NATIONAL QUALITY FORUM

Agenda

All MAP Web Meeting
December 4, 2012
11:00 am – 1:00 pm ET

Participant Instructions:

Follow the instructions below 15 minutes prior to the scheduled start time.

1. Direct your web browser to the following URL: nqf.commpartners.com.
2. Under "Enter a Meeting," type in the meeting number 955195 and click on "Enter."
3. In the "Display Name" field, type in your first and last names and click on "Enter Meeting."
4. **Dial 1-855-226-0347** and use confirmation code **26062492**.
   Note: Committee and workgroup members have closed lines.

If you need technical assistance, you may press *0 to alert an operator or send an email to nqf@compartners.com.

Meeting Objectives:

- Context for HHS List of Measures Under Consideration for MAP 2013 pre-rulemaking
- Orientation to MAP 2013 pre-rulemaking approach
- Consider MAP Dual Eligible Beneficiaries Workgroup cross-cutting input to the pre-rulemaking process

11:00 am Welcome, Review of Meeting Objectives, and MAP Background
George Isham, Co-Chair, MAP Coordinating Committee

11:10 am Context for HHS List of Measures Under Consideration and Implications for MAP
Patrick Conway, Chief Medical Officer, CMS
Tom Valuck, Senior Vice President, NQF

- Discussion

11:50 pm MAP Pre-Rulemaking Approach
Aisha Pittman, Senior Program Director, Strategic Partnerships,NQF
Allen Leavens, Senior Director, NQF

- Review four-step pre-rulemaking approach
- Review contribution of MAP's prior work to pre-rulemaking
- Review information available to evaluate measures under consideration
- Discussion

12:15 pm MAP Dual Eligible Beneficiaries Workgroup Progress and Cross-Cutting Input
Alice Lind, Chair, Dual Eligible Beneficiaries Workgroup

- Discussion

12:40 pm Opportunity for Public Comment

12:55 pm Next Steps
George Isham

1:00 pm Adjourn

Measure Applications Partnership

All MAP Web Meeting

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- MAP Pre-Rulemaking Approach
- MAP Dual Eligible Beneficiaries Workgroup Progress and Cross-Cutting Input
- Opportunity for Public Comment
- Next Steps

Welcome, Review of Meeting Objectives, and MAP Background

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Measure Applications Partnership

Statutory Authority

Health reform legislation, the Affordable Care Act (ACA), requires HHS to contract with the consensus-based entity (i.e., NQF) to **"convene multi-stakeholder groups to provide input on the selection of quality measures" for public reporting, payment, and other programs.**

MAP Purpose

In pursuit of the NQS, MAP informs the selection of performance measures to achieve the goal of improvement, transparency, and value for all

- MAP Objectives:
  1. Improve outcomes in high-leverage areas for patients and their families
  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
  3. Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden

Context for HHS List of Measures Under Consideration and Implications for MAP

CMS 2012 Pre-Rulemaking Measures Under Consideration List

Patrick Conway, MD, MSc
Chief Medical Officer, CMS
Director, Centers for Clinical Standards and Quality

December 4, 2012

Overview

1	• Our Goals and Approach • High-level Objectives
2	• ACA Requirements and Measurement Selection Process
3	• CMS Quality Programs
4	• 2012 MAP Measures Under Consideration List Highlights
5	• Measurement Goals
6	• Things to Consider

