clinician Office/ Clinic, Urgent Care; Behavioral Health/Psychiatric: Outpatient; EMS/ Ambulance; Hospital/ Acute Care Facility	Health Plan; Integrated Delivery System; Population: National, Regional, County, or City	Yes
Use of High-Risk Medications in the Elderly *0022 Endorsed*	Administrative Claims, Electronic Clinical Data: EHR	Ambulatory Care: Clinician Office/Clinic; Pharmacy	Health Plan; Integrated Delivery System; Clinician: Individual, Group/Practice	No
Tobacco Use Assessment and Tobacco Cessation Intervention *0028 Endorsed*	Administrative Claims	Ambulatory Care: Clinician Office/Clinic	Clinician: Individual	Yes
Medication Reconciliation *0097 Endorsed*	Administrative Claims, Electronic Clinical Data: EHR, Paper Medical Records, Other Source	Ambulatory Care: Clinician Office/Clinic, Urgent Care	Integrated Delivery System; Clinician: Group/Practice, Individual; Population: County or City	No
Screening for Fall Risk *0101 Endorsed*	Administrative Claims	Ambulatory Care: Clinician Office/Clinic, Urgent Care; Home Health; Hospice; Nursing Home/Skilled Nursing Facility (SNF)	Clinician: Group/Practice, Team, Individual	Yes
Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment *0209 Endorsed*	Patient Reported Data/Survey	Hospice	Facility; Population: National	No
3-Item Care Transition Measure *0228 Endorsed*	Patient Reported Data/Survey	Hospital/Acute Care Facility	Facility	Yes
Assessment of Health-related Quality of Life (Physical and Mental Functioning) *0260 Endorsed*	Patient Reported Data/Survey	Dialysis Facility	Facility	No

Measure Name, NQF Number, and Status	Data Source	Setting(s) of Care	Level(s) of Analysis	Starter Set?
Advance Care Plan* *0326 Endorsed*	Administrative Claims, Electronic Clinical Data: EHR, Registry	Ambulatory Care: Ambulatory Surgery Center (ASC), Clinic/ Urgent Care, Clinician Office/Clinic; Home Health; Hospice; Hospital/Acute Care Facility; Nursing Home/SNF; Inpatient Rehabilitation Facility	Clinician: Individual	No
Screening for Clinical Depression *0418 Endorsed*	Electronic Clinical Data: EHR	Ambulatory Care: Clinician Office/ Clinic; Hospital/Acute Care Facility; Nursing Home/SNF	Clinician: Individual	Yes
Pain Assessment Prior to Initiation of Patient Therapy* *0420 Endorsed*	Administrative Claims	Ambulatory Care: Clinician Office/Clinic; Other	Clinician: Individual	No
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up *0421 Time-Limited Endorsement*	Administrative Claims	Ambulatory Care: Clinician Office/ Clinic, Outpatient Rehabilitation; Behavioral Health/ Psychiatric: Outpatient; Home Health	Clinician: Group/Practice, Individual; Population: National, State, Regional, County or City	No
Change in Daily Activity Function as Measured by the AM-PAC *0430 Time-Limited Endorsement*	Electronic Clinical Data: EHR	Ambulatory Care: Clinician Office/Clinic; Home Health; Hospital/ Acute Care Facility; Nursing Home/SNF	Facility; Clinician: Individual	No
HBIPS-6 Post Discharge Continuing Care Plan Created *0557 Endorsed*	Administrative Claims, Electronic Clinical Data, Paper Medical Records, Other	Hospital/Acute Care Facility; Behavioral Health/Psychiatric: Inpatient	Facility	No
HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next level of Care Provider Upon Discharge *0558 Endorsed*	Administrative Claims, Electronic Clinical Data, Paper Medical Records, Other	Hospital/Acute Care Facility; Behavioral Health/Psychiatric: Inpatient	Facility	No

Measure Name, NQF Number, and Status	Data Source	Setting(s) of Care	Level(s) of Analysis	Starter Set?
Follow-Up After Hospitalization for Mental Illness *0576 Endorsed*	Administrative Claims, Electronic Clinical Data: EHR	Ambulatory Care: Urgent Care, Clinician Office/Clinic; Behavioral Health/ Psychiatric: Inpatient, Outpatient	Population: National, State, Regional, County, or City; Health Plan; Integrated Delivery System; Clinician: Team	No
Transition Record with Specified Elements Received by Discharged Patients *0647 Endorsed*	Administrative Claims, Electronic Clinical Data: EHR, Paper Medical Records	Ambulatory Care: ASC; Hospital/Acute Care Facility; Nursing Home/SNF; Inpatient Rehab Facility	Facility; Integrated Delivery System	No
Timely Transmission of Transition Record *0648 Endorsed*	Administrative Claims, Electronic Clinical Data: EHR, Paper Medical Records	Ambulatory Care: ASC; Hospital/Acute Care Facility; Nursing Home/SNF; Inpatient Rehab Facility	Facility; Integrated Delivery System	No
Optimal Diabetes Care *0729 Endorsed*	Electronic Clinical Data: EHR, Paper Medical Records, Other Source	Ambulatory Care: Clinician Office/Clinic	Integrated Delivery System; Clinician: Group/Practice	No
Patients Admitted to ICU Who Have Care Preferences Documented* *1626 Endorsed*	Electronic Clinical Data: EHR, Paper Medical Records	Hospital/Acute Care Facility	Facility; Health Plan; Integrated Delivery System	No
CARE – Consumer Assessments and Reports of End of Life* *1632 Endorsed*	Other	Hospice; Nursing Home/SNF	Facility; Population: National, Regional	No
Hospice and Palliative Care – Treatment Preferences* *1641 Endorsed*	Electronic Clinical Data: EHR	Hospice; Hospital/ Acute Care Facility	Facility; Clinician: Group/ Practice	No
Plan All-Cause Readmissions *1768 Endorsed*	Administrative Claims	Behavioral Health/ Psychiatric: Inpatient; Hospital/Acute Care Facility	Health Plan	Yes
Hospital-Wide All-Cause Unplanned Readmissions *1789 Endorsed*	Administrative Claims	Hospital/Acute Care Facility	Facility; Population: National	Yes

Measure Name, NQF Number, and Status	Data Source	Setting(s) of Care	Level(s) of Analysis	Starter Set?
COPD – Management of Poorly Controlled COPD* *1825 Endorsed*	Administrative Claims, Electronic Clinical Data, Healthcare Provider Survey, Patient Reported Data/Survey, Pharmacy	Ambulatory Care: Urgent Care, Clinician Office/Clinic; Home Health; Nursing Home/SNF; Inpatient Rehabilitation Facility	Facility, Clinician: Group/Practice, Individual; Health Plan; Integrated Delivery System; Population: National, Regional, State, County, or City	No
Medical Home System Survey *1909 Endorsed*	Electronic Clinical Data: EHR, Healthcare Provider Survey, Management Data, Paper Medical Records	Ambulatory Care: Clinician Office/Clinic	Clinician: Group/Practice, Team, Individual	No
Cultural Competency Implementation Measure* *1919 Endorsed*	Healthcare Provider Survey	Ambulatory Care: Urgent Care, Clinician Office/Clinic; Dialysis Facility; Hospice; Hospital/Acute Care Facility; Nursing Home/SNF; Inpatient Rehabilitation Facility	Facility; Health Plan; Integrated Delivery System	No
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys* *Multiple Numbers Endorsed, Includes all versions except those for pediatric care*	Patient Reported Data/Survey	Various	Various	Yes
Unhealthy Alcohol Use: Screening and Brief Counseling* *Not Endorsed* *(to be added pending endorsement)*	[not available]	[not available]	[not available]	Yes
SNP 6: Coordination of Medicare and Medicaid Coverage *Not Endorsed*	Documented processes and reports	[not available]	Health Plan	No

Deletion of Measures with Endorsement Removed

The set previously included a measure that is no longer NQF-endorsed®, titled "The Ability to Use Health Information Technology to Perform Care Management at the Point of Care." The measure steward notified NQF that the measure will no longer be maintained and requested that its endorsement be removed. MAP concluded that the measure should be removed from the set because alternative methods of assessing health information technology (IT) and care management are available. For example, it is possible to calculate a simple percentage of providers who have achieved the requirements under each stage of the Meaningful Use Electronic Health Record (EHR) Incentive Program or Medicare's Electronic Prescribing (ePrescribing) Program.

Substitution of Alcohol Use Measures

A measure developed by the Veterans Health Administration (VHA) and titled "Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment" was previously included in the core set. The measure was not NQF-endorsed, and VHA does not intend to submit it for endorsement. A MAP member suggested that it be replaced with a measure developed by the American Medical Association-convened Physician Consortium for Performance Improvement (PCPI) titled "Unhealthy Alcohol Use: Screening and Brief Counseling" that is anticipated to be submitted during NQF's current call for behavioral health measures. After discussion of the measures' specific properties, MAP concluded that the substitution should be performed, pending NQF endorsement of PCPI's measure.

Substitution of Pain Measures

The set previously included a measure titled "Pain Assessment Conducted" (NQF #0523). The measure had time-limited endorsement when it was added to the set. Since that time, endorsement has been removed. In addition, the measure is specific to home health care. MAP chose to remove measure #0523 from the set in favor of a more broadly applicable measure of pain assessment, titled "Pain Assessment Prior to Initiation of Patient Therapy" (NQF #0420).

Substitution and Addition of Measures of Advanced Illness Care

MAP spent a significant amount of time attempting to identify the most suitable measures related to advanced illness care. This effort resulted in the addition of several related measures, each of which addresses a different type of care or opportunity for quality improvement. These measures included:

- Patients Admitted to ICU with Care Preferences Documented (NQF #1626)
- Hospice and Palliative Care Treatment Preferences (NQF #1641)
- Advance Care Plan (NQF #0326)
- CARE – Consumer Assessment and Reports End of Life (NQF #1632)

Subsequent to the addition of measure #1632, MAP removed the measure titled "Family Evaluation of Hospice Care" (NQF #0208) from the set. Newly endorsed measure #1632 is a broader version of the original measure #0208, and keeping both would have been duplicative. MAP generally seeks to include measures with the most possibilities for application. For more information about this topic, please see MAP's June 2012 report, *Performance Measurement Coordination Strategy for Hospice and Palliative Care*.

Addition of Other Newly Endorsed Measures to Fill Gaps

MAP reviewed other measures endorsed since its last deliberations. CAHPS-related measures (NQF #1902, #1904, and #1741) were added to the measure set based on the standing

recommendation that all relevant CAHPS-related items should be included in measurement for dual eligible populations. In addition, the structural measure titled "Cultural Competency Implementation Measure" (NQF #1919) was added to fill a previously identified gap area related to providers' cultural competency. Finally, MAP added the measure titled "Management of Poorly Controlled COPD" (NQF #1825) to incorporate the high-impact condition of chronic obstructive pulmonary disease that is commonly linked to hospital admissions and readmissions.

