Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS

Executive Summary

The dual eligible beneficiary population is defined by the happenstance of two overlapping public insurance programs, rather than a disease, a care setting, or other factor. More than nine million Americans are enrolled in both the Medicare and Medicaid programs. Low-income seniors make up two-thirds of this dual eligible population and people under age 65 with disabilities account for the remaining third. Although this population has heterogeneous medical needs, it includes many of the sickest and most vulnerable individuals covered by either program. The dually eligible—and their providers—also struggle to navigate the differing health insurance benefit structures, rules, and provider networks of the two large public programs.

As a result, care for the dual eligible population is often of poor quality, fragmented, inefficient, and costly. Spending on dual eligible beneficiaries is disproportionately high. Duals account for approximately 35% of federal Medicare spending and 40% of total Medicaid spending.[i]

Measuring and improving the care received by this population has thus become a high priority. Accordingly, the Department of Health and Human Services (HHS) charged the Measure Applications Partnership (MAP), a multistakeholder partnership of 60 private-sector organizations convened by the National Quality Forum (NQF), with developing a quality measurement strategy for care provided to dual eligible beneficiaries. This is one in a series of reports issued by MAP.

This MAP report, building on an October 2011 interim report, takes a comprehensive, person-centered approach to this unique population. It presents both the opportunities and challenges inherent in measuring care received by Medicare-Medicaid enrollees. MAP notes that measurement alone cannot fix the underlying fragmentation in the healthcare system that adversely affects this population, but it can serve as a critical signaling system to emphasize aspects of care that are both highly valued and in need of improvement.

MAP seeks with this report to jump-start a long-term commitment to ensure that all of the major stakeholders are using best-in-class performance measures to monitor and improve care for the dual eligible population. Indeed, this population provides an important case study in promoting aligned performance measurement and quality improvement given that it spans most care settings in the health system as well as two separately managed public insurance programs. Federal healthcare measurement programs have traditionally focused on a single setting or type of health care, such as hospital or nursing home care, rather than a population group.

The report presents five high-leverage opportunity areas in which measurement is expected to have the most benefit. These five measurement domains are: quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures. MAP also lays out a core set of 25 measures (see Appendix F), including a Starter Set of eight. The 25 core measures were winnowed down from hundreds that were evaluated, and represent those MAP feels are most promising for use in the short term. The recommended Starter Set measures address:

- Depression screening and follow-up care;
- Initiation and engagement in alcohol or drug dependence treatment;

- Diabetes management and treatment;
- Capacity for a physician practice to serve as a medical home;
- Screening for fall risk;
- Care transitions
- The Consumer Assessment of Healthcare Providers and Systems® (CAHPS) family of surveys to evaluate patient experience and satisfaction with care; and
- Readmission to a hospital within 30 days of an initial visit.

Overall, the report emphasizes the importance of measuring dual eligible beneficiaries' quality of life and the healthcare system's ability to deliver coordinated services that are consistent with a person- and family-centered plan of care. Critical quality-of-life barometers include pain management, symptom control, and progress toward treatment and recovery goals. MAP recommends that this domain of measurement be expanded over time to encompass non-traditional, psychosocial factors such as level of engagement in community activities, personal choice, and cultural competence.

MAP also provides specific suggestions to the measure development community on how to improve and broaden several existing measures. If suggested modifications can be made, the measures would better apply to dual eligible beneficiaries' experience of care and the limited Starter Set of measures could be expanded. For example, MAP supports—at a conceptual level—a measure that assesses improvement in an individual's ability to perform daily activities. MAP acknowledges that not all patients should be expected to improve and consequently recommends that the measure should allow for maintenance of function if that is the patient's goal and therapeutically achievable.

The report also identifies important measurement gaps that impede a full understanding of the care delivered to the dual eligible population. MAP prioritizes 11 for concerted effort by developers. Among those recommended for the most urgent attention are measures that assess care planning, medication management, the appropriateness of hospitalizations, and screening for cognitive impairment. MAP also found that current measures of affordability and cost are difficult to apply to the dual eligible population because of constraints in available data.

MAP hopes this report informs the many constituents that are critical to the successful implementation of an aligned measurement strategy for dual eligible beneficiaries. These include the newly established Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare and Medicaid Services (CMS), state health and Medicaid officials, health plans, providers, and research organizations. MAP's findings can also contribute to quality measurement and improvement initiatives for other populations with shared characteristics such as low income, complex chronic conditions, disability, and advanced age.