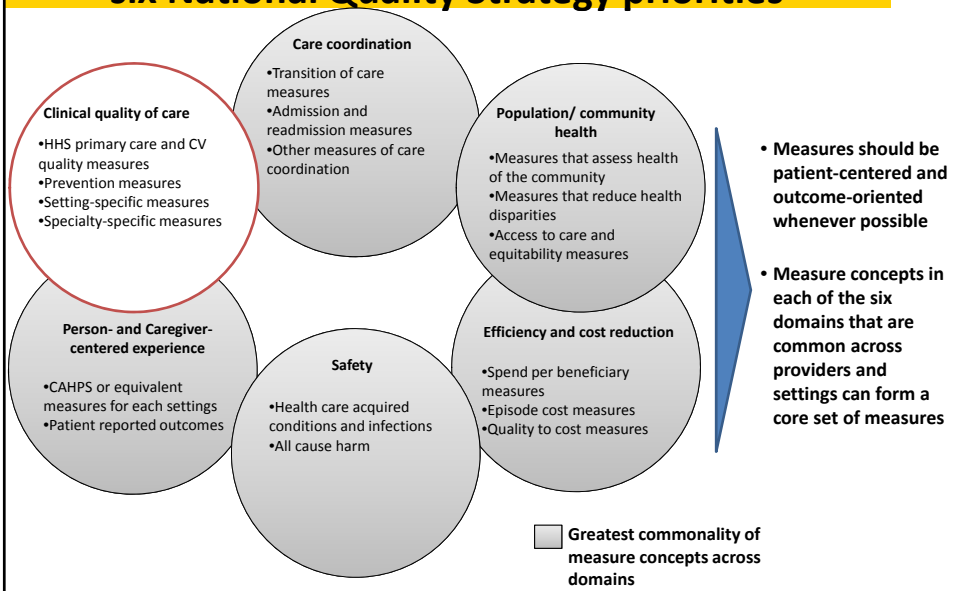
Our Goals for this Process

- To obtain expert multi-stakeholder input on quality and efficiency measures considered for implementation in programs by the Secretary for the 2013 Federal rulemaking process
  - Which measures should we propose in programs?
  - Which are the high priority measures?
  - What are the gaps and how will we fill those gaps in the future?

Our Approach

- In developing the list of measures for potential use in programs, we considered the following questions:
  - What were the 2011 MAP recommendations?
  - Which measures meet national priorities?
  - Which measures fill measurement gaps?
  - Which measures best support alignment across programs?
  - Which measures best support specific program needs?

CMS Framework for measurement maps to the six National Quality Strategy priorities



- **Measures should be patient-centered and outcome-oriented whenever possible**
- **Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures**

Affordable Care Act Statutory Requirements

Section 3014 of the Affordable Care Act establishes a Federal pre-rulemaking process for the selection of quality and efficiency measures that includes:

- Making publicly available by December 1st annually a list of measures under consideration by HHS for qualifying programs;
- Convening multi-stakeholder groups to provide input on the selection of quality and efficiency measures under consideration by HHS;
- Transmission of that input to HHS no later than February 1st of each year;
- Consideration of that input by HHS;
- Publishing rationale for the selection of any quality and efficiency measures not endorsed by the National Quality Forum (NQF); and
- Assessing the impact of the use of endorsed quality and efficiency measures at least every three years (The first report was released to the public in March of 2012. The next impact assessment report is scheduled for release in March of 2015.).

Measure Selection Process: Rulemaking vs. Pre-rulemaking

Pre-Rulemaking Process

- Occurs prior to rule-making annually;
- Requires multi-stakeholder group input on the selection of quality and efficiency measures for HHS rulemaking programs; and
- Provides for an early public preview of measures being considered by HHS;

Rulemaking Process

- Includes notice to the public of measures proposed for adoption;
- Opportunity for public comment on proposed measures; and
- Publication of a final regulation to officially adopt measures.

Measure Selection Process

Measure Implementation Cycle

CMS Quality Programs

Measures Subject to Pre-rulemaking

- All measures must be implemented through the Federal rulemaking process and be either:
  - Used for one of the Medicare Programs identified under 1890(b)(7)(i)(I) of the Social Security Act;
  - Used for reporting performance information to the public; or
  - Used for healthcare programs other than for use under the Social Security Act.

CMS Quality Programs

Hospital Quality Reporting	Physician Quality Reporting	Quality Reporting in PAC and Other Settings	Payment Model Reporting
• Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs • PPS-Exempt Cancer Hospitals • Inpatient Psychiatric Facilities • Inpatient Quality Reporting • Outpatient Quality Reporting • Ambulatory Surgical Center	• Medicare and Medicaid EHR Incentive Program for eligible professionals • Physician Quality Reporting System (PQRS) • E-prescribing-incentive Program • Physician Compare • Physician Feedback	• Inpatient Rehabilitation Facility (IRF) • Nursing Home Compare • Long-Term Care Hospital (LTCH) Quality Reporting • Hospice Quality Reporting • Home Health Quality Reporting	• Medicare Shared Savings Program • Hospital Value Based Purchasing • Physician Value Based Modifier • Hospital Acquired Payment Reduction (ACA 3008) • Hospital Readmission Reduction Program (ACA 3025) • End Stage Renal Disease (ESRD) QIP

2012 Measures Under Consideration List Highlights

CMS Program	NUMBER OF MEASURES UNDER CONSIDERATION
Ambulatory Surgical Center Quality Reporting	5
End Stage Renal Disease Quality Improvement Program	21
Home Health Quality Reporting	2
Hospice Quality Reporting	7
Hospital Acquired Condition Payment Reduction (ACA 3008)	18
Hospital Inpatient Quality Reporting	21
Hospital Outpatient Quality Reporting	7
Hospital Readmission Reduction Program	6
Hospital Value-Based Purchasing	18
Inpatient Psychiatric Facility Quality Reporting	5
Inpatient Rehabilitation Facility Quality Reporting	10
Long-Term Care Hospital Quality Reporting	29
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	2
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	1
Medicare Physician Quality Reporting System (PQRS)	281
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	19
Physician Feedback/Value Based Modifier/Physician Compare	19
Total	502

