Measure Applications Partnership

Comments on the Interim Report to HHS: "Further Exploration of Healthcare Quality Measurement for Dual Eligible Beneficiary Population"

National Quality Forum (NQF) Response to Comments Received:

NQF thanks all those who responded with comments on the 2012 Interim Report on the progress of the Measure Applications Partnership (MAP) Dual Eligible Beneficiaries Workgroup. Input from NQF members and the public will be given careful consideration as MAP's work continues. Commenters from across stakeholder groups highlighted the importance of selecting the most salient measures for high-risk dual eligible beneficiaries across the continuum of care. Commenters supported the workgroup's efforts to minimize the burden of measurement on stakeholders serving vulnerable beneficiaries with a targeted, phased approach consisting of aligned measures that address the most prominent opportunities for improvement. Commenters specifically supported MAP's focus on gathering feedback from the field and offered further specificity around measure gaps related to nutrition, accessibility for people with disabilities, re-hospitalization of individuals with behavioral health needs, and other topics. Commenters raised methodological issues that complicate the application of measures; MAP will continue to explore topics such as alignment, risk adjustment, and attribution for consensus.

Commenters also communicated their desire to better understand the relationship between MAP's work and specific Medicare and Medicaid quality reporting programs. MAP has been asked to provide flexible and cross-cutting recommendations about appropriate measures for dual eligible beneficiaries; the current scope of the work allows for coordination with some federal programs, but not an extensive look at each one. Commenters also urged further consideration of high-need subgroups. MAP has proposed work to identify an aligned family of measures that would address all high-need subgroups, including dual eligible beneficiaries with serious mental illness (e.g., schizophrenia, major depression), substance use disorders, dementia, or intellectual/developmental disabilities.

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1. General comments on the report	Abbott Laboratories	Danna Caller	Abbott commends the MAP on their work to identify performance measures that will assess and improve the quality of care for vulnerable Dual Eligible beneficiaries. We agree that nutrition is an underlying quality issue for this population and plays a fundamental role in improving the high-leverage opportunity areas of patient safety, screening and assessment, and care coordination. Abbott recommends that the MAP Workgroup: Clarify "Assessment of Unmet Needs" in Appendix F on page 72 by adding "(e.g., stable housing, nutrition)". This is consistent with report language on page 26 and with explanations provided in other sections of the table. Evaluate Malnutrition Screening and Assessment as an independent measure g The consequences of poor nutrition or malnutrition create a burden to both patients and our health care system. Malnutrition can occur when patients lack essential nutrients because of excesses (too many calories) and/or deficits (such as not enough calories, protein, vitamins, and minerals). Thus, it is possible for even overweight and obese patients to be malnourished, for example their lean body mass stores may be significantly depleted. Malnutrition is not a new problem, and with an aging population it continues to be a major public health

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			concern. The risk factors for malnutrition are similar to the risk factors that drive health disparities. Malnutrition is particularly common among the elderly, those living in poverty, individuals on restricted diets, patients recovering from surgery, and patients with long term psycho-social problems or specific acute illness or chronic diseases (including COPD, cancer, stage 4-5 CKD, CHF, gastrointestinal disease, HIV/AIDS, stroke, and muscular dystrophy). Malnutrition is associated with poor outcomes such as higher morbidity and mortality rates, decreased quality of life, increased infection and complication rates, higher hospitalization rates, increased length of stay, higher rates of discharge from hospitals to nursing homes, longer rehabilitation, higher medication usage rates and higher readmission rates (Fry et al 2010, Jencks et al 2009, Correia et al., 2003; Covinsky et al., 1999; Vecchiarino et al., 2004). Large-scale studies show that as many as half of hospitalized patients (Robinson et al, 2003; Chima et al 1997; Mazolewski et al, 1999; Braunschweig et al 2000; Santoso et al 2000, Somanchi et al 2011) and 35% to 85% of older long-term care residents (Crogan et al 2003; Burger et al 2000, Thomas et al 2002) are undernourished. Importantly, the poor health outcomes and increased costs associated with malnutrition are generally avoidable. Screening, assessment and intervention for malnutrition are cost-effective and have been shown to both improve health outcomes and reduce costs (Brugler et al1999, Somanchi et al 2011, Lacson et al 2012).
1. General comments on the report	American Geriatrics Society	Susan Sherman	AGS strongly supports any measures which emphasize advanced directives and attention to comfort at end of life stages for the complex, older adult population.
1. General comments on the report	America's Health Insurance Plans	Carmella Bocchino	We support the work on ensuring a cohesive measurement strategy for the dual eligible population. In designing a measurement strategy for this population, alignment across Medicare and Medicaid is critical and needs to be addressed by the MAP. The MAP should be guided by their stated goals and focus on of a parsimonious set of measures, outcomes rather than process measures, and utilizing existing program measures where appropriate (e.g. NCQA, CMS Star Ratings). Areas of improvement need to be prioritized due to measure parsimony and measurement evolution is also critical in order to best meet the needs of the population. While we support the concept of a core set of measures some metrics may not be appropriate for certain sub-populations (e.g. colorectal cancer screenings for institutionalized dual eligible members). We are supportive of phased approach to measure selection and implementation as entities have different capabilities to report on these measures. Such an approach will also allow for establishing baseline measurements with the ability to examine trends in the future, further refine measures, and develop a uniform and concise metric set on which to report and focus improvement efforts. Metrics that rely on chart review and EHR data extraction should be administered as part of existing data collection

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			efforts. For example, we encourage the use of Pharmacotherapy Management of COPD Exacerbation, which is currently used for HEDIS reporting, in lieu of COPD – Management of Poorly controlled COPD. Additional efforts are needed to address the impact that socioeconomic factors has on attainment of performance targets for this population. Finally, the duals are not a homogenous group and comparisons of performance need to occur among sub-populations with similar characteristics.
1. General comments on the report	AmeriHealth Mercy Family of Companies	Thomas James	AmeriHealth Mercy Family of Companies is pleased to offer comment. We support the comments from AHIP. Additionally we would offer that measurement is an essential element of DMAIC (Define, Measure, Analyze, Improve and Control) system for quality improvement.) So the measures need to be informed through the process of definition of gaps in care for the specific population. The work of the Dual Eligible Work Group and the report from that body, is evolving. The report does describe the efforts in the various meetings. The group has recognized the complementary impacts of the environment, the patient's mental health, their health practices as well as the health care system. The Work Group should continue its efforts and should enlarge them to get to real pragmatic measures
1. General comments on the report	GlaxoSmithKline	Deborah Fritz	GSK supports MAP's overall vision of enhanced quality of care for the dual eligible population. GSK agrees that this population is vulnerable and often experiences difficulties navigating the healthcare environment. We applaud federal and state efforts to reduce fragmentation and improve quality and care coordination for dual eligible beneficiaries, as this population has complex healthcare needs. However, more clarification on how these measures are being utilized across CMS programs, as well as the connection with the developed state MOU's focus on quality measures.
1. General comments on the report	Healthfirst	Joyce Chan	1. We appreciate that MAP clearly identifies the level of analysis responsible for reporting each measure. For those measures where the health plan is not explicitly included in the level of analysis, we recommend the following: • The health plan should not be responsible for collecting and reporting the data on behalf of any of the other entities. • The health plan should not be held liable for the results of quality measures reported by other entities. 2. Administrative burden, particularly as it relates to medical record review, is a concern. • Any measures requiring medical record are challenging to report due to the labor associated with chart retrieval and review. • Some measures specify EHR reporting. However, the administrative burden still exists because (1) EHR adoption is not uniform across all providers use EHRs, (2) health plan access to and communication with provider EHRs varies widely, and (3) reporting mechanisms from EHRs are not standardized and typically not automated. 3. Developing a single core set of measures is difficult due to the high variation within the dual population.

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			• We support MAP's intention to use a phased approach to measure selection and implementation since entities have very different capabilities to report on these measures (e.g., hospitals and large practices have more reporting capability than nursing homes and SNFs). We recommend that any core set of measures be limited to entities that have the capability to report today and be expanded in the future to others so they can develop the capability. • We recommend that measures are used to compare similar dual populations to each other. For example, when comparisons are made between plans, they should be made within population sub-group type (e.g., compare chronic care SNP only to chronic care SNPs, dual SNPs only to dual SNPs) • We understand the desire to develop a core set of measures to use across the dual eligible population. However, some measures do not make sense for certain sub-populations. For example, colorectal cancer screenings do not make sense for institutionalized dual eligible members.
1. General comments on the report	Healthfirst	Joyce Chan	4. Some measures are not nationally standardized, originating from smaller organizations (e.g., MN Community, UNC Chapel Hill, Partners Healthcare System, etc.). Because they are not standardized measures, products do not currently exist to report this data. These measures will need to be programmed individually by health plans (or other entities responsible for reporting) and there is potential for variability in the way these measures are reported. This variability means that measures may not be comparable between entities. 5. Some measures are very similar to existing measures. Existing measures should be used for the sake of better comparisons and to minimize measurement burden. (e.g., COPD – Management of Poorly Controlled COPD is similar to HEDIS Pharmacotherapy Management of COPD Exacerbation) 6. Some measures are very setting- or condition-specific, and reporting of these measures will likely fall to facilities with high utilization of dual eligibles. Such highly specialized facilities (e.g., nursing homes, SNF) typically don't have a very robust reporting infrastructure.