MAP's Additional Considerations for Selected Measures

At this point in time, MAP has identified an Evolving Core Measure Set for Dual Eligible Beneficiaries and a Starter Set of Measures within that Evolving Core that are most ready for short-term implementation. These revisions have improved the balance, scope, and applicability of the measures. MAP plans to make further revisions to the Evolving Core and the Starter Set of measures as it continues to identify measures for additional high-need population subgroups in future work.

In the time since MAP began its work on identifying appropriate measures for use with the dual eligible beneficiary population, MAP developed a new way of thinking about and organizing measures for use—called families of measures. A family of measures is defined as a set of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for a specific topic area related to the NQS or a high-impact condition. Families indicate the highest priorities for measurement and best available measures within a particular topic, as well as critical measure gaps that must be filled to enable a more complete and person-centered assessment of quality. Future work is expected to fully transition the Evolving Core Measure Set to a family of measures. Further information about families of measures is available in MAP's report, **MAP Families of Measures: Safety, Care Coordination, Cardiovascular Conditions, Diabetes.**

When considering refinements to the Evolving Core Measure Set for Dual Eligible Beneficiaries and the contents of the Starter Set of measures, MAP discussed contextual factors affecting measurement and potential measure modifications. MAP continued to offer ideas for potential modifications to existing measures, such as broadening the care settings and age groups to which measures can be applied. These deliberations are expected to continue as MAP's work progresses; additional detail is provided in Appendix D and will also be represented in future reports.

SPECIALIZED MEASURES FOR HIGH-NEED SUBGROUPS OF DUAL ELIGIBLE BENEFICIARIES

Performance measures are important tools to monitor and encourage progress on improving quality and cost of care. Among the tasks under its current scope of work, MAP is analyzing special measurement considerations for high-need subpopulations of dual eligible beneficiaries. The objective of this work is to explore and identify a small number of specialized measures that might be added to or combined with the more general Evolving Core Set of Measures for Dual Eligible Beneficiaries discussed in the preceding section. Taken together, the measures would allow evaluation of both subpopulation-specific and broader approaches to improving the care of dual eligible beneficiaries, and ideally, comparison of the two.

Large gains can be achieved by targeting improvements in care toward the most costly types of care and subpopulations with the highest utilization. Based on the most recent data available, dual eligible beneficiaries comprised 20 percent of the Medicare population but 31 percent of Medicare spending, and 15 percent of the Medicaid population but 39 percent of Medicaid spending.[4]

The complex and heterogeneous dual eligible population does not lend itself well to clean categorization by subgroup. MAP considered organizational schemata based on age, functional status, and clinical diagnoses, ultimately combining these factors to produce four high-need groups:

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

Although the groups overlap to some degree, the high-need groups are organized around factors that are predictive of clinical complexity and high expenditures, such as long-term care needs and behavioral health diagnoses. MAP started by considering the first two groups: adults with physical disabilities and medically complex older adults. MAP anticipates addressing the second two populations of beneficiaries with SMI or cognitive impairment in a future phase of work. This staggered approach allows MAP the opportunity to incorporate relevant behavioral health measures currently being considered for NQF endorsement; more measures should be available in 2013.

Multiple Chronic Conditions Measurement Framework

MAP looked to existing frameworks to guide the identification and evaluation of high-leverage opportunities for quality measurement in the care of high-need subgroups of dual eligible beneficiaries. The NQF **Multiple Chronic Conditions (MCCs) Measurement Framework** was particularly informative to MAP's discussions of measure selection and measure gaps. People with MCCs now comprise more than one-quarter of the U.S. population. This is even more significant in the dual eligible beneficiary population, in which 42 percent of beneficiaries have three or more chronic conditions.[5]

The MCCs Framework establishes a definition for MCCs in order to achieve a common

understanding and a shared vision for effectively measuring quality. It also identifies high-leverage measurement areas for the MCCs population in an effort to mitigate unintended consequences and measurement burden. A conceptual model serves as an organizing structure for identifying and prioritizing quality measures. Finally, the Framework offers guiding principles to address methodological and practical measurement issues. The NQF MCCs Framework also aligns with the HHS Initiative on Multiple Chronic Conditions.

The NQF MCC Steering Committee established a definition of MCCs and noted that, from an individual's perspective, the presence of MCCs would

- affect functional roles and health outcomes across the lifespan;
- compromise life expectancy; or
- hinder a person's ability to self-manage or a family member's or caregiver's capacity to assist in that individual's care.

Along with the NQS, this person-centered framework was presented to MAP to inform consideration of subpopulations. MAP incorporated many of the insights from this report into its current work, resulting in similar themes emerging from the two projects. For example, the MCC Framework provides key measurement concepts that align with MAP high-leverage opportunities specific to high-need subgroups. MAP underscored the priorities, especially the need for measures of seamless transitions between multiple providers and sites of care, optimizing function, avoiding inappropriate and non-beneficial care, access, and shared decision-making.

High-Need Subgroup Profiles

MAP sought to better understand the care and support needs of the targeted subpopulations by collecting information on demographics and utilization patterns. MAP attempted to discern the major differences between high-need subpopulations and then identify related quality measurement opportunities. The presence of MCCs, frailty, and disability are clinically distinct but overlapping concepts. Their relationships are not well understood. Both researchers and clinicians lack reliable methods of distinguishing individuals with one or more of those factors and intervening appropriately. In most cases, individuals with MCCs, disability, or frailty are excluded from clinical trials and, subsequently, the evidence that those trials produce.[6,7]

As Medicaid enrollees, both subpopulations are poor by definition; 86 percent had annual incomes less than 150 percent of the federal poverty line in 2008 ($15,600 for individuals or $21,000 for couples).[8] Although older dual eligible beneficiaries are poor, they are not necessarily disabled. Conversely, younger adults who are dually enrolled must have a disability of some type to qualify for Medicare. Further differences can be observed in the different challenges that beneficiaries experience in their daily lives and the range of healthcare and support services they use.

Younger Adults with Physical or Sensory Disabilities

Of the 9 million dual eligible beneficiaries in 2009, 39 percent were adults with disabilities under the age of 65. Among these individuals, 43 percent have three or more chronic conditions and 40 percent require assistance with one or more activities of daily living (ADLs). Additionally, 73 percent of the population has cognitive or mental impairments.[9] All categories of dual eligible beneficiaries with disabilities are significantly more costly to Medicare than their non-dual eligible counterparts.[10] Younger beneficiaries are twice as likely than medically complex older adults to have had at least one emergency department visit in 2008; equally as likely to have had a physician visit and inpatient hospital stays; half as likely to have had a home health visit; and one-third as likely to have stayed in a skilled nursing facility.[11] Annual Medicaid spending for long-term care services for beneficiaries under the age of 65 averaged $9,903, of which $5,529 was for home-based

and personal care, while only $1,811 was for nursing facilities.[12] Younger beneficiaries are more interested in navigating the health and long-term support systems on their own and potentially self-directing their own services. Individuals in this subpopulation are likely to have different goals for their care than do older adults.[13]

Medically Complex Older Adults

Evidence demonstrates that the population of dual eligible beneficiaries aged 65 and older is significantly different than younger dual eligible beneficiaries. Older adult beneficiaries are more likely to need assistance with ADLs, have both a physical and a mental condition, and live in an institution. More than 90 percent of older adult beneficiaries have at least one chronic condition, while half of beneficiaries aged 80 or older have both physical and mental or cognitive conditions. The burden of medical complexity contributes to the type and level of service use. In a given year, more than 40 percent of older beneficiaries with physical and cognitive conditions are hospitalized and almost 35 percent use post-acute care. Thirty-eight percent also use Medicaid-funded nursing home care, and 22 percent use HCBS. Medicaid spending in 2008 was $14,990 per aged beneficiary, of which $11,897 was for long-term care services, including $8,711 for nursing facilities, but only $2,871 for home and personal care.[14]

Prominent Quality Issues for High-Need Subgroups

MAP continues to build on its established position that a measurement strategy should be targeted and focused on areas with substantial room for improvement. Therefore, MAP sought to generate lists of prominent quality issues affecting high-need groups to guide measure selection. The issues were organized under MAP's existing high-leverage opportunity areas for quality measurement. These include quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures.

MAP conducted a targeted scan of peer-reviewed and gray literature for relevant data and research findings, incorporating more than 100 verifiable sources. MAP was further guided by criteria established by the Institute of Medicine (IOM) to identify priority areas. The "Three I's" criteria are as follows:

- **Impact**—the extent of the burden—disability, mortality, and economic costs—imposed by a condition, including effects on patients, families, communities, and societies.
- **Improvability**—the extent of the gap between current practice and evidence-based best practice and the likelihood that the gap can be closed and conditions improved through change in an area; and the opportunity to achieve dramatic improvements in the six national quality aims identified in the Quality Chasm report (safety, effectiveness, patient-centeredness, timeliness, efficiency and equity).
- **Inclusiveness**—the relevance of an area to a broad range of individuals with regard to age, gender, socioeconomic status, and ethnicity/race (equity); the generalizability of associated quality improvement strategies to many types of conditions and illnesses across the spectrum of health care (representativeness); and the breadth of change effected through such strategies across a range of healthcare settings and providers (reach).[15]

Findings from the literature review helped to establish the level to which possible measurable issues in quality fulfilled each criterion. Under this framework, MAP further refined and organized the quality issues. The analysis revealed which of the quality issues were relevant to one or both subgroups. In other cases, the evidence base was lacking and MAP members' expertise was needed to ensure the approach was sufficiently inclusive. For example, few studies examine beneficiaries with a primary physical disability separately from other dual eligible individuals under the age of 65 with other types of disability. MAP representatives

with experience in quality of care for persons with disabilities reviewed a draft list of quality issues important to younger adults with physical disabilities and provided input.

After multiple rounds of review, MAP agreed to the quality issues as listed in Table 2 below:

TABLE 2: QUALITY ISSUES ASSOCIATED WITH HIGH-NEED SUBGROUPS OF DUAL ELIGIBLE BENEFICIARIES

High-Leverage Opportunity Areas	Quality Issues Common Across Subgroups	Issues Especially Important for Adults 18-64 with Physical Disability	Issues Especially Important for Complex Older Adults
Quality of Life	• Consumer and family engagement in and experience of care • Pain management • Preventing abuse and neglect • Maintaining community living and community integration; length of stay • Meaningful activities and involvement in community life		• Advanced illness care
Care Coordination and Safety	• Avoidable admissions, readmissions, and complications • Care transitions and discharge planning • Communication between providers • Communication between provider and beneficiary/caregiver; shared decision-making • Medication management: access, appropriateness, reconciliation, adherence, reducing polypharmacy • Safety: catheter-associated urinary tract infections (CAUTI), pressure ulcers, and falls • Over-utilization and under-utilization • Timely initiation and delivery of services and supports in the plan of care • Cultural sensitivity; cultural competence		

High-Leverage Opportunity Areas	Quality Issues Common Across Subgroups	Issues Especially Important for Adults 18-64 with Physical Disability	Issues Especially Important for Complex Older Adults
Screening and Assessment	• Person-centered planning • Functional abilities including ADLs and IADLs (change in abilities, improvement, managing decline) • Preventive services, immunizations • Nutrition, dehydration, and weight management	• Screening for and treatment of cancer, cardio-metabolic disease, HIV, and other sexually transmitted infections	• Ability to self-manage care
Mental Health and Substance Use	• Screening for depression and other mental illness • Screening for substance use, primarily alcohol and tobacco • Social relationships		
Structural Measures	• Workforce adequacy, stability, and training • Provider access (home health, primary care, specialty care, HCBS, dental care, vision care, durable medical equipment, rehabilitation) • Provider linkages to community resources such as non-medical supports • Caregiver support and training (formal and informal) • Understanding and accessing available services (ADA compliance, physical accessibility)	• Self-direction of services and supports, e.g., choosing and/or employing a personal care worker • Adaptive technology • Provider access (habilitation)	

Implications for Measurement

Challenges inherent in quality measurement for the complex population of dual eligible beneficiaries are many. MAP's working hypothesis was that high-need subgroups have unique needs and access different constellations of healthcare and supportive services. Unique measures would ensure that they are receiving high-quality care to meet those needs. Moreover, some emerging state programs are targeting particular cohorts based on age and/or type of disability, creating the need to design measurement around the types of care they are most likely to access.