MAP Background

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

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

MAP is designed to facilitate alignment of public- and private-sector uses of performance measures to further the National Quality Strategy's (NQS) three-part aim of creating better, more affordable care, and healthier people.[iii] Anticipated outcomes from MAP's work include:

- A more cohesive system of care delivery;
- Better and more information for consumer decision-making;
- Heightened accountability for clinicians and providers;
- Higher value for spending by aligning payment with performance;
- Reduced data collection and reporting burden through harmonizing measurement activities across public and private sectors; and
- Improvement in the consistent provision of evidence-based care.

Further information about MAP's coordination with other quality efforts, function, timeline, and deliverables is provided in Appendix A.

Introduction

MAP has been charged with providing multi-stakeholder input on performance measures to assess and improve the quality of care delivered to individuals who are enrolled in both Medicare and Medicaid. The dual eligible population is notable for its heterogeneity, the particularly intense service needs and health risks of some sub-groups, and the fragmented nature of healthcare and supportive services they receive.

About nine million people are dually eligible for and enrolled in both the Medicare and Medicaid programs.[iv] Low-income seniors make up roughly two-thirds of the dual eligible population, and people under age 65 with disabilities account for the remaining third.[v] The population includes many of the poorest and sickest individuals covered by either Medicare or Medicaid. The two programs were created separately and for different purposes, leaving beneficiaries, providers, health plans, and other stakeholders struggling to navigate differing rules, provider networks, and a bifurcated benefits structure. These misalignments can complicate care coordination, lead to cost-shifting, and severely undermine the quality of care.

MAP considered quality measurement for dual eligible beneficiaries specifically, but some findings could be generalized to similar Medicare- or Medicaid-only populations with characteristics such as low income, complex chronic conditions, disability, and advanced age.

MAP regarded the Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare and Medicaid Services (CMS) as the primary audience for its work. Established under ACA, the MMCO has many goals related to improving dual eligible beneficiaries' experience of care, including assessing and improving the quality of performance of Medicare and Medicaid providers. This office will be a primary user of measures that MAP supports for use with the dual eligible beneficiary population. In addition, the MMCO is currently working with States to design and implement demonstration programs to better integrate and coordinate care for dual eligible beneficiaries. This report also considers the measurement needs of states and local stakeholders in evaluating their success in improving beneficiaries' experience of care and controlling costs.

Terminology

For purposes of this report, a *dual eligible beneficiary* is an individual who qualifies for, and is enrolled in, health insurance through both Medicare and Medicaid. The term is policy-centric in order to refer to a specific group of people who qualify for a particular array of public benefits. While these benefits fundamentally influence how a dual eligible beneficiary interacts with the health system, most individuals with this status would not readily identify themselves as duals. Furthermore, providers of care and supports may not be aware of individuals' status as dually eligible or the associated implications for service delivery. Lacking a more precise alternative, MAP refers to "dual eligible beneficiaries," "individuals who are dually eligible," and "duals" throughout this report.

Methods

The MAP Dual Eligible Beneficiaries Workgroup advised the MAP Coordinating Committee on developing the strategic approach to performance measurement and measures recommended for use with the dual eligible population. The MAP Dual Eligible Beneficiaries Workgroup is a 27-member, multistakeholder group (see Appendix B for the workgroup roster, Appendix C for the Coordinating Committee roster). The workgroup held four in-person meetings and one web meeting to fully develop the contents of this final report. The agendas and materials for the Dual Eligible Beneficiaries Workgroup meetings can be found on the NQF website.

MAP's task to identify performance measures appropriate for use with the dual eligible beneficiary population was divided into two phases. An October 2011 interim report described the first phase. It focused on understanding the unique qualities of the population, identifying deficits in quality that affect the group, defining a strategic approach to measurement, and characterizing appropriate measures.[vi] The second phase of the work is described in this final report. Building on the strategic approach to measurement, MAP prioritized current measures, proposed potential modifications to existing measures, and considered critical gaps in available measures.

Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries

Vision for High-Quality Care

MAP established a vision for high-quality care for dual eligible beneficiaries to provide the foundation for the strategic approach to performance measurement:

> *In order to promote a system that is both sustainable and person- and family-centered, individuals eligible for both Medicare and Medicaid should have timely access to appropriate, coordinated healthcare services and community resources that enable them to attain or maintain personal health goals*.

As a part of the vision and the strategic approach to performance measurement, MAP espouses a definition of health that broadly accounts for health outcomes, determinants of health, and personal wellness. The far-reaching nature of the vision and its multifactorial view of health are both fundamental to MAP's overall approach to quality measurement for the dual eligible population. The vision aspires to high-value care that is centered on the needs and preferences of an individual and that relies on a range of supports to maximize function and quality of life. This is especially important given the complex range of mental, physical, and socioeconomic challenges facing the dual eligible population.