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1. General comments on the report	National Association of State Directors of Developmental Disabilities Services	Charles Moseley	NASDDDS represents the 51 state developmental disabilities services agencies. We appreciate the opportunity to comment. We endorse the comments submitted by Clarke Ross on behalf of CCD. In addition, we offer the following suggestions, meant to complement and enhance those suggested by CCD. NASDDDS suggests the following changes to the High-need sub groups: · Adults 18-64 with physical disabilities, sensory disabilities, or traumatic brain injury. · Medically complex adults 65 and older with functional limitations and co-occurring chronic conditions · Beneficiaries with serious mental illness (SMI) and/or substance use disorders · Beneficiaries with intellectual and developmental disabilities. · Beneficiaries with cognitive impairments related to aging, including dementia and Alzheimer's. We also suggest adding a column in Table 3 titled "Distinct Issues for Adults with ID/DD." In that column, we suggest the following items related to Quality of Life: · Training in key personal-social skills · Expanding employment participation · Participation in community activities · Improving personal independence and self-direction · Ensuring the availability of transportation
1. General comments on the report	National Association of State Directors of Developmental Disabilities Services	Charles Moseley	The following items under "Care Coordination and Safety": Coordination with mental health services Supporting self-direction over staff and individual budgets And that the section on "Screening and Assessment include: Person-centered support delivery We hope these comments are helpful. We would be happy to discuss them further--please contact Chas Moseley at (703) 683-4202
1. General comments on the report	National PACE Association	Juliet Thomas	The National PACE Association (NPA) appreciates the considerable time and work spent by NQF and MAP to develop Healthcare Quality Measurement for the Dual Eligible Beneficiary population, and we are pleased for the opportunity to provide the following comments. NPA does not have any recommendations at this time, but we do have some questions that we feel are important as we think about how these measures can be used for PACE participants. NPA supports the phased approach to implementing the quality measures. A phased approach gives organizations the time to understand the measures and the flexibility to ease into more sophisticated

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			measures over time. We also felt that it was a great idea to go with a broader measure of pain assessment and the need to conduct pain assessment prior to initiation of pain therapy.
1. General comments on the report	PhRMA	Jennifer Van Meter	PhRMA supports the MAP's efforts to identify performance measures that evaluate the quality of care provided to beneficiaries who are dually eligible for Medicaid and Medicare. The health of this population, by nature, is particularly fragile, and receiving appropriate care is critical to achieving good clinical outcomes. Activities such as care coordination, good care transitions, medication reconciliation, discharge planning, medication adherence monitoring and counseling, and assessment of patient care experience are important to evaluating the care of these beneficiaries and reaching or maintaining clinical goals; performance measures that evaluate these activities are important to include in a set of measures about this patient population to demonstrate if improved quality of care, quality of life and health outcomes are achieved. PhRMA notes that the report neglects to clarify how these measures are to be used. How does the MAP foresee these measures interfacing with the dual eligible demonstration projects? How does the MAP foresee these measures relating to the Medicaid programs? How do they align with other measure sets like the Medicaid Core Measure Set and the Medicare Shared Savings Program measures? Are these measures intended to be used for plan evaluation? If so, are they all appropriately specified and tested for that level of use and for accountability purposes within this patient population? We believe these unanswered questions are glaring omissions in the report.
1. General comments on the report	SNP Alliance	Valerie Wilbur	The SNP Alliances strongly supports and appreciates NQF's work in the area of measurement for special needs populations including those who are dually eligible for Medicare and Medicaid and those with Multiple Chronic Conditions. We also greatly appreciate the latest phase of work that is targeting high-need duals. We have read the NAF draft report carefully and offer a number of comments in this chart based on our experience in working with plans serving high-risk duals for many years. Below are some of our highest priorities regarding performance measurement for special needs populations. a. The need for alignment of: • Medicare and Medicaid measures and methods; and • Model of Care requirements with measures and methods for targeted high-risk/high-need subsets b. Validation of self-report survey methods for people with compromised self- reporting capabilities, including validity of proxy methods. c. Benchmarking and case mix adjustment of measures for high-risk, high-need populations. d. Application of Data parsimony principles that ensure the value proposition of high-risk dual measures by: • Use existing measures, such HEDIS, HOS, CAHPS and MA Stars measures if they are relevant and not potentially harmful to special needs beneficiaries based on the subgroup served; SNP structure and

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			process measures; and measures related to SNP Models of Care, the basis for NCQA approval of SNPs. To date, neither S&P nor MOC measures are used to rate SNPs in any meaningful way. • Make recommendations on retiring existing MA measures (e.g., HEDIS, HOS, CAHPS, administrative data, etc.) for high need populations–because they are irrelevant or potentially harmful to certain subgroups such as frail elderly or those with SMI or ESRD – or because they are LESS relevant than other measures. • Adopt the principle of substitution when requiring new reporting – as opposed to adding on to existing measures - to prevent data burden
1. General comments on the report	SNP Alliance	Valerie Wilbur	Stakeholder Input: The Report states that MAP gathered important input from stakeholders that began to implement prior recommendations. Is there a group of plans and providers that are testing specific measures? If so, we suggest that NQF include additional information about the testing and outcomes in the Final Report. Also, will there be future opportunities to participate in testing? If so, the SNP Alliance would appreciate learning of such opportunities so we can alert our members who may be interested in participating in future testing of measures for high-need populations. Phase in of MAP Recommendations: The Report indicates that the MMCO is using a multi-year, phased approach to implementation of MAP recommendations. . . to ensure that the system is measuring the right things to benefits duals in manner that is not overly burdensome. . . and paying attention to minimizing extraneous measures that will not produce improved quality. Please clarify and provide additional detail in the NQF Final Report on Dual Measurement. It isn't clear from reviewing the MOUs issued to date that the principle of parsimony is being applied or whether there is a core set of measures that will be used by all MMPs participating in the FAD demo or which of the NQF's Evolving Core Measurement set may be included in the Financial Alignment Demonstration (FAD) core measurement set. We strongly support using states as test beds for measure development in gap areas and hope that early FAD MMPs are part of this effort. It isn't clear, for example, where MMCO is streamlining measurement for MMPs, such as requiring a single set of HEDIS, CAHPS and functional measures, a single quality improvement reporting vehicle targeting population/subset specific improvements, etc. We consider this a major "gap" that should be addressed ASAP to reduce duplicative reporting and the dual demos represent an opportune starting point. Standard Measures for Specialty Plans: NQF states that if SNPs, MMPs and other plans serving duals used standardized measures, their performance could be compared, but that GAO noted this was not possible under the current Model of Care rules. These are two separate issues. We strongly support establishing a core group of uniform measures of unique importance to SNPs, MMPs and other specialty care plans. And

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			for purposes of the FAD, MMPs will have to submit a MOC for review and approval so CMS will have MOCs for both types of plans. But the Model of Care currently isn't designed to evaluate SNP performance or quality; it's only used to approve SNPs for licensure. As noted in the gap section below, however, we strongly support the alignment of MOC domains and requirements with SNP/MMP performance measures and have urged CMS and NCQA to do so. This alignment would result in measures and an evaluation framework of unique importance to high-need populations. Barriers to Reliable Data: We strongly agree with the need for innovation in the development of valid, reliable satisfaction measures for duals with language barriers, mental illness, cognitive impairments, limited education and other potential impediments to reliable data. The same need exists for other measures that are self-reported such as HOS. We agree that new methods are needed to gather information from individuals who may have difficulty responding without a proxy. We also believe that the issue of proxy use should be studied to determine the reliability of proxy responses. Some geriatric researchers, including Dr. Robert Kane, have indicated that self-report surveys should not be used if they cannot be completed by the beneficiary themselves. We also recommend studying the need for common proxy administration methods across programs. For example, professional health staff can serve as proxies for beneficiaries that routinely receive care in adult day care settings while persons living in the community are much less likely to have access to this type of proxy support. If a non-professional or person filling out the survey does not have regular contact with the beneficiary, responses to the same questions filled out by professional proxies in other environments could be quite different. We support NQF's intent to have a multi-purpose set of optional measures for duals, among which individual plans would choose based on their enrolled population ("fit for purpose") This would offer, for example, plans serving under 65-adults with disabilities a host of appropriate behavioral health measures from which to choose based on their targeted subsets, but would not require them to report measures that are not relevant to younger disabled adults -- such as high-risk drugs for the elderly.
1. General comments on the report	SNP Alliance	Valerie Wilbur	Parsimonious Reporting. We strongly support the concept and discussion regarding parsimony as a guiding principle as well as the statement that measurement is only one component of a larger strategy need to produce quality. In keeping with the objective of parsimony, for SNPs, Medicare-Medicaid plans and others in the dual area: • We urge the use of existing measures such as appropriate/relevant HEDIS, HOS, CAHPS and MA Stars measures, SNP structure and process measures and SNP Model of Care related measures (MOC). There are 11 MOC domains that could provide the basis for measurement for high-need beneficiaries. • We urge NQF to evaluate the current scoring criteria for SNP MOCs and develop recommendations regarding criteria that is more relevant to the needs of specific high-risk subsets and less