2012 Measures Under Consideration List Highlights

1. Over 502 new measures under consideration but most of those (281) are PQRS from a call for measures and almost all programs with less than 20 measures under consideration
2. 19 programs contributed measures to include in this list.
3. If CMS chooses not to adopt a measure under this list for the current rulemaking cycle, those measures remain under consideration by the Secretary and may be considered in subsequent rulemaking cycles.
4. External stakeholders contributed to and support the majority of measures on this list.
5. Many of the measures contained in this list are NQF endorsed or pending NQF endorsement.
6. Measures in this list are for use in either mandatory or voluntary reporting programs.
7. Please help us with alignment and prioritization

Balancing Measurement Goals

CMS Quality Reporting & Public Reporting will…	In order to…
Achieve high participation rates by providers	• Enable improvement and assess the performance of all providers and to empower patients with this information.
Align reporting requirements with National Quality Strategy priorities	• Address and measure high priority conditions and domains in order to provide a comprehensive assessment of the quality of health care delivered.
Increase the reporting of quality data by providers and more rapid feedback loops	• Drive quality improvement of the healthcare delivery system
Increase EHR and registry reporting for quality reporting programs	• Improve quality of care through the meaningful use of EHRs and use of registry-based measures.
Increase patient-centered outcome measures, including patient reported measures	• Ensure measurement focus is on patients , includes information derived from patients, and is useful to patients
Increase the transparency, availability, and usefulness of quality data	• Empower providers and the public with information to make informed decisions and drive quality improvement (e.g., Compare sites)

Things to Consider

- We value this process and your time and expertise.
- We would like for you to consider the following while reviewing the list:
  - Which measures are more appropriate for payment programs vs. quality reporting programs?
  - Are there remaining measure gaps within quality dimensions?
    - If so, are there measures you would recommend to close those gaps?
  - How best to align measures across programs?

Federal Program for MAP Pre-Rulemaking Input	MAP Workgroup
Physician Feedback/Value-Based Payment Modifier	Clinician Workgroup
Physician Quality Reporting System	
Medicare and Medicaid EHR Incentive Program for Eligible Professionals	
Medicare Shared Savings Program	
Physician Compare	
Hospital Inpatient Quality Reporting	Hospital Workgroup
Hospital Value-Based Purchasing	
Hospital Outpatient Quality Reporting	
Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs	
Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting	
Inpatient Psychiatric Facility Quality Reporting	
Hospital Readmission Reduction Program	
Hospital-Acquired Conditions Payment Reduction	
Medicare Shared Savings Program	
Ambulatory Surgical Center Quality Reporting	
Home Health Quality Reporting	PAC/LTC Workgroup
Nursing Home Quality Initiative and Nursing Home Compare Measures	
Inpatient Rehabilitation Facility Quality Reporting	
Long-Term Care Hospital Quality Reporting	
Hospice Quality Reporting	
End Stage Renal Disease Quality Management	

New Federal Programs for 2013 Pre-Rulemaking – Hospital Readmission Reduction Program

- **Program Type**: Performance-based payment – Program began FY 2013
- **Incentive Structure**: Hospitals determined to have excess readmissions will receive a reduction in DRG payment rates. The maximum payment reduction is 1% in FY 2013, 2% in FY 2014, and capped at 3% for FY 2015 and beyond.
- **Statutory Requirements for Measures:**
  - Measures should be NQF-endorsed
  - Readmissions unrelated to prior discharge should be excluded from the measures
  - Begin with measures for acute myocardial infarction (NQF #0505), heart failure (NQF #0330), and pneumonia (NQF #0506)
  - In FY 2015, the Secretary can expand the program to include other applicable conditions

New Federal Programs for 2013 Pre-Rulemaking – Hospital-Acquired Conditions Payment Reduction Program

- **Program Type:** Performance-based payment – Program begins FY 2015
- **Incentive Structure:** Hospitals scoring in the top quartile for rates of HACs based on the national average will have their Medicare payments reduced by 1% for all DRGs.
- **Statutory Requirements for Measures:**
  - Conditions included should be the same as those already selected for the current HAC payment policy
  - Other conditions acquired during the hospital stay deemed appropriate by the Secretary may added

New Federal Programs for 2013 Pre-Rulemaking – Physician Compare

- **Program Type**: Public reporting
- **Incentive Structure**: None
- **Statutory Requirements for Measures:** Measures from PQRS with a focus on:
  - Patient health outcomes and functional status
  - Continuity and coordination of care and care transitions
    - Episodes of care
    - Risk adjusted resource use
  - Efficiency
  - Patient experience and patient, caregiver, and family engagement
  - Safety, effectiveness, and timeliness of care

MAP Pre-Rulemaking Approach

Pre-Rulemaking Approach

1. Build on MAP's prior recommendations
2. Evaluate each finalized program measure set using MAP Measure Selection Criteria
3. Evaluate measures under consideration for what they would add to the program measure sets
4. Identify high-priority measure gaps for programs and settings