An initial version of the list of relevant quality issues in Table 2 sought to assign issues to just one of the high-need subgroups. However, group discussion caused many of those issues to be re-categorized as shared across both subgroups. It proved very difficult to identify major quality problems that would apply to either complex older adults or younger adults with disabilities, but not both. The large number of quality issues found to be common across subgroups caused MAP to revisit its starting assumption. At a certain level, the basic tenets of high-quality, person-centered care are the same regardless of an individual's characteristics. MAP found little value in making strong distinctions between the groups, concerned that those boundaries would be artificial. The differences are a matter of degrees,

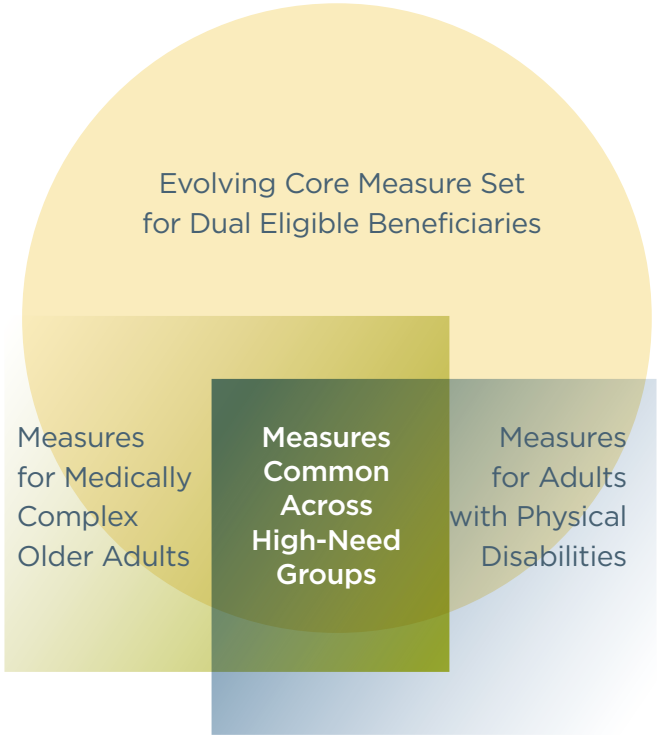
rather than absolutes.

One example of how the group's thinking evolved is to consider the issue of screening for unhealthy substance use. Screening and assessing beneficiaries for substance use had originally been conceptualized as more important to disabled adults aged 18-64 because substance abuse is less common in the older adult population. However, it does occur among older adults, and MAP members agreed that the risks posed by under-detection are significant enough to warrant screening of both subpopulations. This led to the observation that a quality issue might be shared, yet have relatively more importance to one or the other subpopulation. Similarly, cancer screening is very important in the population of younger adults with disabilities because significant disparities have been documented in this area. The issue is also important for older adults, but the benefit of such screenings diminishes with advancing age and clinical complexity.

Similarly, the identified quality issues may be shared at a high level but have different nuances and causal factors for certain groups of beneficiaries. Although pressure ulcers are equally important to avoid in both high-need groups, the etiology of the clinical event is likely to differ between a younger wheelchair user with paralysis and an incontinent older adult with vascular disease. As a result, different quality measures may be needed to accommodate the appropriate response in each case.

Figure 2, below, illustrates how the quality issues specific to high-need subgroups and the measures associated with those issues relate to the Evolving Core Set of Measures for Dual Eligible Beneficiaries. A small number of measures will be unique to particular high-need subgroups, while the majority is expected to be shared across one or more groups, including the general population of dual eligible beneficiaries measured by the Evolving Core Measure Set.

FIGURE 2: RELATIONSHIP BETWEEN THE EVOLVING CORE MEASURE SET FOR DUAL ELIGIBLE BENEFICIARIES AND SPECIALIZED MEASURES FOR HIGH-NEED SUBGROUPS



Available Measures to Address Quality Issues

MAP further considered the ability of current measures to detect differences in the quality of health care that would be most valuable to subgroups of beneficiaries. MAP reviewed a total of 175 NQF-endorsed measures that could address one or more of the quality issues identified in Table 2, above. MAP's goal in reviewing these measures was to form a pool of candidates for further consideration and potential addition to the Evolving Core Set of Measures for Dual Eligible Beneficiaries.

Identification of the measures that had been previously selected by MAP to be included in families of measures for Safety, Care Coordination, Cardiovascular Disease, and/or Diabetes was critical in culling the possible measures and promoting alignment. MAP supported these measures for further consideration, and MAP members suggested other measures that could also be used. From the 175 available measures, MAP has narrowed the field to 31 measures, listed in Table 3 below, beyond its previously identified Evolving Core Measure Set.

These 31 measures are able to address quality issues for certain high-need beneficiaries and should be further considered by MAP. MAP has not yet prioritized the measures in Table 3 and should clarify the relationship of each one to the existing set of measures. Further details about the 31 measures for future consideration are available in Appendix E.

MAP chose to not include the measures identified in this section in the Evolving Core Measure Set at this time because additional measures are expected to come into play when MAP explores quality issues specific to the high-need behavioral health populations. MAP will consider and prioritize three inputs simultaneously: the Evolving Core Measure Set for Dual Eligible Beneficiaries, the 31 measures for potential addition identified in Table 3, and other measures deemed important for remaining high-need subgroups of beneficiaries.

TABLE 3: MEASURES FOR POTENTIAL ADDITION TO EVOLVING CORE MEASURE SET IN FUTURE WORK

Alignment with MAP Families of Measures	Measure Title	NQF Number
Cardiovascular Disease, Diabetes	Controlling High Blood Pressure	0018
Cardiovascular Disease	Cardiac Rehabilitation Patient Referral from an Inpatient Setting	0642
Care Coordination	Hospital Transfer/Admission	0265
Care Coordination	Dehydration Admission Rate (PQI 10)	0280
Care Coordination	Timely Initiation of Care	0526
Care Coordination	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure	0698
Care Coordination	30-Day Post-Hospital HF Discharge Care Transition Composite Measure	0699
Care Coordination, Safety	Emergency Department Use without Hospitalization	0173
Safety	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
Safety	Patient Fall Rate	0141
Safety	Improvement in Management of Oral Medications	0176
Safety	Improvement in Pain Interfering with Activity	0177

Alignment with MAP Families of Measures	Measure Title	NQF Number
Safety	Increase in Number of Pressure Ulcers	0181
Safety	Pressure Ulcer Prevalence (hospital acquired)	0201
Safety	Falls with Injury	0202
Safety	Patient Fall	0266
Safety	Documentation of Current Medications in the Medical Record	0419
Safety	Adoption of Medication E-Prescribing	0486
Safety	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	0646
Safety	Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury	0668
Safety	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	0674
Safety	Appropriate Cervical Spine Radiography and CT Imaging in Trauma	0755
Safety	Hospice and Palliative Care—Pain Screening	1634
Safety	Hospice and Palliative Care—Pain Assessment	1637
	Cervical Cancer Screening	0032
	Pneumonia Vaccination Status for Older Adults	0043
	HIV Screening: Members at High Risk of HIV	0573
	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	0649
	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay)	0680
	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long-Stay)	0688
	Influenza Immunization	1659

Specialized Measures for Adults Aged 18-64 with Physical Disabilities

Two screening measures in Table 3 (NQF #0032 and #0573) were identified as especially applicable to adults aged 18-64 with physical disabilities. Preventive care measures are emphasized at younger ages because there is more potential to reduce downstream morbidity and mortality. However, providers often lack equipment accessible to people with disabilities or incorrectly perceive that there is no need to conduct screening tests. According to one study, 65 percent of women ages 18 and older with activity limitations had a Pap test within the past three years, compared to 83 percent of women without disabilities. This type of disparity could be addressed with measures such as NQF #0032: Cervical Cancer Screening. MAP also stressed the importance of screening adults with disabilities for sexually transmitted infections. One potentially applicable measure is NQF #0573: HIV Screening: Members at High Risk of HIV. MAP will further consider this measure but would prefer a broader measure that also includes persons not at high risk. Additionally, no measures were available related to other types of sexually transmitted infections.

Specialized Measures for Complex Older Adults

Two measures of advanced illness care were identified as especially applicable to complex older adults. Advanced illness care includes end-of-life, hospice, and palliative care to promote comfort and dignity for patients with incurable illness.[16] Enrollment in hospice is associated with a longer average time until death and lower costs for Medicare patients.[17] However, use of hospice services remains higher among non-dual eligible beneficiaries who are older, white, female, and Medicare Advantage participants.[18] MAP continues to emphasize the need for high quality advanced illness care and will further consider two measures of pain screening and assessment in hospice/palliative care: NQF #1634 "Hospice and Palliative Care—Pain Screening" and NQF #1637 "Hospice and Palliative Care—Pain Assessment."

Specialized Measures Common to Both High-Need Subgroups

Among the 31 measures in Table 3, 27 measures address quality issues that are common to both younger adults with physical disabilities and medically complex older adults. They may address other high-need groups as well. MAP will draw from this pool of 27 measures to identify potential additions to the Evolving Core Measure Set for Dual Eligible Beneficiaries. The contents of the pool of measures apply to three of MAP's high-leverage opportunity areas for improving care provided to dual eligible beneficiaries: quality of life (1 measure), care coordination and safety (19 measures), and screening and assessment (7 measures). MAP might have identified more measures assessing treatment of specific conditions, but it chose to limit the inclusion of disease-specific measures in its work on dual eligible beneficiaries because of the clinical heterogeneity of the group. Appendix E provides more details about the measures in Table 3.

MEASURE GAPS AND GAP-FILLING ACTIVITIES

MAP's Further Consideration of Measure Gaps for Dual Eligible Beneficiaries

Since the start of MAP's work on dual eligible beneficiaries, the group has recognized a large number of measurement gap areas. Many of the gaps previously listed in MAP's reports were aspirational; the group is interested in measures of comprehensive, coordinated care. However, the system and its infrastructure must continue to evolve to make measurement of such concepts feasible.