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			volume driven. This would provide the basis for developing aligned quality measures. • We urge NQF to consider recommendations on meaningful use of SMP Structure and Process measures which SNPs have reported to NCQA since 2009, and which are not used to evaluate or rate SNP performance in any meaningful way. We believe that SNP model of care domains and structure and process measures should be combined and refined into an aligned set single set of MOC requirements with related measurements. Five of the six S&P measures do not have corresponding domains under the model of care and 10 out of 11 MOC domains do not have a direct corollary in the S&P measures. If an aligned set of factors were identified for MOC domains and S&P measures, the MOC could be used to outline care related requirements and the S&P measures could be used to evaluate plan performance in relation to these care domains/requirements. • Finally, we urge NQF to evaluate the appropriateness of current MA measures (HEDIS, HOS, CAHPS, administrative data, etc.) for duals and high-need populations and to make recommendations regarding which measures should be excluded from reporting for all SNPs or for specific subgroups – because they are irrelevant or potentially harmful to certain subgroups such as frail elderly or those with SMI or ESRD – or because they are LESS relevant than other measures that could be substituted instead of just added on to existing measures. To date, SNPs have not been exempted from any MA measures, including those that are irrelevant or potentially harmful; all SNP specific measures have been add-ons, not substitutes. This creates a tremendous administrative burden to all SNPs, but especially for smaller plans with a limited number of lives over which to spread administrative costs, without improving quality or providing any added value.
2. Comments on the Evolving Core Measure Set for Dual Eligible Beneficiaries or stakeholder feedback on MAP's prior recommendations	Abbott Laboratories	Danna Caller	Abbott supports the MAP Workgroup prior recommendations to include the following measures in the Evolving Core Measure Set: NQF# 421: Preventive Care and Screening: Body Mass Index (BMI Screening & Follow-Up) NQF# 430: Change in Daily Activity Function as Measured by the AM-PAC NQF#729: Optimal Diabetes Care
2. Comments on the Evolving Core Measure Set for Dual Eligible Beneficiaries or stakeholder	American Geriatrics Society	Susan Sherman	The AGS appreciates how the workgroup continues to describe the recommendations as an evolving work in progress. We also appreciate the grid and its clarity around source, settings, and its level of analysis. We would like to encourage further attention into the following areas: safe transitions, safe medications, and medication reconciliation for the frail multi-morbid population. Lastly, we would like to see further attention on how to present and communicate advanced directives. Although it is challenging, we strongly support attention to the measure around coordination of medical care and community long-term care. As

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feedback on MAP's prior recommendations			geriatrics health providers, partnering with colleagues in the community services arena is critical. This level of coordination is often the differentiator between high and low quality care.
2. Comments on the Evolving Core Measure Set for Dual Eligible Beneficiaries or stakeholder feedback on MAP's prior recommendations	American Psychiatric Institute for Research and Education	Robert Plovnick	NQF #1789: Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) Unplanned readmission is an important consideration for quality improvement and healthcare efficiency, and the American Psychiatric Association supports the need to measure this aspect of care. Patients with primary psychiatric illness are likely to experience unplanned readmissions for a variety of factors, some pertaining to the hospitalization which could potentially be modified, others related to the course of illness and post-discharge conditions and services over which the hospital will have far less control. Measure #1789 excludes patients with primary psychiatric disease with the rationale that "patients admitted for psychiatric treatment are typically cared for in separate psychiatric or rehabilitation centers which are not comparable to acute care hospitals." While we agree that psychiatric patients should be excluded from this measure due to technical considerations, we note that a significant number of patients are treated within acute care hospitals for primary psychiatric illness. Further, psychiatric illness, whether primary or secondary, is prevalent, particularly in the dual eligible population. Excluding this population limits the reach of the measure. We therefore suggest unplanned readmissions in the population of patients with psychiatric illness be prioritized for further study and the development of quality improvement resources.
2. Comments on the Evolving Core Measure Set for Dual Eligible Beneficiaries or stakeholder feedback on MAP's prior recommendations	America's Health Insurance Plans	Carmella Bocchino	This report would benefit from better definitions as to the appropriate attribution of measures (i.e. what measures are appropriate for gauging health plan performance vs. assessing performance of office-based physicians, community-based organizations, in-home service providers, etc.). Such guidance is important as the MAP proposes measure sets that decision makers could adopt in whole without specification for attribution and which may ultimately lack applicability and appropriateness for the reporting entity (i.e. health plan, physician, or both). The reporting entity must have the ability to improve practice or influence outcomes to ensure that measures are not applied indiscriminately. Additionally, the report also does not address stratification of the dual eligible population within the core or starter measure sets. We recommend that both sets include measures that examine stratification of the population in detail. There is also an overemphasis on completion of care plans, evaluations, instruments, and the transmission of such instrument. We recommend a balanced focus on and inclusion of functional and outcomes-based measures that reflect the throughput of a series of processes. Extremely disparate requirements exist between Medicare and Medicaid and health plans rely on the Federal and State governments to lead the coordination of Medicare and Medicaid coverage. There are also issues with specific measures proposed: some measures such as High Risk Medications in

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			the Elderly, Tobacco Cessation, and Screening for Depression will require burdensome medical chart review, audits or manual submission of data by practitioners. Additionally, the most appropriate measure to produce an accurate reflection of actual patient experience with provider cultural competency is NQF #1904, which is based on the CAHPS Cultural Competence Item Set and is derived from patient ratings of experience with providers. We also recommend deletion of #1919 that relies on self-evaluation. This report would also benefit from including a description of the proposed CAHPS-related measures #1902, 1904, and 1741.
2. Comments on the Evolving Core Measure Set for Dual Eligible Beneficiaries or stakeholder feedback on MAP's prior recommendations	AmeriHealth Mercy Family of Companies	Thomas James	AmeriHealth Mercy Family of Companies is pleased to comment on the Report. We are in agreement with the comments by Carmella Bocchino of AHIP. Additionally we offer the following comment: The issue of attribution and of accountability remains very difficult for this population of vulnerable individuals who have limited resources for self-management. The Level of Analysis becomes a proxy for the accountability. There are measures in the list for which health plans also bear accountability such as 0097-Medication Reconciliation; 0101 Screening for fall risk, and 0729 Optimal diabetes care. The issue of burden of measurement must be balanced with the need to measure in order to improve. With finite resources available, health plans can engage in a number of efforts to improve specific quality of health care. As part of the National Quality Strategy, there is a recognition of prioritizing the health care needs. This is the area of "parsimony" of measures to lead the prioritization of quality areas for improvement
2. Comments on the Evolving Core Measure Set for Dual Eligible Beneficiaries or stakeholder feedback on MAP's prior recommendations	GlaxoSmithKline	Deborah Fritz	Dual eligibles differ from others on Medicare in their demographic composition, health care needs, service utilization and tend to have more chronic conditions, 55% for duals vs 44% for all other Medicare beneficiaries. Focus on chronic conditions such as diabetes, copd and asthma should be considered. GSK recommends inclusion of measures that increase continuity of care and Comprehensive Medication Management, such as Medication Reconciliation & HBIPs-6 measures identified as core measures but not as starter measures. GSK supports the improvement of CMM that is a continuous process used by providers to ensure patients' medications are coordinated & appropriate. This population is unique where members are trying to navigate two separate health care programs. GSK believes CMM measures are an important mechanism to ensure patients receive adequate care. Dual eligibles had a higher hospitalization rate than other Medicare recipients and more likely to have two or more hospitalizations1GSK recommends the following measure "COPD-Management of Poorly Controlled COPD" into the starter measures. COPD is the third leading cause of death in the U.S. and causes serious, long-term disability. In addition to high morbidity, COPD is associated with increased healthcare resource utilization and spending. Smoking is the primary risk factor for COPD. Smoking cessation is the single most effective –and cost effective–intervention to reduce the risk of developing COPD and slow its