Guiding Principles

In considering how to achieve the desired vision, MAP established guiding principles for the approach to measurement. While measurement alone cannot fix underlying fragmentation in the health system, it can signal the aspects of care that are most highly valued. The guiding principles inform and direct the design of measurement programs. Once a program has been established, the guiding principles and MAP's Measure Selection Criteria (Appendix D) can be applied to evaluate the appropriateness of potential measures to meet the program's goals. Because the guiding principles were previously presented in MAP's interim report, they are briefly summarized in the Table 1 and fully discussed in Appendix E.

Table 1: Guiding Principles for Measurement in the Dual Eligible Beneficiary Population

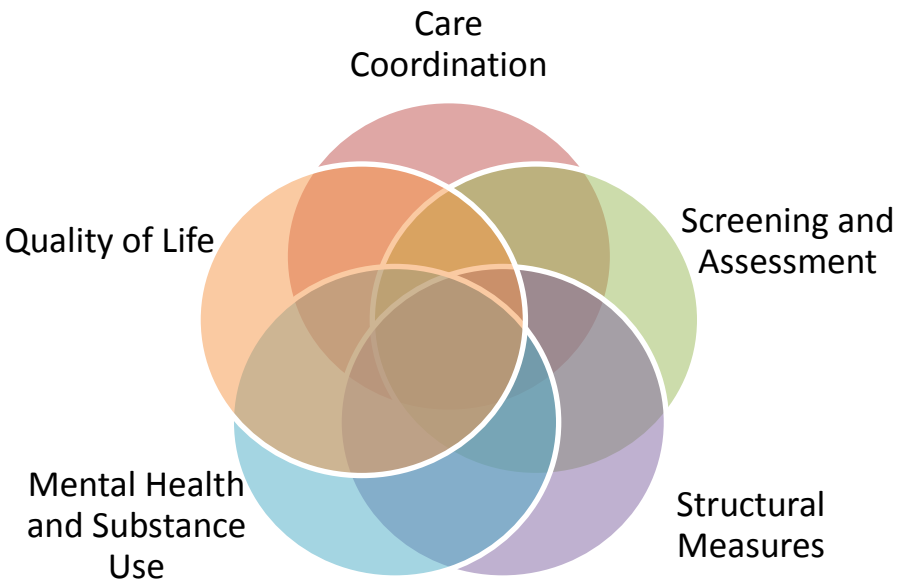
Desired Effects of Measurement	Promoting Integrated Care
	Ensuring Cultural Competence
	Health Equity
Measurement Design	Assessing Outcomes Relative to Goals
	Parsimony
	Cross-Cutting Measures
	Inclusivity
	Avoiding Undesirable Consequences of Measurement
Data Platform Principles	Data Sharing
	Using Data for Multiple Purposes
	Making the Best Use of Available Data

High-Leverage Opportunities for Improvement Through Measurement

Countless opportunities exist to improve the quality of care delivered to dual eligible beneficiaries. In recognition that a measurement strategy should be parsimonious and focused on areas with substantial

room for improvement, MAP reached consensus on five domains where measurement can drive significant positive change. The high-leverage opportunity areas are quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures. As depicted in Figure 1, the topics are heavily inter-related.

Figure 1. High-Leverage Opportunities for Improvement Through Measurement



MAP concluded that, wherever possible, selection of measures to fit these areas should drive broad improvements in healthcare delivery and community supports by promoting shared accountability, addressing affordability along with quality, encouraging health IT uptake, and pushing toward longitudinal measurement.

Quality of Life

The measurement strategy should promote a broad view of health and wellness, encouraging the development of a person-centered plan of care that establishes goals and preferences for each individual. Ideally, that care plan and its goals would form the basis for measurement. For example, in situations in which an individual who is near the end of life has stated health-related goals oriented toward palliative care instead of interventions to extend life, the measurement strategy should accommodate that choice. In the short term, measurement can focus on discrete opportunities to elicit health-related goals, for example, ensuring assessments include information about wishes for end-of-life care.

Measures in this care domain should focus on outcomes, such as functional status. Other facets of quality of life might include an individual's ability to determine his or her home environment, participate in the community, develop meaningful relationships, and meet employment and education goals. MAP also considered measures related to comfort, pain management, and symptom control under this domain. While some quality-of-life measures may be more difficult to determine for dual eligible

beneficiaries who cannot self-report objectively, assessing progress toward treatment or recovery goals remains appropriate.