Sample Discussion Guide

Pre-Rulemaking Discussion Guide

Time	Issue/Question	Considerations
9:00am	**Pre-Rulemaking Input on Value-Based Payment Modifier Program Measures**	
9:00	1. Review program summary and previously finalized measures, additional input on the measure set.	• 54 measures are finalized, 10 measures are under consideration • The workgroup previously evaluated the proposed Value-Modifier program measure set. Few changes were made to the finalized measure set. o The vast majority of the finalized measures are NQF-endorsed. Half of the measures under consideration are endorsed. o All NQS priorities are addressed by finalized measures. Measures under consideration address safer care, effective care coordination, and making care more affordable. o Parsimony is partially addressed as the majority of the finalized measures and a few of the measures under consideration are used across multiple programs. However, the set lacks measures that cross conditions ore specialties. • The MAP Coordinating Committee reviewed the value modifier set as a potential core set; removing some measures that should not be considered core.
9:30	2. One measures under consideration is endorsed and utilized in other programs	NQF #0036 Use of Appropriate Medications for Asthma • Promotes alignment across programs—finalized for PQRS and Meaningful Use • This measure was previously proposed for the value-modifier set and was not finalized.
9:35	3. One measure under consideration is endorsed and proposed for use in another program.	NQF #0097 Post-discharge Medication Reconciliation • Addresses a high-leverage opportunity Identified by the Duals Workgroup • Potentially promotes alignment across programs- proposed for use in Meaningful Use
9:40	4. Three measures under consideration are endorsed and are not utilized in other programs	NQF #0279 Ambulatory Sensitive Conditions Admissions: Bacterial pneumonia NQF #0280 Ambulatory Sensitive Conditions Admissions: Dehydration NQF #0281 Ambulatory Sensitive Conditions Admissions: Urinary Infections
10:00	5. Five measures under	Diabetes composite: Combines NQF #0727, 0638, 0274, 0285 which are Ambulatory

1. Build on MAP's Prior Recommendations

MAP's Prior Efforts	Pre-Rulemaking Use
Coordination Strategies (i.e., Safety, Clinician, PAC-LTC, Dual Eligible Beneficiaries Cross-Cutting Input)	• Provides setting-specific considerations that will serve as background information for MAP's pre-rulemaking deliberations. • Key recommendations from each coordination strategy will be compiled in background materials.
Gaps Identified Across All MAP Efforts	• Provides historical context of MAP gap identification activities. • Will serve as a foundation for measure gap prioritization. • A universal list of MAP's previously identified gaps will be compiled and provided in background materials.

***While MAP's prior efforts serve as guidance for this work, pre-rulemaking decisions are not restricted to measures identified within these efforts.**

1. Build on MAP's Prior Recommendations

MAP's Prior Efforts	Pre-Rulemaking Use
2012 Pre-Rulemaking Decisions	• Provides historical context and represents a starting place for pre-rulemaking discussions. • Prior MAP decisions will be noted in the individual measure information.
Families of Measures **NQS priorities (safety, care coordination)** **Vulnerable populations (dual eligible beneficiaries, hospice)** **High-impact conditions (cardiovascular, diabetes, cancer)**	• Represents a starting place for identifying the highest-leverage opportunities for addressing performance gaps within a particular content area. • Setting- and level-of-analysis-specific core sets will be compiled, drawing from the families and population cores. Core measures will be flagged in the individual measure information. • MAP will compare the setting and level-of-analysis cores against the program measure sets.

Families of Measures and Core Measure Sets

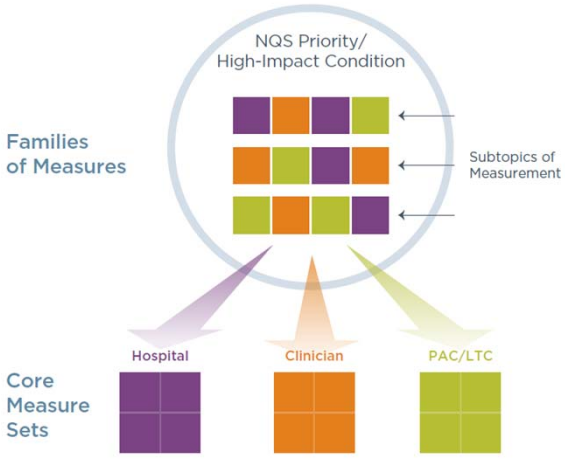
Families of Measures

"Related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS " (e.g., care coordination family of measures, diabetes care family of measures)