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			progression. GSK also recommends consideration of the following measures for further measure inclusion: NQF #0102: COPD Bronchodilator Therapy, NQF#0091: COPD: spirometry evaluation, NQF#0102: COPD: inhaled bronchodilator therapy, NQF#0577: Use of spirometry testing in the assessment and diagnosis of COPD, NQF#1825: COPD - management of poorly controlled COPD, NQF#0028: Tobacco Use Assessment & Cessation Intervention, NQF#0577: Use of Spirometry Testing in the Assessment and Diagnosis of COPD, NQF# 0549: Pharmacotherapy Management of COPD Exacerbation GSK strongly supports inclusion into the starter set of measures, NQF#1800 "Asthma Medication Ratio". The ratio of controller medication to total asthma medication achieves the dual purpose of identifying patients who are not adequately persistent in their use of controller medication and identifies patients who are high utilizers of rescue medications. Overuse of SABAs is associated with increased risk of hospitalization and is a marker for poor control and disease severity.
2. Comments on the Evolving Core Measure Set for Dual Eligible Beneficiaries or stakeholder feedback on MAP's prior recommendations	Healthfirst	Joyce Chan	1. Use of High Risk Medications in the Elderly: there are currently 2 high risk medication measures (HEDIS, Pharmacy Quality Alliance) that health plans currently manage and monitor. We recommend that MAP clearly align this measure with one of the existing measures. 2. Follow-up After Hospitalization for Mental Illness: health plan is not listed in the "Level of Analysis" column. However, this is a measure that health plans currently report for HEDIS. 3. Patients Admitted to ICU Who Have Care Preferences Documented: We recommend that this be measured more broadly so that patients with an existing advance care plan are considered compliant. 4. COPD – Management of Poorly Controlled COPD: Health plans currently report a similar measure based on administrative data, which is less of a burden than the combination of data sources (claims, electronic clinical data, provider survey, patient survey, pharmacy data) specified by the MAP measure. We recommend that MAP align this measure to the existing NCQA measure. 5. Cultural Competency Implementation Measure: It is not clear how relevant this self-reported (by facility / plan) measure will be to the actual experience of the consumer/patient/member. We suggest that if cultural competency is a focus area that the member experience be the primary measurement. We also recommend that this measure accounts for regional / geographic variations in cultural diversity that may make this measure more challenging for some regions. 6. SNP 6: Coordination of Medicare and Medicaid Coverage: It is extremely difficult for health plans to take the lead on this due to the extremely disparate requirements that exist between Medicare and Medicaid. Health plans are reliant on the Federal and State government leading this important effort.
2. Comments on the Evolving Core	National PACE Association	Juliet Thomas	In an effort to understand how these quality measures can be used across dual eligible beneficiaries, NPA has several questions that we would like to ask NQF and the MAP team.

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Measure Set for Dual Eligible Beneficiaries or stakeholder feedback on MAP's prior recommendations			· To what extent were the quality bonus measures taken into consideration when developing these measures for the duals? How will the core measure developed by MAP be used in quality reporting and quality bonus payment? ·The quality measures developed for the first phase of the project focused on adults ages 18-64 with physical disabilities. However, PACE programs provide services to adults 55 years and older with functional impairment and co-occurring chronic conditions. For the measures developed in the first phase of the project did MAP explore the measures applicability across settings, disabilities and age? Also, with the "fit for purpose" concept, how will this be used across duals? · How does MAP envision capturing the dual eligible experience of care when this group has significant cognitive and language barriers?
2. Comments on the Evolving Core Measure Set for Dual Eligible Beneficiaries or stakeholder feedback on MAP's prior recommendations	PhRMA	Jennifer Van Meter	PhRMA supports the Evolving Core Measure Set and the starter set of measures. However, we urge the MAP to provide more details about the criteria for selecting the starter set of measures. The report indicates that the starter set was chosen based on ability to implement the selected measures, but it does not comment on whether these measures also impact high-leverage areas in need of improvement. We think that the measures included in the starter set should be endorsed by a multi-stakeholder consensus-based organization such as NQF, should address a high priority measure area, and should be ready for implementation. PhRMA also suggests that the MAP consider including measures related to the optimal care of chronic diseases be included in the starter set. Measures about diabetes and COPD are included in the Evolving Core Set and could be added to the starter set. Other common chronic conditions amongst dual eligible beneficiaries could also be added. Additionally, for this population, care coordination is critical to ensure that appropriate care is being rendered. Measures related to care coordination, such as the medication reconciliation, care transition, and post-discharge care plan measures, should be included in the starter set.
2. Comments on the Evolving Core Measure Set for Dual Eligible Beneficiaries or stakeholder feedback on MAP's prior recommendations	SNP Alliance	Valerie Wilbur	Table 1 – Evolving Core Measures Four of the newly proposed measures potentially overlap with measures that SNPs already report through Care of Older Adults (COA) – a HEDIS measure for SNP enrollees 65 and above. There appears to be overlap with 3 NQF advance planning related measures (Advance Care Plan (0326), Patients Admitted to ICU with Care Preferences Documented (1626), and Hospice & Palliative Care Treatment Preferences (1641)) and the COA measure for Advance Care Planning which measures the percentage of patients aged 65 years and older with documentation of a surrogate decision maker or advance care plan in the medical record. Since we know NQF is committed to the practice of data parsimony, we think NQF should reconsider the

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			need for multiple advance care plan related measures for different settings. We urge NQF to consider whether these measures could be consolidated this into one reporting measure—and whether the current COA measure for advance care planning could be used for duals. Since 85% of SNP enrollees are duals (not just DSNP members), and SNPs have been reporting COA data for 2-3 years, it would be administratively efficient to continue using an existing measure. Since the Financial Alignment Demonstration is using many of the SNP protocols/requirements, it seems likely that the new MMPs will be required to report the COA measures. Pain Assessment Prior to Initiation of Patient Therapy (0420). Similar to the comment above, SNPs already report a COA pain assessment measure which measures the percentage of members 65 years of age and older who received a pain screen during the measurement year. We recommend consolidating reporting on pain screening so that plans are not duplicating data collection and reporting.
2. Comments on the Evolving Core Measure Set for Dual Eligible Beneficiaries or stakeholder feedback on MAP's prior recommendations	United Spinal Association	Carol Tyson	Founded in 1946 by paralyzed veterans, United Spinal Association (United Spinal) is the largest disability-led nonprofit organization serving and representing the interests of more than a million Americans living with spinal cord injuries and disorders (SCI/D). It has approximately 40,000 members in all 50 states and reaches out to these individuals through its chapters and support group network. Throughout its history, United Spinal Association has dedicated its energy, and programs to improving the quality of life for these Americans of all ages and advancing their independence. United Spinal Association is also one of approximately 100 members of the Consortium for Citizens with Disabilities (CCD). United Spinal supports a person-centered framework (p. 6) that values self-determination, and allows for a transition to or maintenance of independent living and integration in the community. We strongly agree with MAP members who have noted that "current measures are not sufficient to reflect …diverse needs." Methods should be developed to allow consumers with cognitive and/or physical disabilities to utilize a proxy or make use of alternative tools so that their interests and experiences are included which will ensure that consumer access to quality healthcare will be a reality for all people with disabilities.

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3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	Abbott Laboratories	Danna Caller	Abbott agrees that nutrition, as identified in Table 2 on page 21, is a quality issue that is common across subgroups; complex older adults and younger adults with disabilities. While nearly 20 years ago an expert panel ranked malnutrition—specifically undernutrition--as the third leading condition in the hospital and home care for which quality improvement efforts would enhance the functional health of older persons (Miller et al, 1995), malnutrition still remains a frequent problem across the continuum of healthcare. Today, malnutrition is identified as one of the important contributing factors of the emerging "post-hospital syndrome," which was recently characterized as an acquired, transient condition of generalized risk (Krumholz, 2013). Malnutrition is also common among patients recovering from surgery, patients with long term psycho-social problems and/or specific acute illness or chronic diseases (such as COPD, cancer, stage 4-5 CKD, CHF, gastrointestinal disease, HIV/AIDS, stroke, and muscular dystrophy). In addition, we support the MAP Workgroup recommendation that screening and assessment is a high-leverage opportunity area. Screening, assessment and intervention related to malnutrition are cost-effective and have been shown to both improve outcomes and reduce costs. (NAIT and ASPEN, 2010) Recommendation: Clarify "Assessment of Unmet Needs" in Appendix F on page 7 by adding "(e.g., stable housing, nutrition)". This is consistent with report language on page 26 and with explanations provided in other sections of the table.
3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	American Geriatrics Society	Susan Sherman	With respect to the subgroup of complex, high-needs older adults, we appreciate the break out of complex older adults versus the young disabled. Regarding the subgroup of "cognitive impairment," we feel that the crossover to medically complex patients might lead to confusion. Furthermore, when thinking about subgroups, we believe that "dialysis" is an area that needs further attention. It may be covered in other forums, however this subgroup drives massive amounts of resources, has poor transitions, and goals of care can be challenging. Specifically, in looking at "Table 2-Quality Issues that Need Measurement," the AGS supports this area. Measuring care coordination, functional issues and trajectories, and more patient-centered outcomes is the future of our work. It is crucial that we have improved measures of quality, however it must be acknowledged that clinicians who care for these fragile populations are severely lacking in numbers.