MAP revisited its previous work on measure gap identification and prioritization with the goals of providing greater specificity and adding new gap areas of interest for high-need subgroups. MAP noted measure gaps throughout its discussions. New and refined topics included:

- Presence of medical equipment accessible to people with disabilities (e.g., exam tables, scales)
- Screening for all types of substance use/abuse (e.g., alcohol, pain medication) and links to treatment
- Appropriateness of care and care setting, including home- and community-based settings
- Use of emergency services for nonemergency care
- Measures sensitive to healthcare disparities
- Assessment of independent living skills
- Assessment of unmet needs (e.g., stable housing, nutrition)
- Self-determination

MAP members continued to discuss and emphasize gap concepts from their prior work. Highlighted measure gaps related to care transitions; the cultural competence of health systems, teams, and individual providers (including disability culture); pain management; supports and training for formal and informal caregivers; and the need to maintain optimal functioning (recognizing that improvement may not be the appropriate goal). MAP also continued to discuss the importance of measures to assess the connection between the health system and long-term supports and services systems. The need for long-term supports and services funded by Medicaid is a prominent issue for a majority of dual eligible beneficiaries and a factor that makes them different from other complex patients.

An updated list of prominent measure gap concepts is presented in Table 4. Additionally, a comprehensive list of all measure gaps for the dual eligible population identified to date can be found in Appendix F. The updated comprehensive list continues to reflect MAP's desire to emphasize a person-centered approach to care and cross-cutting opportunities such as addressing social determinants of health. This contrasts with a more traditional approach to clinical performance measurement that has propagated a large number of disease-specific measures and models. Most dual eligible beneficiaries have significant clinical needs, yet the measure gap areas that MAP feels are most important relate to the *coordination* of clinical care or factors entirely outside of the health system. Further gap identification and prioritization is anticipated to take place in the next phase of work that considers high-need behavioral health subgroups.

TABLE 4: PROMINENT MEASURE GAPS FOR ASSESSING THE CARE OF DUAL ELIGIBLE BENEFICIARIES

Prominent Measure Gaps
Goal-directed person-centered care planning and implementation of care plan
HCBS quality, including system structures to connect health system and long-term supports/services
Appropriate prescribing and comprehensive medication management
Assessing and accommodating cognitive impairment, poor psychosocial health, poor health literacy
Appropriateness of hospitalization (e.g., avoidable admission/readmission)
Optimal functioning (e.g., improving when possible, maintaining, managing decline)
Sense of control/autonomy/self-determination
Independent living skills
Appropriateness of care and care setting
Level of beneficiary assistance navigating Medicare/Medicaid
Utilization benchmarking (e.g., outpatient/emergency department/nursing facility)

Barriers to Measure Gap-Filling

MAP members have expressed frustration with the pace of measure development in important areas, such as care coordination and person-centered planning. The complexity inherent in quantifying many topics continues to limit measure development. Primary barriers that have limited measure development include:

- **Limited funding.** Creation or modification of measures is highly technical work. Development and testing a measure generally requires months or years of costly effort.
- **Lack of evidence base.** Strong empirical evidence is required to support valid measure design. Clinical measures are usually derived from treatment guidelines. For cross-cutting domains more oriented toward overall wellness, the evidence base is less developed and interventions are not studied in the same way. For example, developing a measure on the topic of screening for poor psychosocial health requires identifying who should be targeted, who should be held accountable, the current standard of care, how often the screenings should occur, and how they should be conducted.
- **Data.** Information required for development and use of innovative measures is not readily available. Building on the prior example, identifying the appropriate data source for a psychosocial screening could prove challenging because this process may not be reliably captured in claims, medical charts, or EHRs. In parallel to a separate NQF effort on the methodology of patient-reported outcome measures, MAP also discussed the need for more information reported directly by beneficiaries regarding their needs. Systems are rarely configured to efficiently collect, aggregate, and share beneficiary-reported data. Moreover, providers of LTSS are not eligible for Meaningful Use incentives, so adoption of EHR platforms is significantly lagging in this sector.
- **Attribution.** Assigning accountability for performance on measures is difficult, particularly when multiple individuals and groups contribute to a particular outcome. For example, MAP has recently discussed the important role of safe and stable housing in supporting beneficiaries' health, but an appropriate approach to measuring this concept is still unclear.

A better understanding of barriers will facilitate informed recommendations about which gaps can be filled most readily given the limited funding and bandwidth.

Gap-Filling Activities

MAP is communicating with stakeholders best positioned to address measure gaps. Although the process takes time, progress is already being made. For example, MAP previously suggested modifications to existing measures to broaden their applicability. Expanding the range of ages captured by a measure is one example of a fairly straightforward change that developers can make. In response to NQF's suggestions, NCQA is currently expanding the age range of NQF measure #0097: Medication Reconciliation, to include all adults instead of those aged 65 and older. The successful expansion of the denominator population directly addresses a previously identified gap in available measures for adults aged 18-64. A number of other measures that MAP has considered for dual eligible beneficiaries have been recommended for similar modifications.

Other gap-filling activities are related to *de novo* development. A major effort is currently under way to develop and test a participant experience survey for Medicaid HCBS. Work on the survey is funded by CMS and conducted by Truven Health Analytics and the American Institutes for Research (AIR). Two of every three HCBS recipients are dual eligible beneficiaries.[19,20] MAP previously noted measures of HCBS as a major development gap area and has underscored their importance for evaluating many of the non-medical aspects of high-quality care. The goal of the survey is to gather feedback on an individual's experience with HCBS at the program level. Many of the survey domains address social and nonmedical factors such as whether an individual is getting needed services, how well providers communicate, personal safety, and community inclusion and empowerment. Once testing is complete, the research team plans to pursue a CAHPS trademark from AHRQ. MAP will follow progress of this effort through testing and refinement of the instrument.

Filling Disability-Specific Gaps

The literature on which to base measurement recommendations for people with disabilities is growing slowly but is still limited in many areas. A recent AHRQ review of more than 15,000 articles found that the body of research contains few direct examples of healthcare outcomes conducted from the perspective of people with disabilities.[21] Many in the disability community are concerned about the use of surveys and other methods that do not allow for a proxy respondent to answer on behalf of a person with a disability, resulting in that person's data being excluded altogether. Moreover, when dual eligible beneficiaries are studied, results rarely distinguish between individuals with a primary physical disability and individuals with other types of disabilities. MAP continues to explore available resources for measurement in disability populations, including the following resources that can inform future measure development:

Measuring the Healthcare Experience of Adults with Disabilities:[22] Under a grant from the National Institute of Disability and Rehabilitation Research (NIDRR), researchers developed a quality reporting system for health plans and programs serving beneficiaries with activity limitations. The multi-year study developed and tested more than 40 measures based on the structure of existing administrative measures like HEDIS. Work concluded several years ago, and MAP has explored the potential for an entity to serve as a measure steward for the NQF endorsement process.

National Core Indicators (NCI):[23] The NCI is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute. The NCI is a nationally recognized set of performance and outcome indicators for developmental disabilities service systems and has been in use since 1997. MAP will

explore the potential for this set of measures to be applied to other disability groups in its future work.

Personal Outcome Measures (POM):[24] The Council on Quality and Leadership (CQL) developed a set of 21 Personal Outcome Measures® that define the quality of human services from the perspective of the individual receiving those services. The use of person-centered outcomes is designed to shift focus of quality from the program to an individual. Outcome measures emphasize responsiveness to individual needs rather than compliance with organizational process or program requirements.

Independent Monitoring Teams:[25] Pennsylvania, Maryland, Massachusetts, and Wisconsin use third-party, consumer- and family-operated monitoring teams to determine individuals' experiences with public LTSS. Quality is assessed in terms of outcomes and beneficiary satisfaction. MAP will also explore the use of measures in this context in its future work.

uSPEQ Consumer Experience Survey:[26] This data collection and reporting system gathers feedback from consumers regarding their perception of the quality of services as well as their satisfaction. It is designed to be used by any health, human service, employment, aging services, or residential provider.

NEXT PHASE OF WORK

This interim report described a segment of MAP's activities focused on refinements to an Evolving Core Measure Set for Dual Eligible Beneficiaries and the consideration of specialized measures for high-need subgroups. This report considered quality issues in the care of adults aged 18-64 with physical disabilities as well as adults aged 65 and older with functional impairments and co-occurring chronic conditions. The next phase of the work will explore issues related to quality of care within the high-need groups of beneficiaries with SMI, substance use, and different types of cognitive impairment. MAP will also continue to hone and prioritize the available measures, finalizing a family of measures for dual eligible beneficiaries.

Continuing activities could include an in-depth exploration of CAHPS® tools. Numerous CAHPS tools and supplements are available to gather consumers' input on their experiences with different types of care. MAP has supported the use of CAHPS to assess the care of dual eligible beneficiaries to capture consumers' perspectives, but it believes there would be value in a more systematic review of the tools to identify the most relevant components. MAP's discussions also raised several methodological challenges in the administration of CAHPS, such as the need for proxy respondents and other alternative response methods to improve usability by people with disabilities. Questions have also been posed about the best way to use results generated by CAHPS to evaluate and incentivize quality.

Future work might also leverage MAP's expertise to provide HHS with input on the types of analyses that would be most beneficial to advancing measurement and improving quality of care. Data capabilities and the availability of linked administrative claims data from CMS have improved greatly since the start of MAP's work (see Appendix G). Deliberate development of an agenda for analytic research would ensure that the strategy for quality measurement is supported by current information.

ENDNOTES

1 U.S. Government Accountability Office (GAO), *Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance,* Washington, DC: GAO; 2012. Available at http://www.gao.gov/products/GAO-12-864. Last accessed December 2012.

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APPENDIX A:
MAP Background

Purpose

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

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

MAP is designed to facilitate progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable. Accordingly, MAP informs the selection of performance measures to achieve the goals of improvement, transparency, and value for all.