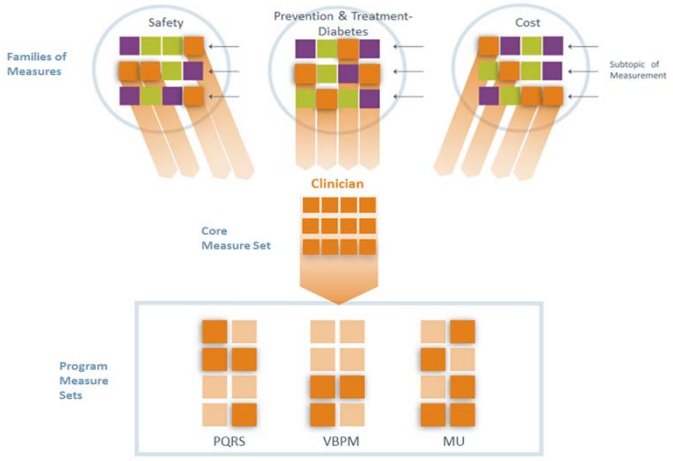
Core Measure Sets

"Available measures and gaps drawn from families of measures that should be applied to specified programs, care settings, levels of analysis, and populations" (e.g., ambulatory clinician measure set, hospital core measure set, dual eligible beneficiaries core measure set)

Families of Measures



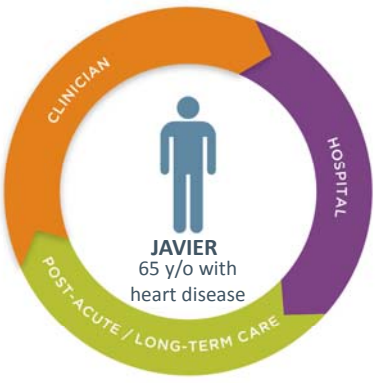
Families of Measures Populating Core Sets and Program Sets



A Patient-Centered Approach to Core Measure Sets

Physician Quality Reporting System (PQRS)

NQF #0018 **Blood Pressure Control** (Cardiovascular and Diabetes Families)
NQF #0326 **Advance Care Plan** (Care Coordination, Hospice, and Dual Eligible Beneficiaries Families)



Hospital Inpatient Quality Reporting Program (IQR)

NQF #0289 **Median Time to ECG** (Care Coordination and Cardiovascular Families)
NQF #0141 **Patient Fall Rate** (Safety Family)

Inpatient Rehabilitation Facilities Quality Reporting Program (IRF)

NQF #0418 **Screening for Clinical Depression** (Dual Eligible Beneficiaries Family)
NQF #0648 **Timely Transmission of Transition Record** (Care Coordination, Hospice, and Dual Eligible Beneficiaries Families)

2. Evaluate Finalized Program Measure Set Using MAP Measure Selection Criteria

MAP will identify:

- Potential measures for inclusion (e.g., from core sets, newly endorsed measures)
- Potential measures for removal
- Gaps—implementation gaps (core measures not in the set) and other gaps (e.g., development, endorsement) along the measure lifecycle
- Additional programmatic considerations (e.g., guidance on implementing MAP recommendations, data collection and transmission, attribution methods)

3. Evaluate Measures Under Consideration

MAP will indicate a decision and rationale for each measure under consideration:

MAP Decision Category	Rationale (Examples)
Support	• Addresses a previously identified measure gap • Core measure not currently included in the program measure set • Promotes alignment across programs and settings
Support Direction	• Addresses a gap, but not tested for the setting • Promotes parsimony, but data sources do not align with programs data sources
Phased Removal	• Measure previously finalized in the program, but a better measure is now available • NQF endorsement removed or retired
Do Not Support	• Overlaps with a previously finalized measure
Insufficient Information	• Measure numerator/denominator not provided

Sample Measure Table

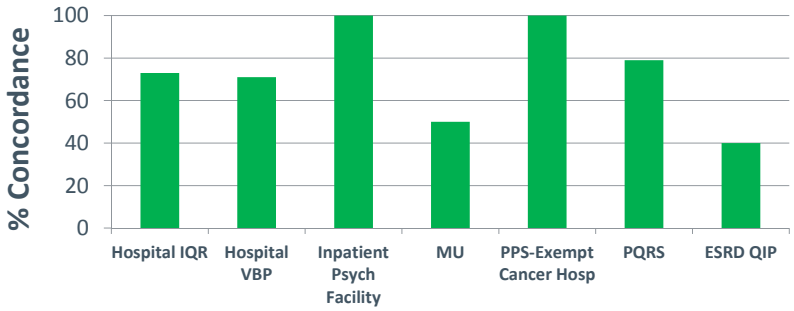
Row #	PQRS		Measure Name/ Title	NQF#	NQS Priority						Measure Type	Addresses Disparities	HIC	Public Alignment	Private Alignment	MAP Prior Decisions	Staff Comments (e.g. staff proposed rationale)
					Patient Safety	Effective Comm/Care Coordination	Prevention & Treatment	Person/Family Centered	Health and Well Being	Affordable Care							
	Fin		Asthma: Asthma Assessment	0001		x			x		Process	No	Yes	PQRS: Fin, MU: Fin, VBM: Fin	eValu8	Previously Supported	Topped out
	Fin		Appropriate Testing for Children with Pharyngitis	0002						x	Process	No	No	PQRS: Fin, MU: Fin, VBM: Fin	eValu8, IHA P4P	Previously Supported	Addresses known gap area
	Fin		Prenatal Care: Anti-D Immune Globulin	0012						x	Process	No	No	PQRS: Fin, MU: Fin	IHA P4P	Previously Supported	Addresses known gap area
	Fin		Hypertension (HTN): Plan of Care	0017		x					Process	No	Yes	PQRS: Fin, VBM: Fin	eValu8	Previously Supported	Known Data collection burden
	Fin		Controlling High Blood Pressure	0018		x					Outcome	No	Yes	PQRS: Fin, MU: Fin, VBM: Fin	eValu8, IHA P4P	Previously Supported, Cardio. Family	Frequently selected measure by clinicians