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3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	America's Health Insurance Plans	Carmella Bocchino	The report should clearly articulate the linkage between the" Quality Issues Associated with High-Need Subgroups of Dual Eligible Beneficiaries" and the "Measures for Potential Addition to Evolving Core Measure Set in Future Work." It is not clear to which high-level opportunity area certain measures link and the addition of this information would offer a more comprehensive perspective on rational for measure inclusion. We are supportive of measuring care coordination as well as patient-centered outcomes. We are also supportive of separately considering the needs of adults with physical disabilities and medically complex seniors as they have distinct and specific needs. Other sub-groups that require focus include dialysis patients, beneficiaries with highly complex medical conditions, children with disabilities, and distinction between beneficiaries with Substance Use Disorders and Severe Mental Illness. While there is a single subgroup of beneficiaries with SUD and SMI, the MAP report should recognize the similarities and differences between these conditions as they relate to care regimes, quality standards, and related criteria. While there is overlap of measures for subgroups, age and evidence-base considerations need to apply for preventive or HIV screening measures, otherwise there can be an increase in inappropriate use. The report should reconsider use of a uniform assessment of self-determination preferences across populations as these can vary for baby boomer versus non-baby boomer individuals.
3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	AmeriHealth Mercy Family of Companies	Thomas James	AmeriHealth Mercy Family of Companies appreciates the opportunity to comment on the Report. We stand in agreement with the comments offerred by Carmella Bocchino of AHIP. Additionally AMFC appreciates the evolution of the measure sets. The Dual Eligible Work Group has evolved the process because of the nature of the vulnerable populations. The Work Group recognized that the baseline set of single condition or single resource-based measure would be difficult in patients with complex social, behavioral and physical conditions. The Dual Eligible Work Group tried to focus on a constellation of measures that encompassed all of these issues as well as health care system responses in terms of transitions of care and care coordination. The Work Group has called for development of new measures for multiple comorbidities, for integrated behavioral-physical health measures, and more environmental measures (such as with the falls prevention) AMFC would support NQF and MAP in encouraging development of such measures. That may be through AHRQ which has interest in these

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3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	DREDF	Mary Lou Breslin	MAP has pointed out in earlier reports and in the December 2012 interim report that measures are lacking that effectively evaluate outcomes for managed long-term services and supports for people with disabilities and seniors, and also has identified related efforts that could fill these gaps. We applaud MAP for noting measure gaps related to LTSS and the intersection of LTSS with clinical care. Adding to the discussion, we would like to focus attention on recent work by Professor H. Stephen Kaye, Center for Personal Assistance Services, University of California San Francisco entitled, "Selected Inventory of Quality of Life Measures for Long Term Services and Supports Participant Experience Surveys."[i]Recognizing the growing urgency of monitoring outcomes for Medicaid Managed LTSS, Professor Kaye points out that the proper goal of LTSS is to foster independence, self-determination and meaningful participation in community life for people with disabilities. To begin to address this gap, and help advocates and policymakers respond to data collection needs, particularly with respect to outcomes related to Quality of Life (QOL), he identifies previously fielded questions related to QOL in general and to 12 domains found in Wisconsin's Personal Experience Outcomes Integrated Interview and Evaluation System, or PEONIES.[ii]While the list of measures is not exhaustive, they suggest existing measures that might be used or adapted to construct concise surveys useful for monitoring particular programs serving specific populations. Within the PEONIES domains, similar survey items are grouped by theme. The paper presents a table that lists the correspondence between the PEONIES domains and those of other QOL conceptual frameworks for LTSS, which reflects an independent living perspective. We urge MAP to review this work during its deliberations. Finally, the National Senior Citizens Law Center and DREDF have published a guide for advocates on quality measures in managed LTSS. It presents some of the key concerns of seniors and peoples with disabilities as more and more states are moving to managed LTSS. It can be accessed at http://dredf.org/2013-documents/Guide-LTSS-Outcome-Measures.pdf [i]Kaye, S.H., "Selected Inventory of Quality-of-Life Measures for Long-Term Services and Supports Participant Experience Surveys. Center for Personal Assistance Services, University of California San Francisco. December 2012. (Available at http://www.dredf.org/Personal-experience-domains-and-items.pdf) (January 29, 2013) [ii]PEONIES domains: Personal Experience Outcomes Integrated Interview and Evaluation System. Center for Health Systems Research & Analysis. University of Wisconsin, Madison. (Available at http://chsra.wisc.edu/peopnies/index.htm) (January 29, 2013).
3. Comments on	GlaxoSmithKline	Deborah	GSK supports measures targeted at the high need populations and agrees that a high focus on care

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specialized measures for high-need subgroups of dual eligible beneficiaries		Fritz	coordination would be a tremendous asset to this patient population. We believe that addressing care transitions, comprehensive medication management, hospital readmissions, immunizations, and chronic disease within this population is critical to improving quality for these beneficiaries
3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	Healthfirst	Joyce Chan	1. Cervical Cancer Screening: This is a medical record review measure, and will be an additional burden to report. 2. Pneumonia Vaccination Status for Older Adults: We are concerned about the validity of survey data for this measure due to the long recall period. We suggest that MAP considers changing this to a medical record review measure (even though it will increase administrative burden) because it will improve measure accuracy. 3. The HIV screening measure includes a comment that MAP suggests modifying the measure to promote broader screening for HIV. We have questions about the clinical basis for broadening the population for the measure and suggest that this measure not be modified.
3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	National Alliance for Infusion Therapy	Alan Parver	The National Alliance for Infusion Therapy (NAIT) commends the MAP for recognizing the clinical value to dual-eligible beneficiaries of screening for nutrition issues. As the interim report properly notes, dual-eligible beneficiaries have especially complex and intense needs for care and support. NAIT supports the inclusion of such screening, and in fact urges MAP to strengthen this area as described below. We believe malnutrition screenings, followed by assessments as well as appropriate interventions if indicated, should be incorporated into performance measures for public reporting and performance-based payment programs and other health delivery system initiatives. Establishing a nutritional baseline and tracking subsequent changes is an important component for measuring whether a patient's health is improved during any interaction with the healthcare system. Malnourished patients are more likely to experience complications, such as pneumonia, pressure ulcers, nosocomial infections, and death. In addition, malnutrition is a risk factor for other severe clinical events, such as falls and worse outcomes after surgery or trauma. Malnutrition has a negative impact on patients with specific chronic diseases and conditions, such as stroke patients, and patients with heart failure, cancer, or COPD. Addressing malnutrition through appropriate screening can address the "inclusiveness" criteria, as such an intervention broadly targets an number of conditions. Malnutrition is a common cause for patients to be readmitted to hospitals (Kassin MT, et al. 2012). A recent study found that malnourished patients with heart failure were 36 percent more likely to be

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			readmitted to the hospital within 30 days than nourished patients with heart failure (Zapatero A, et al. 2012). Malnourished patients and patients with nutrition-related or metabolic issues are frequently readmitted to the hospital (Kassin MT, et al. 2012, Jencks SF, et al. 2009). One study found that there were 11,855,702 Medicare fee-for-service patients discharged from hospitals between October 1, 2003 and September 30, 2004 who were at risk for rehospitalization; 19.6 percent of the patients were readmitted within 30 days, resulting in a cost of $17.4 billion (Jencks SF, et al. 2009). Recommendation: Nutrition screening, assessment and intervention should be evaluated as an independent measurement gap.
3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	National PACE Association	Juliet Thomas	MAP created four high need groups, organized around factors that are predictive of clinical complexity and high expenditures. How did MAP account for groups that may overlap with physical disabilities and medical complex participants?
3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	SNP Alliance	Valerie Wilbur	High-Need Subgroups: We support a number of the specific categories NQF has identified for high-need subsets, but suggest a reordering of the subsets into the following categories: • Adults 18-64 with (1) physical or sensory disabilities; (2) severe and persistent mental illness; (3) intellectual/developmental disabilities; and/or (4) substance use disorders. • Seniors 65+ with (1) frailty; (2) functional impairments; and/or (3) cognitive impairments. • Beneficiaries with medically complex conditions such as AIDS, ESRD, comorbidities, and/or other medically complex conditions. The categories above are consistent with SNP Model of Care Element 10, "care management of the most vulnerable populations" which originally was defined as beneficiaries who are frail, disabled, those who have ESRD or multiple chronic conditions and those who are at the end of life. For this element, plans are required to have procedures in place for identifying the most vulnerable enrollees and providing them with additional services unique to their needs. MOC domain 11 requires SNPs to identify measures for evaluating MOC effectiveness. Accordingly, SNPs have already begun reporting data under this structure. These categories also are consistent with the way many states have classified their dual beneficiary subsets for many years under demonstration and waiver authority (PACE, Social HMOs, dual integration demos, HCBS waiver programs, etc.). We also believe it is important to maintain consistency with FAD/state approaches since MMCO is one of the primary audiences for NQF's dual measurement work, these categories reflect subsets that have been proposed by the states participating in the Financial Alignment Demonstrations, some states and plans are gearing up to report data in relation to these