MAP's objectives are to

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

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decision-making, aligning payment with value, rewarding providers and professionals for using health information technology (health IT) to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including

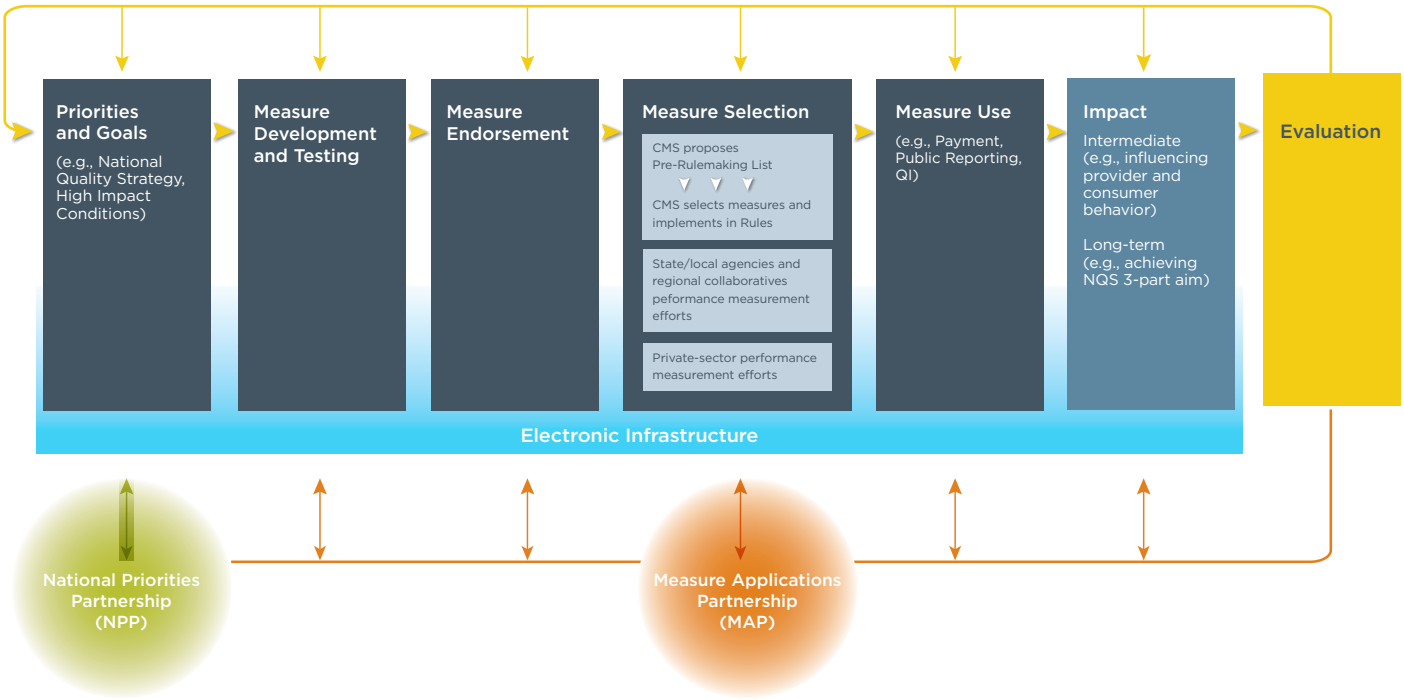
federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare.

Foundational to the success of all of these efforts is a robust Quality Enterprise (see Figure A-1) that includes:

- **Setting priorities and goals.** The National Priorities Partnership (NPP) is a multi-stakeholder group convened by NQF to provide input to HHS on the NQS, by identifying priorities, goals, and global measures of progress. The priorities and goals established serve as a guiding framework for the Quality Enterprise.
- **Developing and testing measures.** Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies).
- **Endorsing measures.** NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.
- **Measure selection and measure use.** Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the Quality Enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.
- **Impact.** Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate if measures are having their intended impact and are driving improvement, transparency, and value.
- **Evaluation.** Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements.

MAP seeks to engage in bi-directional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

FIGURE A-1. FUNCTIONS OF THE QUALITY ENTERPRISE



Structure

MAP operates through a two-tiered structure (see Figure A-2). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations.

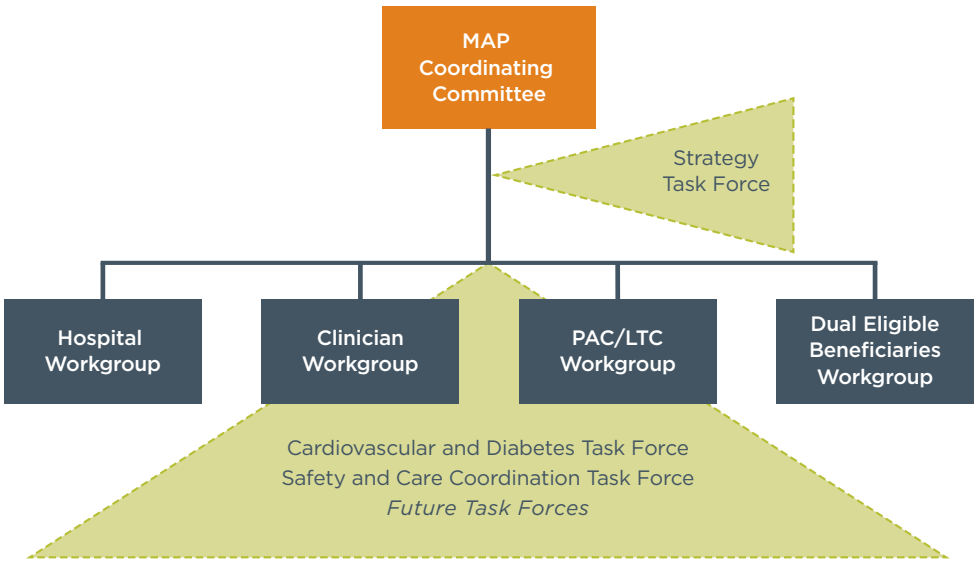
Time-limited task forces charged with developing "families of measures"—related measures that cross settings and populations—and a multi-year strategic plan provide further information to the MAP Coordinating Committee and workgroups. Each multi-stakeholder group includes representatives from public- and private-sector organizations particularly affected by the work as well as individuals with content expertise.

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

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

MAP decision-making is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the high-impact conditions determined by the NQF-convened Measure Prioritization Advisory Committee, the NQF-endorsed® Patient-Focused Episodes of Care framework,[1] the HHS Partnership for Patients safety initiative,[2] the HHS Prevention and Health Promotion Strategy,[3] the HHS Disparities Strategy,[4] and the HHS Multiple Chronic Conditions framework.[5]

FIGURE A-2. MAP STRUCTURE



Additionally, the MAP Coordinating Committee has developed Measure Selection Criteria to help guide MAP decision-making. The MAP Measure Selection Criteria are intended to build on, not duplicate, the NQF endorsement criteria. The Measure Selection Criteria characterize the fitness of a measure set for use in a specific program by, among other things, how the measure set addresses the NQS's priority areas and the high-impact conditions, and by whether the measure set advances the purpose of the specific program without creating undesirable consequences.

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (MAP 2012 Pre-Rulemaking Report, submitted to HHS on February 1, 2012).

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall to inform MAP's pre-rulemaking input. To date MAP has

- Engaged in **Strategic Planning** to establish MAP's goal and objectives. This process identified strategies and tactics that will enhance MAP's input.
  - MAP Approach to the Strategic Plan, submitted to HHS on June 1, 2012
  - MAP Strategic Plan, submitted to HHS on October 1, 2012
- Identified **Families of Measures**—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities and high-impact conditions—to facilitate coordination of measurement efforts.
  - MAP Families of Measures: Safety, Care Coordination, Cardiovascular Conditions, Diabetes, submitted to HHS on October 1, 2012

- Provided a measurement strategy and best available measures for evaluating the quality of care provided to Medicare/Medicaid **Dual Eligible Beneficiaries**.
  - Measuring Healthcare Quality for the Dual Eligible Beneficiary Population, submitted to HHS on June 1, 2012)
- Developed **Coordination Strategies** intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives. Each coordination strategy addresses measures, gaps, and measurement issues; data sources and health information technology implications; alignment across settings and across public- and private-sector programs; special considerations for dual-eligible beneficiaries; and the path forward for improving measure application.
  - Coordination Strategy for Clinician Performance Measurement, submitted to HHS on October 1, 2011
  - Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers, submitted to HHS on October 1, 2011
  - MAP Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement, submitted to HHS on February 1, 2012
  - Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals, submitted to HHS on June 1, 2012
  - Performance Measurement Coordination Strategy for Hospice and Palliative Care, submitted to HHS on June 1, 2012

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APPENDIX B:
Roster for the MAP Dual Eligible Beneficiaries Workgroup

CHAIR (VOTING)
Alice Lind, MPH, BSN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
Center for Medicare Advocacy	Alfred J. Chiplin, JD, MDiv
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE, FACP, FACC, FCCP
L.A. Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

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

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Administration for Community Living	Henry Claypool
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Substance Abuse and Mental Health Services Administration	Frances Cotter, MA, MPH
Veterans Health Administration	Daniel Kivlahan, PhD

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

APPENDIX C:
Roster for the MAP Coordinating Committee

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

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

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

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

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

APPENDIX D:
Details of Evolving Core Set of Measures

NQF-endorsed measures are linked to the online **Quality Positioning System (QPS)** to provide additional details, including numerator and denominator statements, exclusions, classification, contact information for stewards, and measures' history of updates.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment *0004 Endorsed*	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	National Committee for Quality Assurance	• Identification of dependence, initiation of treatment, and engagement in treatment could be represented as separate elements in a composite measure. • Health plans concerned about how much accountability can be placed on providers and plans; improvement is tied to social and individual factors. When using in a program, consider a composite measurement strategy of multiple elements that allows for "partial credit." • Included in Federal Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, Meaningful Use (EHR Incentive Program) - Eligible Professionals (MU-EP), Physician Quality Reporting System (PQRS). • Included in Private Programs: Healthcare Effectiveness Data and Information Set (HEDIS).