Information to Evaluate Measures Under Consideration

Information Type	Use for Pre-Rulemaking	Primary Sources	Information Available
Measurement Opportunities	Identify high-leverage opportunities (per impact, improvability, and inclusiveness)	National Quality Strategy/NPP	2012 National Quality Strategy and NPP reports provide consensus priorities
		HHS websites	AHRQ, CDC, CMS, Partnership for Patients, and other sites provide stats and research findings
		NQF partnerships	Multiple NQF-convened groups identified/prioritized measurement gaps; a new report on gaps is expected in Dec 2012
Measure use	Determine which public and private programs use measures, including dates of use where available	HHS rules	Proposed and Final rules list measures in programs, dates of implementation, and rationale for selection
		NQF reports/tools	NQF reports describe recommendations and actual use in multiple settings; Alignment Tool describes community use; NQF measure database contains developer info on use
		HHS measure inventory	Tracks measures in HHS programs
		Private organization websites	Multiple private program sites list measures in use (e.g., Alternative Quality Contract, eValue8, Joint Commission, Leapfrog)
		AHIP Survey	Identifies measures used by a majority of health plans

MAP Pre-Rulemaking Recommendations: Concordance with HHS Final Rules

- The MAP 2012 Pre-Rulemaking report included specific recommendations on measures under consideration by HHS, as well as some previously finalized measures, for use in Federal programs
- Concordance of MAP "Support" and "Do Not Support" recommendations with HHS final rules released through November 2012 is shown below:



Information to Evaluate Measures Under Consideration

Information Type	Use for Pre-Rulemaking	Primary Sources	Information Available
Performance Results	Examine recent results and trends to gauge potential future value	CMS Impact Assessment	CMS measure trends over 2+ years
		HHS Compare sites	National, state, and local results for select measures in various programs
		AHRQ NHQRDRnet	National and state results for select measures, with demographic stratification
		Private organization websites and reports	Some private organizations provide limited performance data (e.g., ASC Quality Collaboration, Joint Commission Annual Report, NCQA 2011 State of Health Care Quality Report)

Information to Evaluate Measures Under Consideration

Information Type	Use for Pre-Rulemaking	Primary Sources	Information Available
Implementation Experience	Assess practical issues of measure implementation in programs, such as adoption rates and unintended consequences	CMS 2010 Reporting Experience (PQRS & eRx)	Describes participation rates, including measures reported by the largest # of EPs in PQRS
		Alignment Tool measurement stories	Provides details on measure use experiences of three AF4Q communities
		Pubmed	Limited research has been done on impact of measures used in the field
		NQF feedback loops	Comments submitted through QPS; CDP implementation feedback and developer responses; Future sources of implementation info
Measure Impact	Establish the effectiveness of using measures in specific applications	2015 CMS Impact Assessment	In planning stages; MAP will focus on aligning with RE-AIM framework
		Various from above	Many of the other sources for measure use, performance, and implementation experience info can inform impact assessment
		NQF feedback loops	Future source of impact info
		QASC survey	Future source of impact info

4. Identify High-Priority Measure Gaps for Programs and Settings

MAP's Previously Identified Gaps

- Compiled from all of MAP's prior reports
- Categorized by NQS priority and high-impact conditions
- Compared with gaps identified in other NQF efforts (e.g., NPP, endorsement reports)

MAP will:

- Identify priorities for filling gaps across settings and programs
- Present measure ideas to spur development
- Capture barriers to gap filling and potential solutions

MAP Dual Eligible Beneficiaries Workgroup Progress and Cross-Cutting Input for Pre-Rulemaking