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			groupings – and many operating under earlier demo authority already are doing so. In the spirit of consistency with current models and data parsimony, we think it makes sense to maintain the current framework for high-need beneficiaries as described above. Beneficiaries with serious chronic conditions such as ESRD and AIDS and others with serious or late stage conditions and/or with co-morbidities cut across both under 65 and over 65 categories and are consist with categories served by SNPs. Dialysis patients are responsible for a significant amount of health care spending and resource utilization, tend to have poor care transitions and challenging care needs. HIV is complicated to treat and to maneuver the social stigma patients still experience and AIDS patients have a unique set of care needs (e.g., HIV PCPs and RN Care coordinators with expertise in AIDS care, specialty network with HIV experience within their specialty and the social/community knowledge to address the isolation and stigma enrollees face, etc.) We also urge NQF to distinguish between persons with Serious Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) and Substance Use Disorder (SUD) since the cause of these conditions is very different, treatment and responses to care interventions differs and these differences create different measurement needs.
3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	SNP Alliance	Valerie Wilbur	NQF indicated that it will address measurement needs of those with SMI and cognitive impairment in future work. Will this work be part of the second phase of the current Report – or a future report altogether? We understand that NQF, NCQA, the Substance Abuse and Mental Health Services Administration and ASPE are working collaboratively on behavioral health measurement issues and look forward to the product of their collaboration. We assume this effort will also reduce the potential for duplication or conflicts in reporting requirements across agencies. NQF indicates that we lack reliable methods for distinguishing individuals with MCCs, frailty and disability and appropriate interventions. We recommend that NQF looks at work done by Linda Fried, MD et al at Johns Hopkins on Untangling the Concepts of Disability, Frailty and Comorbidity and also Rand's ACOVE measures. Fried suggests that frailty can be defined as having 3 or more of the following factors: unintentional weight loss; general feeling of exhaustion; weakness; slow walking speed; low levels of physical activity. Kaiser Permanent research published in 1997 indicated that over 90% of the population could be correctly classified based on 4 criteria including age; indicating that health conditions interfered with daily activities; needing or receiving assistance with bathing; and needing or receiving assistance from another person for taking medications . There is a large body of literature devoted to frailty that offers a starting point for the work of distinguishing frailty from other disease states as well as interventions and measures. For example, if we know balance is a marker for frailty, reducing falls is a possible quality measure.

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3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	SNP Alliance	Valerie Wilbur	High Leverage opportunity areas identified by MAP include quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures. We recommend adding two more areas for duals: • integration of Medicare and Medicaid administration, financing, benefits and services, and oversight; and • medication management. Given the unprecedented interest in Medicare/Medicaid integration, the establishment of the MMCO under the ACA, the Financial Alignment Demos and other state efforts to integrate, it would be a critical missed opportunity not to identify measures for evaluating the degree to which CMS, states, and plans are integrating Medicare and Medicaid at various levels. The legacy FIDESNP demos are often criticized for not being able to produce meaningful quality or cost data, but CMS never established a core set of common integration measures on the front end for comparative analysis since each of the demos were state driven and had different goals. Since there are a common set of goals for the FAD demo, evaluation criteria and measures should be established up front so that plans, providers and states know how they will be evaluated and CMS, states and plans can evaluate the effectiveness of these models. Since the MMCO is a primary audience for NQF dual measurement work, an integration measure should be in important part of NQF's work on behalf of the Dual office. We believe that SNP Structure and Process measure 6 on Coordinating Medicare and Medicaid Benefits is the only measure currently being reported routinely by plans – and only by SNPs so far -- and that measure is not outcome oriented. It provides little of the info Congress would look for to evaluate successful integration and no data on cost savings, the issue of greatest interest to Congress, at present, given the multiple budget issues they are facing from sequestration to the debt ceiling debate. The SNP Alliance believes that effective medication management is among the highest leverage opportunities for improving health outcomes for duals and high-need special needs beneficiaries, given, for example: • the percentage of duals with multiple chronic conditions who are proscribed several distinct medications; • the potential for improving outcomes through drug therapy; • the potential for serious adverse drug events as a result of poor interaction among multiple providers serving the same beneficiaries and failure to use a common care plan as a general rule; • the number of hospitalizations and readmissions that are related to adverse drug events; and • multiple reasons for lack of compliance.
3. Comments on specialized measures for	SNP Alliance	Valerie Wilbur	MAP's identification of priority areas also was guided by IOM criteria for impact, improvability and inclusiveness. Are there other factors that should be taken into account in prioritizing dual measurement priorities? For example, NQF indicates that few studies examine beneficiaries with a primary physical

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high-need subgroups of dual eligible beneficiaries			disability separately from other duals under the age of 65 with other types of disabilities. We also note that the research/measurement community has never evaluated plans that exclusively serve duals to determine the reliability of CAHPS weighing in the downward adjustment of satisfaction ratings for poorly educated low-income beneficiaries. We also are not aware of any research regarding the reliability of self-report surveys based on plans that exclusively or disproportionately serve beneficiaries with mental, cognitive or behavioral issues. The same is true for HEDIS, HOS and CAHPS and other measures. As Rand pointed out in their work on ACOVE measures, little scientific research on quality measures for the over 75 population has ever been conducted. We believe it is critical for the on-going work in measurement for high-need populations to focus on plans that exclusively serve specific high-risk populations – such as the 3 categories we identify above as well as the proposed subsets.
3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	SNP Alliance	Valerie Wilbur	Table 2- Quality Issues for Adults with Physical Disabilities, Complex Older Adults and Both • Quality of Life issues common across subgroups: We recommend adding "self-determination in care and treatment decisions." • Care Coordination and Safety: We recommend adding health risk assessment and reassessment to common issues; and medication administration for seniors living at home (e.g., improvement in management of oral meds- NQF #0176) to the list for complex older adults. • Screening and Assessment: We recommend adding pain assessment to the list of common issues and abuse to both subsets. We believe domestic abuse is more commonly referenced in the under 65 population and elderly abuse for the over 65 population, but defer to experts on how to classify the issue appropriately. Both groups are at higher than average risk of abuse given their vulnerable physical and emotional states. • Mental Health and Substance Abuse: Recommend adding to Social relationships "and isolation." • Structural Issues: o Add to common workforce issues "and safety related to home visitation of enrollees with substance abuse." This risk has been reported to us by SNP members serving adults with disabilities who send home care workers on home visits for people with drug abuse problems. o Add new bullet to common issues --"Appropriate coverage and payment policies" since the second bullet on provider access is strongly affected by both. o Add to complex older adult issues "Access to family caregiver support" since it is often central to beneficiaries' ability to remain in community-based care settings. NQF indicated that "unique measures would ensure that high need subgroups are receiving high quality care to meet those needs." SNP Alliance disagrees. Without appropriate coverage and payment policies, plans may not be able to meet unique needs and that reality should be taken into account in the development of measures. For example, if NQF proposed that home and community-based measures be applied to SNPs that do not provide full coverage of Medicaid LTSS services, they may score poorly since