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Use of High-Risk Medications in the Elderly *0022 Endorsed*	a: Percentage of Medicare members 66 years of age and older who received at least one high-risk medication. b: Percentage of Medicare members 66 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	National Committee for Quality Assurance	• The measure steward is aware of a change in clinical guidelines around high-risk medications and is working with NQF to update the measure. • Many drug/disease interactions are possible and vary across populations; the measure could benefit from being modified to apply to other age groups. • Would be valuable to measure in home health and nursing facilities. • Included in MAP's family of measures for safety. • Included in Federal Programs: MU-EP, Medicare Part D Plan Rating, Physician Feedback, PQRS, Value-Based Payment Modifier Program. • Included in Private Program: HEDIS.
Tobacco Use Assessment and Tobacco Cessation Intervention *0028 Endorsed*	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received tobacco cessation counseling intervention if identified as a tobacco user.	AMA-PCPI	• Individuals with mental illness are disproportionately affected by tobacco use. • Would be valuable to measure in behavioral health outpatient setting. • Included in MAP's families of measures for cardiovascular disease and diabetes. • Measure addresses a high-impact condition. • Included in Federal Programs: MU-EP, Medicare Shared Savings Program (MSSP), PQRS. • Included in Private Programs: eValue8 and at least one Beacon Community.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Medication Reconciliation *0097 Endorsed*	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	National Committee for Quality Assurance	• Suggest that the time window in which patient should see physician after discharge be condensed, potentially to 30 days or fewer. • Suggest that denominator population be expanded to include all age groups. • Measure #0554 is similar and may be an alternative for health plans, but it has been recommended by NQF that the two be combined. • Included in MAP's family of measures for hospice. • Included in Federal Programs: MSSP, Physician Feedback, PQRS.
Screening for Fall Risk *0101 Time-Limited Endorsement*	Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months.	National Committee for Quality Assurance	• Measure in Medicare Health Outcomes Survey (HOS) requires beneficiary to recall and report if he or she was screened and counseled. Suggest alternative data sources to supplement. • Suggest that the measure be expanded to include anyone at risk for a fall (e.g., individuals with mobility impairments), not just individuals older than 65. • Suggest that an intervention be incorporated for those who screen positively. • Included in Federal Programs: MU-EP, MSSP, PQRS.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment *0209 Endorsed*	Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours.	National Hospice and Palliative Care Organization	• Give consideration to operationalizing this measure as pain assessment across settings; at a minimum could be applied more broadly to other types of palliative care. • Supported because achieving pain control, as reported by the individual receiving care, is central to the measure. • Included in MAP's family of measures for care coordination. • Included Federal Programs: Hospital Inpatient Quality Reporting (IQR), Hospital Value-Based Purchasing. • Included in Private Programs: Wellpoint.
3-Item Care Transition Measure *0228 Endorsed*	Uni-dimensional self-reported survey that measures the quality of preparation for care transitions.	University of Colorado Health Sciences Center	• Broaden to additional settings beyond inpatient, such as emergency room and nursing facility discharges. • Supported because it captures an individual's self-efficacy around a transition in care. • Included in MAP's family of measures for care coordination. • Included in Federal Program: IQR.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Assessment of Health-related Quality of Life (Physical and Mental Functioning) *0260 Endorsed*	Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year.	RAND Corporation	• Emphasized for its consideration of quality of life, a rarity among available measures. • Current survey is dialysis-specific and therefore inappropriate to use more broadly. It should be used as a template for the development of a broader measure of general health-related quality of life that can include other populations. • Many additional constructs are often a part of the concept of "quality of life" and should be considered for measurement. • Outcome measure would be preferred over this process measure. • Measure supported because it incorporates patient-reported outcomes. • Measure addresses a high-impact condition.
Advance Care Plan *0326 Endorsed*	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	National Committee for Quality Assurance	• Suggest to remove age restrictions and allow the measure to apply to all adults. • Measure is sensitive to disparities. • Measure is included in MAP's families of measures for care coordination and hospice. • Included in Federal Programs: Physician Feedback, PQRS.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Screening for Clinical Depression *0418 Endorsed*	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented.	Centers for Medicare & Medicaid Services	• Clinicians have freedom to use validated tool of their choice (e.g., PHQ-9). • Claims and encounter data may be incomplete for this process. • Measure addresses a high-impact condition. • Included in Federal Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, MU-EP, MSSP, Physician Feedback, PQRS, and at least one HRSA program. • Included in Private Programs: Bridges to Excellence.
Pain Assessment Prior to Initiation of Patient Therapy *0420 Endorsed*	Percentage of patients with documentation of a pain assessment (if pain is present, including location, intensity, and description) through discussion with the patient including the use of a standardized tool on each initial evaluation prior to initiation of therapy and documentation of a follow-up plan.	Centers for Medicare & Medicaid Services	• Measure was added to replace NQF #0523: Pain Assessment Conducted, which is no longer endorsed. • Supported because it prompts physician to have a structured discussion around pain. • Included in Federal Programs: Physician Feedback, PQRS.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up *0421 Time-Limited Endorsement*	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented Normal Parameters: Age 65 years and older BMI ≥to 23 and <30 Age 18-64 years BMI ≥ to 18.5 and <25	Centers for Medicare &Medicaid Services	• Lack of accessible scales/ equipment may lead to people with disabilities being excluded. • Noted as especially important in psychiatric patients but may have unintended consequences related to medication adherence because appropriate use of psychotropic medications may dramatically increase body mass. • Physical activity may be equally important to measure. • Measure addresses a high-impact condition. • Included in MAP's families of measures for cardiovascular disease and diabetes. • Measure is sensitive to disparities. • Included in Federal Programs: MU-EP, MSSP, Physician Feedback, PQRS, at least one HRSA program. • Included in Private Programs: Wellpoint and at least one Beacon Community.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Change in Daily Activity Function as Measured by the AM-PAC *0430 Time-Limited Endorsement*	The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. It was built using Item Response Theory (IRT) methods to achieve feasible, practical, and precise measurement of functional status (Hambleton 2000, Hambleton 2005). Based on factor analytic work and IRT analyses, a Daily Activity domain has been identified, which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing (Haley, 2004, 2004a, 2004b).	CREcare	• Measure is not widely applicable but MAP included it because it captures change in functional status, a rarity among available measures. • Measure has curative orientation. Consideration should be given to account for not only measuring improvement, but also maintaining functional status and management of decline. • Need to address floor effects observed when tool is applied to complex patients. • Presents data collection burden, relies on EHRs, and applies to small patient population. • Tested in multiple settings, but designed for use in post-acute populations. Not part of the Centers for Medicare & Medicaid Services' required quality reporting for home health or nursing home reimbursement, so it does not contribute to parsimony of a measure set. • Included in Private Program: Massachusetts' Alternative Quality Contract.
HBIPS-6 Post Discharge Continuing Care Plan Created *0557 Endorsed*	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge.	The Joint Commission	• This type of transition planning/communication is universally important and should apply to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox. • Consider importance of components beyond healthcare in transitions. • Included in MAP's family of measures for care coordination. • Included in Federal Program: Inpatient Psychiatric Hospital Quality Reporting.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next level of Care Provider Upon Discharge *0558 Endorsed*	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-6: Post discharge continuing care plan created.	The Joint Commission	• This type of transition planning/communication is universally important and should apply to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox. • Consider importance of components beyond healthcare in transitions. • Information should be transmitted to both nursing facility and primary care provider, if applicable. • Included in MAP's family of measures for care coordination. • Included in Federal Program: Inpatient Psychiatric Hospital Quality Reporting.
Follow-Up After Hospitalization for Mental Illness *0576 Endorsed*	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	National Committee for Quality Assurance	• Suggest expansion to incorporate substance use disorders/detox. • Consider importance of components beyond healthcare in transitions and links to the system of community mental health providers. • Health plans requested experience collecting this measure before it is used for accountability purposes. • Included in MAP's family of measures for care coordination. • Included in Federal Programs: Children's Health Insurance Program Reauthorization Act Quality Reporting, Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, Medicare Part C Plan Rating, Physician Feedback, PQRS. • Included in Private Programs: Wellpoint, HEDIS.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Transition Record with Specified Elements Received by Discharged Patients *0647 Endorsed*	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements.	AMA-PCPI	• Suggest broadening beyond specified sites/settings. • Included in MAP's families of measures for care coordination and hospice. • Measure is sensitive to disparities. • Included in Private Programs: ABIM Maintenance of Certification (MOC), Highmark.
Timely Transmission of Transition Record *0648 Endorsed*	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	AMA-PCPI	• Suggest broadening beyond specified sites/settings. • Providers may require experience collecting this measure before it is used for accountability purposes. • Included in MAP's family of measures for care coordination. • Measure is sensitive to disparities. • Included in Federal Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults. • Included in Private Programs: ABIM MOC, Highmark.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Optimal Diabetes Care *0729 Endorsed*	The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Patients ages 18-75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component.	MN Community Measurement	• While the all-or-none composite measure is considered to be the gold standard that reflects the best patient outcomes, the individual components may be measured as well. • Concern that the individual targets within the measure may be too aggressive, especially for individuals who are older and/or who have multiple chronic conditions. • Comments received by MAP considered this measure to be resource-intensive because it requires review of medical charts; proposed that diabetes measures in the HEDIS set would be less burdensome to report. • Stratification of measure results may be needed to target quality improvement efforts (e.g., SMI, elderly, etc.). • Included in MAP's family of measures for care coordination.
Patients Admitted to ICU Who Have Care Preferences Documented *1626 Endorsed*	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	RAND Corporation	• Important to capture if possible, but ICU patients are often incapable of communicating. Preferences should be documented across all care settings and before this level of disease severity. • Included in MAP's families of measures for care coordination and hospice.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
CARE – Consumer Assessments and Reports of End of Life *1632 Endorsed*	The CARE survey is mortality follow-back survey that is administered to the bereaved family members of adult persons (age 18 and older) who died of a chronic progressive illness receiving services for at least 48 hours from a home health agency, nursing homes, hospice, or acute care hospital. The survey measures perceptions of the quality of care either in terms of unmet needs, family reports of concerns with the quality of care, and overall rating of the quality of care. The time frame is the last 2 days of life up to last week of life spent in a hospice, home health agency, hospital, or nursing home. This is the "parent" survey of the Family Evaluation of Hospice Care Survey.	Center for Gerontology and Health Care Research	• Replaces NQF measure #0208, "Family Evaluation of Hospice Care," because it applies beyond the hospice setting. • Supported measure's goal of collecting information about experience of care from family members. • Included in MAP's families of measures for care coordination and hospice.
Hospice and Palliative Care – Treatment Preferences *1641 Endorsed*	Percentage of patients with chart documentation of preferences for life sustaining treatments.	University of North Carolina-Chapel Hill	• Supported measure because it involves working with an individual to document their preferences, but MAP notes that preferences should be expressed across all care settings, not just hospice. • Included in MAP's family of measures for hospice. • Measure is sensitive to disparities.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Plan All-Cause Readmissions *1768 Endorsed*	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/Denominator) 5. Total Variance Note: For commercial, only members 18-64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	National Committee for Quality Assurance	• Note that the measure is risk-adjusted and has been updated to differentiate between planned and unplanned readmissions. • Would be valuable to measure in integrated health systems. • Included in Federal Programs: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and Medicare Part C Plan Rating. • Included in Private Programs: Wellpoint, HEDIS, IHA, and AHIP survey indicates it is used by a majority of health plans.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Hospital-Wide All-Cause Unplanned Readmissions *1789 Endorsed*	This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.	Centers for Medicare & Medicaid Services	• Note that the measure is risk-adjusted and has been updated to differentiate between planned and unplanned readmissions. • Would be valuable to measure in integrated health systems. • This measure excludes behavioral health populations, so it should be used in conjunction with NQF #576 to account for the full spectrum of dual eligible beneficiaries. • Included in MAP's care coordination family of measures. • Included in Federal Program: Hospital Inpatient Quality Reporting Program.
COPD – Management of Poorly Controlled COPD *1825 Endorsed*	The percentage of patients age 18 years or older with poorly controlled COPD, who are taking a long acting bronchodilator.	ActiveHealth Management	• Measure added to address a high-impact condition commonly linked to hospital admissions and readmissions.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Medical Home System Survey *1909 Endorsed*	The following 6 composites are generated from the Medical Home System Survey (MHSS). Each measure is used to assess a particular domain of the patient-centered medical home. Measure 1: Enhance access and continuity Measure 2: Identify and manage patient populations Measure 3: Plan and manage care Measure 4: Provide self-care support and community resources Measure 5: Track and coordinate care Measure 6: Measure and improve performance	National Committee for Quality Assurance	• Consider broader application in shared accountability models such as accountable care organizations and health homes. • Care management might be appropriately conducted by other parties besides primary care physician (e.g., family member, clinical specialist, PACE site). Also, there are varying levels of medical "homeness" (e.g., different levels of readiness, targeted populations). • A health home's approach to care management must consider both Medicaid and Medicare benefits and non-healthcare related components of wellness. • This NCQA accreditation standard for a medical home is extensive and may not be widely applicable. May be more important to measure beneficiaries' access to a usual source of primary care rather than the primary care providers' ability to meet these high standards. • Included in MAP's care coordination family of measures.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Cultural Competency Implementation Measure *1919 Endorsed*	The Cultural Competence Implementation Measure is an organizational survey designed to assist healthcare organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed® cultural competency practices prioritized for the survey. The target audience for this survey includes healthcare organizations across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations. Information from the survey can be used for quality improvement, to provide information that can help healthcare organizations establish benchmarks and assess how they compare in relation to peer organizations, and for public reporting.	RAND Corporation	• Measure added to fill a previously identified gap in cultural competence. • Suggested modification to include the concept of cultural competence in serving persons with disability.
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys *Multiple Numbers Endorsed*	The various CAHPS surveys ask consumers and patients to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to healthcare services.	Various	• High prevalence of cognitive impairment and language barriers in population complicates data collection, and some stakeholders have expressed concerns about over-surveying consumers. • Case mix and risk adjustment are considerations when comparing across health plans, providers, or other entities.