Dual Eligible Beneficiaries Workgroup Charge for 2012/2013

- Determine most suitable performance measures currently available, concentrating on high-need subgroups:
  - Older adults with functional limitations and chronic conditions
  - Adults younger than 65 with physical disabilities
  - Individuals with serious mental illness
  - Individuals with cognitive impairment
- Document potential strategies to address measurement limitations
- Delineate specific gaps in measures and available evidence to inform future measure development

Themes from Draft Interim Report

Feedback Loop with Stakeholders Who Are Using MAP's Recommendations

- Following publication of the MAP June 2012 report on measurement for dual eligible beneficiaries, MAP sought to create a two-way exchange with policymakers, end-users of measures, and other audiences
- Feedback on the initial measure set for dual eligible beneficiaries and other content was gathered from:
  - CMS Medicare-Medicaid Coordination Office
  - State Medicaid agencies
  - Health plans
  - Consumer groups
  - Other users of measures

Stakeholder Responses

CMS Medicare-Medicaid Coordination Office

- Informed by MAP strategy, cross-agency collaboration at HHS is leveraging resources and spurring progress (e.g., core set of measures for HCBS)

State Medicaid Agencies

- Helped states conceptualize high-quality care as they planned integrated care demonstrations
- Highlighted the role of data in driving the selection of measures

Health Plans

- Accountability needs to be assigned appropriately; some measures are not designed to be used at the health plan level of analysis
- Need to have clear technical specifications for consistent reporting

Consumer Groups

- Many important concepts and services are not yet able to be measured

Evolving Core Measure Set for Dual Eligible Beneficiaries

NQF Measure Number/Status	Measure Name
NQF 0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
NQF 0022 Endorsed	Use of High-Risk Medications in the Elderly
NQF 0028 Endorsed	Tobacco Use Assessment and Tobacco Cessation Intervention
NQF 0097 Endorsed	Medication Reconciliation
NQF 0101 Time-Limited Endorsement	Screening for Fall Risk
NQF 0209 Endorsed	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment
NQF 0228 Endorsed	3-Item Care Transition Measure
NQF 0260 Endorsed	Assessment of Health-related Quality of Life [Physical and Mental Functioning]
NQF 0326 Endorsed	Advance Care Plan
NQF 0418 Endorsed	Screening for Clinical Depression
NQF 0420 Endorsed	Pain Assessment Prior to Initiation of Patient Therapy
NQF 0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
NQF 0430 Endorsed	Change in Daily Activity Function as Measured by the AM-PAC
NQF 0557 Endorsed	HBIPS-6 Post Discharge Continuing Care Plan Created
NQF 0558 Endorsed	HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next level of Care Provider Upon Discharge

Evolving Core Measure Set for Dual Eligible Beneficiaries

NQF Measure Number/Status	Measure Name
NQF 0576 Endorsed	Follow-up after Hospitalization for Mental Illness
NQF 0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients
NQF 0648 Endorsed	Timely Transmission of Transition Record
NQF 0729 Endorsed	Optimal Diabetes Care
NQF 1632 Endorsed	CARE – Consumer Assessments and Reports of End of Life
NQF 1626 Endorsed	Patients Admitted to ICU who Have Care Preferences Documented
NQF 1641 Endorsed	Hospice and Palliative Care – Treatment Preferences
NQF 1768 Endorsed	Plan All-Cause Readmissions
NQF 1789 Endorsed	Hospital-Wide All-Cause Unplanned Readmissions
NQF 1825 Endorsed	COPD – Management of Poorly Controlled COPD
NQF 1909 Endorsed	Medical Home System Survey
NQF 1919 Endorsed	Cultural Competency Implementation Measure
Multiple Surveys Endorsed	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys
Not Endorsed; to be added pending endorsement	Unhealthy Alcohol Use: Screening and Brief Counseling
Not Endorsed	SNP 6: Coordination of Medicare and Medicaid Coverage

Specialized Measures for High-Need Subgroups of Dual Eligible Beneficiaries

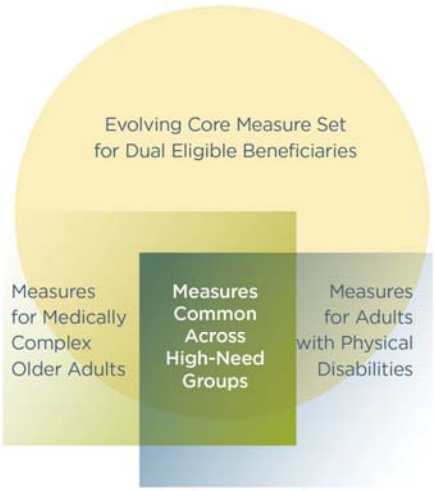
Initial focus on two subgroups of dual eligible beneficiaries:

- Older than 65 with one or more functional impairments and one or more chronic conditions
  - shorthand title = medically complex older adults
- Younger than 65 with a physical or sensory disability