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			Medicare supplemental benefit policies are so restrictive.
3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	SNP Alliance	Valerie Wilbur	We believe that the need for population specific measures should be given greater emphasis in the Report. We do not believe that condition specific measures are needed in only a small number of cases. Further, the discussion of dual stratification did not seem to be consistent in the report; in some cases NQF appears to be supporting stratification, such as in the identification of 4 or more specific high-need subgroups, while in other cases, NQF seems to be recommending against, such as in the case of ESRD which happens to be one of the categories CMS identified as one of 15 "severe and persistent chronic conditions" that qualify for C-SNP designation. Also, since CMS initiated a C-SNP demonstration that specifically targets the ESRD population, we assume CMS identified methods to address potential measurement challenges so the agency could establish criteria for evaluate the effectiveness of the demonstration. We invite NQF to work with the SNP Alliance and its clinical and measurement experts to identify population specific measures for high-risk/high-need subsets we identified above. We think high-need measures should include: • Cross-cutting measures such as care management, care transitions, etc.; • Condition specific measures such as CD4 counts and viral loads for AIDS beneficiaries; and • Greater use of outcome measures such as avoidable inpatient admissions, readmission rates, long-term nursing home stays over 90 days, and adverse drug events/improved drug compliance. We believe that population specific measures should be identified for each high-need subgroup identified in addition to common measures that cross high-need groups. For example, CD4 counts and viral loads are unique measures for AIDS patients that are critical to their health and well-being. In fact, our AIDS plan has indicated that even if they scored 100% on all of their HEDIS measures but did not closely monitor these AIDS specific measures, their patients could die or quickly decline. Good measures for the mental illness include ER visits and behavioral health (BH) hospitalization rates measured continuously for 24 months to determine if the ER and BH hospitalization rates drop over time as a result of behavioral health interventions. Since alcohol abuse is a major issue for persons with SPMI, detoxification rates/1000 and detoxification bed days/1000 also would be good measures to monitor in six months increments to determine if rates decline over time. New members skew plan statistics at a given point in time since new members typically have high ER and inpatient rates until plan interventions begin to reduce high use. Medication adherence is another critical issue for persons with severe and persistent mental illness since anti-psychotic, depression and anxiety meds are crucial to controlling their conditions and helping them to adhere to other aspects of their treatment. Periodically (e.g., every 2 - 3 years) beneficiaries can come to believe that their medications are making them mentally ill and if they stop taking them they will feel better. Others simply don't want to spend their limited funds on medications. Some plans strive for an 85% possession rate. These are just a few examples of population-specific measures that could be used.

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3. Comments on specialized measures for high-need subgroups of dual eligible beneficiaries	United Spinal Association	Carol Tyson	United Spinal supports the quality issues associated with high-need subgroups on pages 20 and 21. We are especially supportive of the following measures: maintaining community living and community integration; meaningful activities and involvement in community life; timely initiation and delivery of services and support in the plan of care; cultural sensitivity and cultural competence; person-centered planning in screening and assessment. United Spinal supports each of the structural measures identified, specifically: access to specialty care, durable medical equipment, rehabilitation and habilitation; access to community resources such as non-medical supports; understanding and accessing available services (ADA compliance, physical accessibility); adaptive technology and provider access for habilitation.
4. Comments on measure gaps or future work	Abbott Laboratories	Danna Caller	Abbott supports the potential measure additions to the "Evolving Core Measure Set" in future work. As malnutrition can lead to increased rates of hospital morbidity, including increased incidence of hospital-acquired pressure ulcers and infections, delayed wound healing (Stechmiller 2010), as well as increased risk for falls (Tinetti et al, 1996; Vivanti et al, 2009; Neyens et al, 2013), we support measures listed in Table 3 that focus on decreasing pressure ulcers, falls, and patient dehydration (understanding that even well-hydrated patients can still be malnourished). Recommendation: As nutrition plays a fundamental role in improving the high-leverage opportunity areas of patient safety, screening & assessment, and care coordination, evaluate Malnutrition Screening & Assessment as an independent measure gap. We agree these are the best available measures to include in the Evolving Core Measure Set and to consider in future work. However, existing quality measures are limited as they only address individual metrics that may predict risk or identify a subset of malnourished or at-risk patients. There continues to be a measure gap with nutritional screening, assessment, and intervention for malnourished and at-risk patients in the acute care setting. As nutrition plays a fundamental role in improving the high-leverage opportunity areas of patient safety, screening and assessment, and care coordination for Dual Eligible beneficiaries, we recommend MAP evaluate Malnutrition Screening and Assessment as an independent measure gap. Today, malnutrition is identified as one of the important contributing factors of the emerging "post-hospital syndrome," which was recently characterized as an acquired, transient condition of generalized risk (Krumholz, 2013). Importantly, the poor health outcomes and increased costs associated with malnutrition are generally avoidable. Screening, assessment and intervention for malnutrition are cost-effective and have been shown to both improve health outcomes and reduce costs. Hospital accreditation

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			standards require a nutrition screening when warranted by the patient's needs or conditions within 24 hours after in-patient admission; however, it is left to the individual hospital to define the at-risk populations for screening and the time frame for a nutrition consult. In a recent study conducted by Johns Hopkins only 20% of malnourished patients had a nutrition consultation and the time to consultation was 4.90 to 7.34 days from admission. Studies have demonstrated that implementation of a comprehensive nutrition pathway from in-patient to post-discharge improved identification of high-risk patients, decreased time to nutrition consult and decreased length of stay and 30-day readmission rates (Brugler et al 1999, Somanchi et al 2011, Lacson et al 2012).
4. Comments on measure gaps or future work	American Geriatrics Society	Susan Sherman	We are in favor of the way the measure gap concepts emphasize a person-centered approach rather than disease specific measures. One small suggestion would be to revise the focus on pain to symptom management, as pain is not the only symptom commonly experienced by the complex older adult population. Fall and fall injury measures: We are concerned that care settings will resort to chemical and physical restraints in an attempt to decrease falls. At a minimum, this measure needs to be paired with all types of restraints (bed alarms, net beds, as well as physical/chemical restraints) to ensure that the focus on falls does not lead to increased restriction of elders activities. Organizations will be accountable for the failure of those methods if falls measures are retained. We recommend equally transparent and rigorous measures of efforts to maximize clients' physical and cognitive functioning. We also recommend broader and more transparent measures of restraints for patients involved in their own activities of daily living. Lastly, we are concerned about the tight control of both diabetes and high blood pressure in the frailest patients, given emerging evidence around the risk of hypoglycemia in these populations.
4. Comments on measure gaps or future work	America's Health Insurance Plans	Carmella Bocchino	The term "Core Measure Set" implies standard and essential metrics to be used to assess the quality of care provided and we are supportive of this set of metrics as a first step toward more effectively measuring the care of the vulnerable dual eligible population. We encourage an increased focus on areas such as care transitions, medication reconciliation and safety (with special attention to psychotropic uses and doses of vascular/antihypertensives), and advanced directives. Specifically, care coordination of medical care and community long-term care and the coordination of Medicare and Medicaid services are needed. In addition, we recommend measurement efforts that track completion of advanced directive documents, as well as communicating patients' wishes to the appropriate medical personnel. We encourage development of measures that capture self-determination, integrated care, and patient-centered outcomes measures such as functional status. Efforts to address measure gaps in these areas should build upon existing state programs such as Kansas Medicaid program. Lastly, we recommend that MAP develop a process for a timely response to identified shortcomings of measurement efforts as the

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			dual eligible population has unique challenges that impact the cost of care and the effectiveness of efforts.
4. Comments on measure gaps or future work	AmeriHealth Mercy Family of Companies	Thomas James	AMFC appreciates the the opportunity to comment on the Report. We agree with and support the comments of AHIP. In addition we believe that the future success of filling measure gaps will come as the result of prioritization of areas where the greatest gaps between goals and practice occur, especially those where there are significant disparities in achievement of those goals. The process may be more tightly defined and use the work group to discuss those priorities. Ultimately, however, there needs to be a new process for the measurement of quality that can measure the overall quality of care at the personal, behavioral, physical, spiritual, environmental, and social levels. This future direction may evolve from the social sciences rather than from the true scientific process the MAP currently expects.
4. Comments on measure gaps or future work	DREDF	Mary Lou Breslin	MAP notes that structural measures can include quality issues such as understanding and assessing available services (e.g., ADA compliance, physical accessibility) and these can affect multiple subgroups. In recognition of this measure gap, MAP has specifically added as a new and refined topic, "Presence of medical equipment accessible to people with disabilities (e.g., exam tables, scales)." We are pleased that MAP has incorporated these issues into a quality measures paradigm. However, we urge MAP to consider seeking ways to measure the well-known additional communication and policy barriers with which the disability community has long been familiar. Such barriers include lack of access to Sign Language interpreters for individuals who are deaf or hard-of-hearing; lack of print materials and instructions in accessible formats such as audio, digital, large print or Braille for people who are blind or who have vision impairments; or inflexible policies that fail to allow additional examination time for individuals with speech, cognitive, or other impairments who require more time to communicate effectively with their healthcare provider. We propose development of measures that directly assess health care provider processes used to deliver healthcare for patients with specific impairments—often referred to as Programmatic Access.[i] In addition to filling a critical gap, such measures would also meet MAP's stated criteria of building on its "…established position that a measurement strategy should be targeted and focused on areas with substantial room for improvement." The California Department of Health Care Services (DHCS) now requires the use of a primary care provider access survey that could serve as a starting point. The survey includes queries on accessible tables and scales and is being used by over 20 Medicaid managed care health plans in the state. http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-013.pdfData collected using an earlier, similar survey shows that among 2389 provider offices in California, an accessible weight scale was present in only 3.6% and a height adjustable examination table in only 8.4% of the sites.[ii]