Measure Name, NQF Measure Number, Status	Measure Description	Measure Steward	Potential Modifications or Other Considerations
Unhealthy Alcohol Use: Screening and Brief Counseling *Not Endorsed* *(to be added pending NQF endorsement)*	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.	AMA-PCPI	• Measure expected to be submitted to NQF by AMA-PCPI during a current call for measures. • A similar measure is needed for screening for other types of risky substance use.
SNP 6: Coordination of Medicare and Medicaid Coverage *Not Endorsed*	Not available	National Committee for Quality Assurance	• Measure currently applies to Medicare Advantage Special Needs Plans only. Suggest modification and expansion to other entities if possible.

APPENDIX E:
Details of Measures for Potential Addition to Evolving Core Set in Future Work

NQF-endorsed measures are linked to the online **Quality Positioning System (QPS)** to provide additional details, including numerator and denominator statements, exclusions, classification, contact information for stewards, and measures' history of updates.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
Controlling High Blood Pressure *0018 Endorsed*	The percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	Ambulatory Care: ASC, Clinician Office/Clinic, Urgent Care; Hospital/Acute Care Facility	Clinician: Individual, Group/Practice	National Committee for Quality Assurance	• Measure also included in MAP's families of measures for cardiovascular care and diabetes care. • Dual eligible beneficiaries have higher rates of chronic disease than Medicare-only enrollees, including stroke and heart attack.
Cervical Cancer Screening *0032 Endorsed*	Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.	Ambulatory Care: Clinician Office/Clinic	Clinician: Individual, Group/Practice; Health Plan	National Committee for Quality Assurance	• Measure may help to mitigate observed disparities in screening individuals with disabilities. • Lack of accessible exam equipment has been noted as a barrier that needs to be addressed.
Pneumonia Vaccination Status for Older Adults *0043 Endorsed*	The number of patients in the denominator who responded "Yes" to the question "Have you ever had a pneumonia shot? This shot is usually given only once or twice in the person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."	Ambulatory Care: Clinician Office/Clinic; Home Health; Hospital/Acute Care Facility; Nursing Home/Skilled Nursing Facility (SNF); Pharmacy; Inpatient Rehabilitation Facility	Population: County or City; Facility; Integrated Delivery System; Health Plan; Clinician: Group/Practice, Individual, Team	National Committee for Quality Assurance	• Bacterial pneumonia is a leading cause of potentially preventable hospitalizations among dual eligible beneficiaries. • Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) *0138 Endorsed*	Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (CAUTI) will be calculated among patients in the following patient care locations: Intensive Care Units, Specialty Care Areas, other inpatient locations	Hospice; Hospital/Acute Care Facility; Inpatient Rehabilitation Facility; Long-Term Acute Care Hospital; Nursing Home/SNF	Facility; Population: National, State	Centers for Disease Control and Prevention	• Measure also included in MAP's family of measures for safety. • Measures a clinical outcome of high interest for populations using hospital and long-term care services. • Measure could be modified to better account for persons with CAUTI present upon admission, particularly when an individual is receiving home and community based services (HCBS).
Patient Fall Rate *0141 Endorsed*	All documented falls, with or without injury, experienced by patients on an eligible unit in a calendar quarter.	Hospital/Acute Care Facility	Clinician: Group/Practice	American Nurses Association	• Measure also included in MAP's family of measures for safety. • The measure is currently specified to apply to hospitals; MAP would prefer to measure falls across care settings. • Reducing injuries from falls assists in preventing functional decline among vulnerable beneficiaries.
Emergency Department Use without Hospitalization *0173 Endorsed*	Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.	Home Health	Facility	Centers for Medicare & Medicaid Services	• The measure is currently specified to apply to individuals receiving home health services; MAP would prefer to measure emergency department utilization more broadly across populations.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
Improvement in Management of Oral Medications *0176 Endorsed*	Percentage of home health episodes of care during which the patient improved in ability to take his or her medicines correctly, by mouth.	Home Health	Facility	Centers for Medicare & Medicaid Services	• Measure also included in MAP's family of measures for safety. • Medication management is an important opportunity for quality improvement. • The measure is currently specified to apply to individuals receiving home health services; MAP would prefer to measure this ability more broadly across populations.
Improvement in Pain Interfering with Activity *0177 Endorsed*	Percentage of home health episodes of care during which the frequency of the patient´s pain when moving around improved.	Home Health	Facility	Centers for Medicare & Medicaid Services	• Measure also included in MAP's family of measures for safety. • MAP would like to see measures of functional abilities and ADL/IADLs be used to motivate the system to assist individuals in gaining or maintaining abilities needed to live independently. • The measure is currently specified to apply to individuals receiving home health services; MAP would prefer to measure this ability more broadly across populations.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
Increase in Number of Pressure Ulcers *0181 Endorsed*	Percentage of patients who had an increase in the number of pressure ulcers.	Home Health	Facility	Centers for Medicare & Medicaid Services	• Measure also included in MAP's family of measures for safety. • The measure is currently specified to apply to individuals receiving home health services; MAP would prefer to measure this common safety issue more broadly across populations. • Measure could be modified to better account for persons with pressure ulcers present upon start of the home health episode, particularly when an individual had been receiving home and community based services (HCBS).
Pressure Ulcer Prevalence (hospital acquired) *0201 Endorsed*	The total number of patients that have hospital-acquired category/stage II or greater pressure ulcers on the day of the prevalence measurement episode.	Hospital/Acute Care Facility; Inpatient Rehabilitation Facility; Long-Term Acute Care Hospital; Nursing Home/SNF	Facility; Clinician: Team	The Joint Commission	• Measure also included in MAP's family of measures for safety. • Measure could be modified to better account for persons with pressure ulcers present upon admission, particularly when an individual had been receiving home and community based services (HCBS).

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
Falls with Injury *0202 Endorsed*	All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as Injury falls per 1000 Patient Days.	Hospital/Acute Care Facility; Inpatient Rehabilitation Facility	Clinician: Team	American Nurses Association	• Measure also included in MAP's family of measures for safety. • The measure is currently specified to apply to inpatient settings; MAP would prefer to measure falls across care settings. • Reducing injuries from falls assists in preventing functional decline among vulnerable beneficiaries.
Hospital Transfer/ Admission *0265 Endorsed*	Rate of ambulatory surgery center (ASC) admissions requiring a hospital transfer or hospital admission upon discharge from the ASC.	Ambulatory Care: ASC	Facility	ASC Quality Collaboration	• Measure also included in MAP's family of measures for care coordination.
Patient Fall *0266 Endorsed*	Percentage of ASC admissions experiencing a fall in the ASC.	Ambulatory Care: ASC; Hospital/Acute Care Facility	Clinician: Individual	ASC Quality Collaborative	• Measure also included in MAP's family of measures for safety. • The measure is currently specified to apply to ASCs; MAP would prefer to measure falls across care settings. • Reducing injuries from falls assists in preventing functional decline among vulnerable beneficiaries.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
Dehydration Admission Rate (PQI10) *0280 Endorsed*	This measure is used to assess the number of admissions for dehydration per 100,000 population.	Hospital/Acute Care Facility	Population: County or City	Agency for Healthcare Research and Quality	• Measure also included in MAP's family of measures for care coordination. • Dehydration is a highly preventable condition that leads to hospitalization of vulnerable beneficiaries. It is especially important for individuals receiving HCBS or living in long-term care facilities.
Documentation of Current Medications in the Medical Record *0419 Time-Limited Endorsement*	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route.	Ambulatory Care: Clinician Office/Clinic; Dialysis Facility; Home Health; Nursing Home/SNF; Other; Behavioral Health/Psychiatric: Outpatient; Inpatient Rehabilitation Facility	Clinician: Individual; Population: National	Centers for Medicare & Medicaid Services	• Measure also included in MAP's family of measures for safety. • Complements NQF #0486 to measure medication management capabilities. • Vulnerable beneficiaries frequently have multiple medications and receive treatment and prescriptions from more than one provider.
Adoption of Medication E-Prescribing *0486 Endorsed*	Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting.	Ambulatory Care: Clinician Office/Clinic	Clinician: Individual, Group/Practice	Centers for Medicare & Medicaid Services	• Measure also included in MAP's family of measures for safety. • Complements NQF #0419 to measure documentation of medications.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
Timely Initiation of Care *0526 Endorsed*	Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.	Home Health	Facility	Centers for Medicare & Medicaid Services	• Measure also included in MAP's family of measures for care coordination. • Measure addresses a noted quality issue for high-need subpopulations, i.e., timely provision of services.
HIV Screening: Members at High Risk of HIV *0573 Endorsed*	To ensure that members diagnosed or seeking treatment for sexually transmitted diseases be screened for HIV.	Ambulatory Care: Clinician Office/Clinic, Urgent Care; Laboratory	Health Plan; Clinician: Individual	Health Benchmarks-IMS Health	• MAP suggests a possible modification to the measure in order to promote broader screening for HIV.
Cardiac Rehabilitation Patient Referral from an Inpatient Setting *0642 Endorsed*	Percentage of patients admitted to a hospital with a primary diagnosis of an acute myocardial infarction or chronic stable angina or who during hospitalization have undergone coronary artery bypass (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery (CVS), or cardiac transplantation who are referred to an early outpatient cardiac rehabilitation/secondary prevention program.	Hospital/Acute Care Facility; Inpatient Rehabilitation Facility	Clinician: Group/ Practice, Team; Individual; Integrated Delivery System	American College of Cardiology	• Measure also included in MAP's family of measures for cardiovascular care. • Dual eligible beneficiaries have higher rates of chronic disease than Medicare-only enrollees, including heart attack.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) *0646 Endorsed*	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories.	Hospital/Acute Care Facility; Ambulatory Care: ASC; Nursing Home/SNF; Inpatient Rehabilitation Facility	Facility; Integrated Delivery System	AMA-PCPI	• Measure also included in MAP's family of measures for safety.
Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care) *0649 Endorsed*	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements	Ambulatory Care: Urgent Care; Hospital/Acute Care Facility	Facility; Integrated Delivery System	AMA-PCPI	• Measure also included in MAP's family of measures for care coordination. • Measure complements Evolving Core Set measures 0647 and 0648.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury *0668 Endorsed*	Percentage of adult patients who presented within 24 hours of a non-penetrating head injury with a Glasgow coma score (GCS) >13 and underwent head CT for trauma in the ED who have a documented indication consistent with guidelines prior to imaging.	Hospital/Acute Care Facility; Other	Facility; Clinician: Group/Practice	Partners HealthCare System, Inc.	• Measure also included in MAP's family of measures for safety.
Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) *0674 Endorsed*	This measure is based on data from all non-admission MDS 3.0 assessments of long-stay nursing facility residents, which may be annual, quarterly, significant change, significant correction, or discharge assessment. It reports the percentage of residents who experienced one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) in the past year (12-month period). The measure is based on MDS 3.0 item J1900C.	Nursing Home/ SNF	Facility; Population: National	AMA-PCPI	• Measure also included in MAP's family of measures for safety. • Reducing injuries from falls assists in preventing functional decline among vulnerable beneficiaries.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay) *0680 Endorsed*	The measure reports the percentage of residents or patients who are assessed and appropriately given the influenza vaccine. This measure will include only residents or patients 6 months of age or older in the denominator. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments of nursing home residents, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) assessments for Inpatient Rehabilitation Facility (IRF) patients, and the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set assessments of LTCH patients.	Nursing Home/ SNF; Other; Inpatient Rehabilitation Facility	Facility; Population: National	Centers for Medicare & Medicaid Services	• Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long-Stay) *0688 Endorsed*	This measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents in a nursing facility whose need for help with late-loss Activities of Daily Living (ADLs), as reported in the target quarter's assessment, increased when compared with a previous assessment. The four late-loss ADLs are: bed mobility, transferring, eating, and toileting. This measure is calculated by comparing the change in each item between the target MDS assessment (OBRA, PPS, or discharge) and a previous assessment (OBRA, PPS, or discharge).	Nursing Home/ SNF	Facility; Population: National	Centers for Medicare & Medicaid Services	• MAP would like to see measures of functional abilities and ADL/ IADLs be used to motivate the system to assist individuals in gaining or maintaining abilities needed to live independently.
30-Day Post-Hospital AMI Discharge Care Transition Composite Measure *0698 Endorsed*	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of acute myocardial infarction for three types of events: readmissions, ED visits and evaluation, and management (E&M) services.	N/A	Population: National	Centers for Medicare & Medicaid Services	• Measure also included in MAP's family of measures for care coordination. • Heart attacks are a high-impact condition within the dual eligible beneficiary population. • Measure assesses successful care transitions.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
30-Day Post-Hospital HF Discharge Care Transition Composite Measure *0699 Endorsed*	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation, and management (E&M) services.	N/A	N/A	Centers for Medicare & Medicaid Services	• Measure also included in MAP's family of measures for care coordination. • Heart failure is a high-impact condition within the dual eligible beneficiary population. • Measure assesses successful care transitions.
Appropriate Cervical Spine Radiography and CT Imaging in Trauma *0755 Endorsed*	Percentage of adult patients undergoing cervical spine radiography or CT imaging for trauma who have a documented evidence-based indication prior to imaging (Canadian C-Spine Rule or the NEXUS Low-Risk Criteria).	Hospital/Acute Care Facility	Facility; Clinician: Group/Practice; Population: National, Regional, State	Partners HealthCare System, Inc.	• Measure also included in MAP's family of measures for safety. • Measure addresses possible overuse of advanced imaging technology.
Hospice and Palliative Care - Pain Screening *1634 Endorsed*	Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation/palliative care initial encounter.	Hospice; Hospital/Acute Care Facility	Facility; Clinician: Group/Practice	University of North Carolina-Chapel Hill	• Measure also included in MAP's family of measures for safety. • Appropriate management of pain contributes to high-quality care for advanced illness.
Hospice and Palliative Care - Pain Assessment *1637 Endorsed*	This quality measure is defined as: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.	Hospice; Hospital/Acute Care Facility	Facility; Clinician: Group/Practice	University of North Carolina-Chapel Hill	• Measure also included in MAP's family of measures for safety. • Appropriate management of pain contributes to high-quality care for advanced illness.