Behavioral health populations to follow in 2013 for inclusion in July 2013 Final Report

Understanding that the complex and heterogeneous dual eligible population does not lend itself well to clean categorization…

Relationship Between the Evolving Core Measure Set and Specialized Measures for High-Need Subgroups



Measure Gaps and Gap-Filling Activities

- Revisited identification of high-priority measure gaps to provide greater specificity and add areas of interest for high-need subgroups
- MAP has suggested modifications to existing measures to improve their applicability to the dual eligible beneficiary population
- Gap-filling activities underway include:
  - NCQA expanding the age range of NQF measure #0097, "Medication Reconciliation," to include all adults instead of only those 65 and older
  - Development and testing of a participant experience survey based on CAHPS for Medicaid HCBS

Using Evolving Core Measure Set for Dual Eligible Beneficiaries to Inform MAP Pre-Rulemaking

Year 1 MAP Pre-Rulemaking Uptake of Dual Eligible Beneficiaries Workgroup Recommendations

- During MAP's 2011/2012 pre-rulemaking cycle, the Dual Eligible Beneficiaries Workgroup encouraged other MAP workgroups to recommend measures relevant to dual eligible beneficiaries
- MAP Coordinating Committee and the MAP Clinician, Hospital, and PAC/LTC Workgroups responded by supporting several measures across a range of programs
  - 11 measures from the Dual Eligible Beneficiaries Core Measure Set are now proposed or finalized in two or more HHS programs
  - An additional 8 measures from the set are proposed or finalized in one HHS program

What to Expect Related to Dual Eligible Beneficiaries

- Federal measurement programs have traditionally focused on a single setting or type of healthcare.
- To expand the use of measures that are relevant to the dual eligible population's unique needs, those types of measures must be added to existing programs.
- Where a measure from the Evolving Core Measure Set is under consideration by HHS for use in a program, MAP should recommend it for inclusion
- Chair and Liaisons from MAP Dual Eligible Beneficiaries Workgroup will help carry communications between the groups
- Written guidance customized to each setting-specific workgroup will also be provided

Hospital Program Input

- For hospitals, quality is tightly linked to person-centeredness, patient safety, medication management, care coordination/transitions, and readmissions from both community and long-term care settings
- Considering the heterogeneity of the population, think broadly about measures of care coordination, patient experience, outcomes, and integration of care needs and care teams across specialty areas
- Dual Eligible Beneficiaries Workgroup would support measures for inclusion in hospital programs in these areas, if under consideration by HHS:
  - Emergency department use
  - Participation in a registry for nursing
  - Catheter-associated urinary tract infections
  - Pressure ulcers

Clinician Program Input

- For clinicians, quality is tightly linked to screening, ongoing assessment, and management of chronic conditions (including mental illness); care coordination through primary care or other medical home; and medication management
- Focus on alignment opportunities presented by the Evolving Core Measure Set for Dual Eligible Beneficiaries and clinician measurement programs
- For example, the workgroup would recommend two measures in use across other programs be added to Value-Based Payment Modifier (VBPM)
  - NQF #0022 "Use of High Risk Medications in the Elderly"
  - NQF #0418 "Screening for Clinical Depression"

Post-Acute/Long-Term Program Input and Stratification by Dual Eligibility Status

- Most of the issues in PAC/LTC are relevant to duals and vice versa
- In these settings, quality is linked to person- and family-centered care and planning, delivering care in the least intense setting possible, medication management, and care coordination/transitions
- Workgroup discussed pros and cons of stratification as a potential opportunity to assess care provided to dual eligible beneficiaries
  - Stratification may be promising but requires further investigation into baseline demographics that might confound strata (SES, age, race) as well as testing any modifications to the measures before implementation
  - Workgroup requested that CMS use new linked data to perform an analysis of demographics and to identify opportunities for improvement

Next Steps for Dual Eligible Beneficiaries Workgroup

- Dual Eligible Beneficiaries Workgroup will convene via web meeting on December 19
- Workgroup will review recommendations from other workgroups and provide further recommendations to the MAP Coordinating Committee, if needed

Public Comment

Next Steps

Next Steps

- **December 10-19**: MAP workgroup meetings to provide input on program measure sets and measures under consideration
  - December 10-11: Clinician Workgroup In-Person Meeting
  - December 12-13: Hospital Workgroup In-Person Meeting
  - December 18: PAC/LTC Workgroup In-Person Meeting
  - December 19: Dual Eligible Beneficiaries Workgroup Web Meeting
- **January 8-9, 2013**: MAP Coordinating Committee In-Person Meeting to finalize MAP's recommendations to HHS
- **January 14-28**: 2-week public comment period on draft MAP Pre-Rulemaking Report
- **February 1**: MAP Pre-Rulemaking Report due to HHS