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			[i]Mudrick, N.R., Yee, S., "Defining Programmatic Access to Healthcare for People with Disabilities." Disability Rights Education and Defense Fund (DREDF), Berkeley, California. Spring 2007. (Available at http://www.dredf.org/healthcare/Healthcarepgmaccess.pdf) (January 29, 2013). [ii]Mudrick, N.R., Breslin, M.L., Liang, M., Yee, S., "Physical Accessibility in Primary Health Care Settings: Results from California On-site Reviews." Disability and Health Journal 5 (2012) 159 – 167.
4. Comments on measure gaps or future work	GlaxoSmithKline	Deborah Fritz	GSK supports the measures that MAP identified as development gaps, particularly the gaps in care coordination, focused on comprehensive medication management and patient activation, as well as appropriate screening and assessment. GSK supports the development and implementation of CMM performance measures that focus on improving patient outcomes, including mortality. GSK encourages future developmental work to be focused on clinical status of the patient, clinical goals of therapy for each medication, number of drug therapy problems, and guideline clinical goals of therapy achieved. GSK supports the guidelines of practice and documentation for CMM as suggested by the Patient-Centered Primary Care Collaborative (PCPCC). As described by PCPCC, essential elements for successful CMM include patient-centered consistent and systematic processes through which care plans are developed. Care plans should include individualized therapy goals and personalized interventions and should be developed in conjunction with the patient and the patient's health care providers. The care plan recommends interventions to help alleviate any medication related problems that are interfering with the intended goals of therapy. Follow-up evaluations should occur to determine the outcomes resulting from the recommended interventions and improvements in clinical and patient goals of therapy. GSK supports healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care." GSK encourages the utilization of the CAHPS survey to assess patient activation as defined as patients having specific qualities, such as knowledge, confidence, and skills, to manage their own health, function effectively on a care team, and participate in decision-making regarding their health care. Patient activation is similar to patient engagement and also refers to the dynamic role of the patient in their own

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			care. GSK strongly supports MAP's focus on measure transition from core measures to a family of measures.GSK believes that a family of measures play an important role in quantifying optimal care for a patient population that is both holistic and outcomes-based. However, GSK recommends caution when developing families of measures that they don't become composite measures were reporting is done in an "all or nothing" fashion.
4. Comments on measure gaps or future work	Healthfirst	Joyce Chan	We appreciate the request for review and comment on MAP's work so far. We look forward to future opportunities to provide feedback.
4. Comments on measure gaps or future work	PhRMA	Jennifer Van Meter	PhRMA supports the gaps in measurement that MAP identified. We commend MAP for recognizing medication related gaps, particularly comprehensive medication management, appropriate prescribing of medication, and medication adherence and persistence for all behavioral health conditions. We also support development regarding a measure about patient activation, since a patient's willingness to engage in his care affects his health outcomes. Ultimately, improved health outcomes are the desired goal.
4. Comments on measure gaps or future work	SNP Alliance	Valerie Wilbur	Gap Areas Below are a list of measurement gaps for high-need duals that are not addressed in the draft report: • Validation of self-report survey methods for people with compromised self- reporting capabilities, including validity of proxy methods. • CAHPS weighting of member satisfaction scores for low-income, poorly educated beneficiaries. • Case mix adjusted measures that account for health risk, socioeconomic, geographic and demographic factors and other factors affecting quality independent of plan interventions and outside plan control. • Core set of benchmarks that are case mix adjusted and particularly relevant to high-risk, high-need populations such as care management, care transitions, and MOC requirements as well as a core set of outcome measures related to utilization. • Measures to evaluate the degree of integration between Medicare and Medicaid benefits, services, administration, financing and oversight. • The need for greater alignment between SNP and MMP models of care and performance measures. • Identification of strategies to achieve data parsimony by reducing duplicative reporting such as separate Medicare and Medicaid reporting of HEDIS and CAHPS surveys and information found in HOS such as functional status; multiple separate quality improvement projects (CCIP, QIP, CQI, PIP), etc.
4. Comments on measure gaps or future work	SNP Alliance	Valerie Wilbur	The SNP Alliance strongly supports MAP's desire to address social determinants of health as a critical issue in quality and performance measurement and recommend that MAP consider Shawn Bishop's paper "Are MA Star Ratings Biased Against Plans Serving Disadvantaged Populations" as well as the 5 specific

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			recommendations included in the paper. This paper notes that notes that "a sizeable body of evidence from social epidemiological literature shows that non-health characteristics of individuals contribute significantly to health and health outcomes" including income, education and occupation and that "income, education, occupation, race/ethnicity, and income inequality have a large and significant effect on a person's health, self-rated health and utilization of health care services, all of which the MA quality ratings system attempts to measure." It also notes that since the MA plan rating system does not control for these factors that are known to affect outcomes, "the rating system assumes that physicians and hospitals as well as activities by health plans are responsible for the full differences observed in these measures between MA plans." The paper also notes that significant disparities in health are likely to persist in populations with the lowest socioeconomic status, regardless of the interventions employed by plans and providers and that the plan rating system should develop a methodology to account for these differences to avoid biasing quality results. To address these issues, the paper recommends case mix adjusting HEDIS and HOS data; constructing standards/cut-points based on performance in the same geography, not nationally; making quality improvement a greater part of the Star rating system; selecting measures for SNPs that are more relevant to the populations they serve; and conducting rulemaking on the MA Star rating system.
4. Comments on measure gaps or future work	SNP Alliance	Valerie Wilbur	Care transitions was identified as one of the highlighted measure gaps. We agree that care transitions are one of the most important areas of focus for high-need populations and one of the most important areas for study, given the inadequacy of many existing care transition measure which are focus on structure, process and paper compliance instead of outcomes, and create a tremendous administrative burden without proven improvements in outcomes. The Report on Multiple Chronic Conditions notes that "strict adherence to disease-specific measures for patients with MCCs may lead to the unintended consequences of delivering inappropriate care that is not aligned with the patients goals and preferences" (and needs). A number of the recommendations made by MAP in the chapter on MCCs undoubtedly would also be appropriate for this Report on measures for high-need duals. Similarly, research by Cynthia Boyd, MD, et al from Johns Hopkins indicates "adhering to current clinical practice guidelines in caring for an older person with several comorbidities may have undesirable effects. Basing standards for quality of care and pay for performance on existing CPGs could lead to inappropriate judgment of the care provided to older individuals with complex comorbidities and could create perverse incentives that emphasize the wrong aspects of care for this population and diminish the quality of their care. Developing measures of the quality of the care needed by older patients with complex comorbidities is critical to improving their care." These issues are critically important for high-need duals as well. Proposed Interim Measures for High Need Beneficiaries: The SNP Alliance Performance Evaluation Leadership Group identified a core group of measures that it recommends for evaluation of SNP and

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			Medicare Medicaid Plan (MMP) performance evaluation until a gap analysis can be conducted and new measurement requirements identified. These measures could be used for comparing various SNP types and targeted subgroups with findings for comparable subpopulations in Medicare FFS and/or standard MA plans. We suggest that MAP consider our recommendations in Attachment 1.
4. Comments on measure gaps or future work	United Spinal Association	Carol Tyson	The Consortium for Citizens with Disabilities (CCD) has identified six gaps in existing quality standards for persons with disabilities. United Spinal supports CCD's identified measure gaps, including those on pages 26 and 27. The presence of accessible medical equipment, assessments of unmet needs such as housing, quality of home and community-based services, cultural competence of health systems, including disability culture, the quality of healthcare teams and providers, as well as self-determination are critical for consumers with SCI/D. We appreciate your attention to person-centered directed service, timely access to care, integrated primary and specialty care as well as unmet needs such as housing that reflects a consumer's choice. We urge the National Quality Forum to implement funding streams for all of these measure gaps to ensure better care, more affordable care and quality care delivery to people with disabilities enrolled in both Medicare and Medicaid, also known as dual-eligibles. United Spinal urges MAP to consider including in your list of measure gaps consumer satisfaction levels with services and supports as well as measures of quality employment. United Spinal is dedicated to ensuring independence, integration and a high quality of life for people with disabilities. Employment that is appropriate for a consumer and allows for the utilization of their full range of skills is key to ensuring community integration and independence. As the MAP report notes, "86 percent [of dual eligible beneficiaries] had annual incomes less than 150 percent of the federal poverty line in 2008 ($15,600 for individuals or $21,000 for couples)" (p. 18). Without access to employment, many low-income dual eligible consumers and consumers with multiple chronic conditions have difficulty paying for housing, transportation, food and the daily bills that enable them to maintain their chosen level of independence and community integration that many Americans take for granted. We appreciate the opportunity to comment on the interim report. Should you have any questions, please contact United Spinal Association's Vice President, Government Relations, Alexandra Bennewith, at 202-556-2076, ext, 7102 or at abennewith@unitedspinal.org.