Measure Name, NQF Number, and Status	Measure Description	Care Setting	Level of Analysis	Measure Steward	Alignment and Other Considerations
Influenza Immunization *1659 Endorsed*	Inpatients age 6 months and older discharged during October, November, December, January, February, or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.	Hospital/Acute Care Facility	Facility; Population: National, Regional, State	Centers for Medicare & Medicaid Services	• Vaccinations are especially important for persons living in institutional settings or otherwise at high risk of infection.

APPENDIX F:
Complete List of Measure Gaps for Dual Eligible Beneficiaries

High-Leverage Opportunity Area	Measure Gap
Quality of Life	Appropriateness of care and care setting (e.g., nursing facility placement vs. HCBS)
	Caregiver support, formal and informal
	Consumer choice of support provider
	Degree to which consumers were satisfied with overall services
	Life enjoyment/satisfaction
	Maintaining community living
	Meaningful activities and involvement in community life
	Optimal functioning (e.g., improving when possible, maintaining, managing decline)
	Pain and symptom management
	Satisfaction with relationships with close friends and/or family
	Self-determination
	Sense of control/autonomy
Care Coordination	Ability to identify and contact care manager
	Ability to obtain follow-up care
	Appropriateness of hospitalization (e.g., avoidable admission/readmission)
	Case manager helpfulness
	Comprehensive medication management
	Consumer assessment of goal-oriented planning and care delivery
	Coordinating care across Medicare and Medicaid benefits
	Effective communication (e.g., provider-to-patient/family, provider-to-provider)
	Fidelity to care plan
	Goal-directed, person-centered care planning and implementation
	Patient activation
	System structures to connect health system and long-term supports and services
	Timely communication of discharge information to all relevant parties
	Transition management
	Use of emergency services for nonemergency care

High-Leverage Opportunity Area	Measure Gap
Screening and Assessment	Appropriate follow-up intervals
	Appropriate prescribing of medication
	Assessment for rehabilitative therapies
	Assessment of independent living skills
	Assessment of poverty/socioeconomic status
	Assessment of unmet needs
	More "optimal care" composite measures (e.g., NQF #0076)
	Proportion of people with disabilities receiving preventive healthcare visits
	Safety risk assessment
	Screening for all types of substance use/abuse and links to treatment
	Screening for cognitive impairment, poor psychosocial health
	Screening for poor health literacy
	Sexual health screenings
Mental Health and Substance Use	Initiation of pharmacotherapy after diagnosis of substance abuse or dependence
	Medication adherence and persistence for all behavioral health conditions
	Regular assessment of weight/BMI for all patients on anti-psychotic medication
	Suicide risk assessment for any type of depression diagnosis
	Tobacco cessation outcomes
Structural Measures	Ability to capture encounter data with health IT
	Access to services (e.g., transportation, appointment availability, accessible provider site)
	Capacity to serve as a medical home or health home
	Consideration of global costs and/or utilization benchmarking
	Frequency of change in Medicaid or health plan eligibility
	Harmonization of program benefits
	Level of beneficiary assistance navigating Medicare/Medicaid
	Percent of adults age 18+ with disabilities in the community usually or always getting needed support
	Presence of coordinated or blended payment streams
	Presence of medical equipment accessible to people with disabilities (e.g., exam tables, scales)
	Proportion of total Medicaid LTC spending for HCBS
	Provider cultural competence
	Waiver waitlist length
	Workforce capacity

APPENDIX G:
Technical Requirements and Data Needs

Availability of Linked Data

Since MAP's last report on measures for the dual eligible population, the Centers for Medicare & Medicaid Services (CMS) has made important progress in the availability of data to support analysis and underpin quality improvement efforts. Going forward, MAP has the opportunity to provide the Medicare-Medicaid Coordination Office (MMCO) with input on what the priority topics for analysis should be.

The interface for much of the new information is CMS' Chronic Condition Warehouse (CCW). This administrative claims database started with a focus on the Medicare population but has since been expanded to incorporate information about the Medicaid population. The CCW database has historically included 27 flags for specific conditions that allowed researchers to quickly extract claims for individuals with certain diagnoses. The MMCO recently finalized an additional 9 flags to reflect conditions more prevalent among dual eligible beneficiaries younger than 65. Eight flags relate to mental health conditions, and one relates to tobacco use. Flags related to HIV/AIDS and intellectual and developmental disabilities are also planned.

CMS is also making available a linked data file for claims from calendar year 2008. Soon after its release, CMS expects to do the same with 2006 and 2007 data. Claims from 2009 will be available as soon as Medicaid data are complete for that year. By reducing time that researchers had previously spent linking and scrubbing data, the linked set will expedite analyses of the dual eligible population.

The third point of progress with data is CMS' effort to more efficiently share Medicare data with state Medicaid agencies for the purpose of care coordination for dual eligible beneficiaries. After releasing the data, the MMCO learned that it was an important step but was not enough. Because of differences in data systems and other infrastructure challenges, technical assistance was needed for states to make use of the information. The MMCO has since secured a contractor to assist state staff in understanding the content of the information, how to read the files, and the nuances of coding.

Confidentiality

Restrictions on the exchange of information across providers are frequently cited as a barrier to effective performance measurement. The most prominent federal requirements are privacy rules found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Federal Regulation 42 CFR Part II.[1,2] While the health system has largely learned how to deal with HIPAA requirements, 42 CFR Part II and similar state laws around the confidentiality of data related to behavioral health continue to challenge the field of measurement.

According to 42 CFR Part II, the confidentiality of alcohol and drug abuse client records maintained by a program is protected by law. The regulation prohibits direct and indirect disclosure of client-identifiable information related to substance abuse treatment. However, information can be disclosed in many situations. These include having the individual's written consent, when the information has been de-identified, a medical emergency, for purposes of an audit or evaluation, and when program designates another entity a "qualified service organization" or QSO.

The intention of the regulation is to protect individuals receiving treatment for substance

use problems. However, lack of understanding inadvertently poses challenges to ongoing care coordination and communication across providers. In the case of performance measurement, data are typically aggregated and de-identified. 42 CFR Part II does not apply in those cases. MAP discussed other implications, noting that problems with access to data in behavioral health plan carve-outs or pharmacy benefit managers should not be confused with privacy constraints. Resources are available to assist practitioners in better understanding the specific applicability of the 42 CFR Part II regulation.[3,4]

ENDNOTES

1 Code of Federal Regulations. Health Insurance Portability and Accountability Act of 1996 (HIPAA), *Confidentiality of alcohol and drug abuse patient records*. Title 42 C.F.R. Part 2; 1996.

2 Substance Abuse and Mental Health Services Administration (SAMHSA), Legal Action Center, *Frequently Asked Questions Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE)*, Rockville, MD: SAMHSA; 2010. Available at http://www.samhsa.gov/healthprivacy/docs/EHR-FAQs.pdf. Last accessed November 2012.

3 SAMHSA, *Applying the Substance Abuse Confidentiality Regulations 42 CFR Part 2 (REVISED)*, Rockville, MD: SAMHSA; 2011. Available at http://www.samhsa.gov/about/laws/SAMHSA_42CFRPART2FAQII_Revised.pdf. Last accessed November 2012.

4 Legal Action Center, Webinar series on 42 CFR Part 2, New York: Legal Action Center; 2012. Available at http://www.lac.org/index.php/lac/webinar_archive. Last accessed November 2012.

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