Care Coordination

Care coordination is a vital feature of high-quality care for dual eligible beneficiaries. NQF has previously endorsed preferred practices and performance measures related to care coordination.[vii] MAP discussed that measures in this domain should promote coordination across multiple dimensions, such as across care settings, between the healthcare system and community supports, across provider types, and across Medicare and Medicaid program benefit structures.

To ensure adequate care coordination, measures should address desired components of such coordination. MAP emphasized the importance of a shared plan of care developed jointly between providers and patients, proactive medication management and monitoring, access to an inter-professional team that crosses settings of care, advance care planning, and palliative care. A thorough approach to care coordination would account for patient engagement and relevant factors (e.g., symptom control) in the span between encounters with the health system.

Measurement in this area could be oriented to identifying missed opportunities or breakdowns in care. Some warning signs of poor care coordination are incidents in which patients are transferred across settings without complete medical records, a long-term care case manager has not been notified that a beneficiary has been hospitalized, or a clinician has prescribed a medication contraindicated by the plan of care.

Screening and Assessment

Approaches to screening and assessment should be thorough and tailored to address the complex care needs of the dual eligible beneficiary population. MAP regarded the routinely recommended clinical preventive screenings as generally necessary but not sufficient for this group. Measures of these services are included in HHS' initial core set of health care quality measures for Medicaid-eligible adults, which MAP did not revisit. The measurement approach should encourage providers to screen for factors that particularly affect vulnerable populations, such as poor nutrition, drug and alcohol use, housing insecurity, falls, underlying mental and cognitive conditions, and HIV/AIDS.

Assessment goes hand in hand with screening but does not have to occur in a single clinical encounter. The ongoing assessment process should use person-centered principles and go beyond the basics to account for the home environment, economic insecurity, availability of family and community supports, capacity of formal and informal caregivers, caregiver stress, access to healthful food, transportation, and consideration of whether the individual is receiving care in the most appropriate, least restrictive setting. After screening and assessment is complete, the results should be incorporated into an individual's person-centered plan of care.

Mental Health and Substance Use

Mental health conditions such as depression are highly prevalent in the dual eligible population. Other serious psychiatric conditions such as schizophrenia are less common but heavily concentrated in the dual eligible population less than 65 years old.

Mental health conditions commonly co-occur with substance use disorders and chronic medical conditions such as diabetes and cardiovascular disease. As such, behavioral health cannot be considered

and measured in isolation. MAP echoed a recommendation from the Institute of Medicine (IOM) that mental health and substance abuse treatment should be more closely coordinated with primary care.[viii] MAP also discussed that measures in this domain should be able to evaluate care across the continuum, including screening, treatment, outcomes, and patient experience. Approaches to both treatment and performance measurement should be grounded in the recovery model, as appropriate.

Structural Measures

Structural measures are necessary to provide a sense of the capacity, systems, and processes that exist to provide care and supports for dual eligible beneficiaries. In particular, MAP views structural measures as a critical part of a parsimonious measure set and a high-leverage opportunity because they can assess disconnects between Medicare, Medicaid, and the other supports that are necessary for the well-being of high-need beneficiaries. It will be necessary to identify the extent of current problems and attempt to fix underlying structures and processes before providers and other stakeholders will be comfortable being held accountable for outcome measures in the other high-leverage opportunity areas.

Structural measures can reflect the presence of elements that relate to other high-leverage opportunities such as quality of life and care coordination. For example, structural elements related to quality of life include the availability of Medicaid-funded home- and community-based services (HCBS) within a state and an individual's ability to self-direct those services. Additional structural measures related to care coordination might assess the presence of contracts between state Medicaid agencies and Medicare Advantage Special Needs Plans (SNP) to coordinate care, health IT uptake among Medicaid providers in a region, or capacity for information sharing within and across health provider and community support services organizations.

Appropriate Measures for Use with the Dual Eligible Beneficiary Population

In the interim report *Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries,* MAP presented a set of illustrative measures to highlight the high-leverage measurement opportunities. Building on that work, MAP undertook a series of activities to generate a list of available measures appropriate for use with the dual eligible beneficiary population. MAP examined hundreds of currently available measures, gradually winnowing and revising the set until a core of 25 measures emerged (Appendix F). A draft version of the core set was used as an input to MAP's pre-rulemaking process.

It is important to note that unlike other programs for which MAP has provided input on measures, there is not a federal measurement program devoted to monitoring the quality of care for dual eligible beneficiaries. Thus, MAP anticipates that its guidance regarding appropriate measures for use with this population may be applied to multiple programs. Stakeholders are still in the process of defining the purpose, goals, data platform, and levels of analysis for new initiatives.

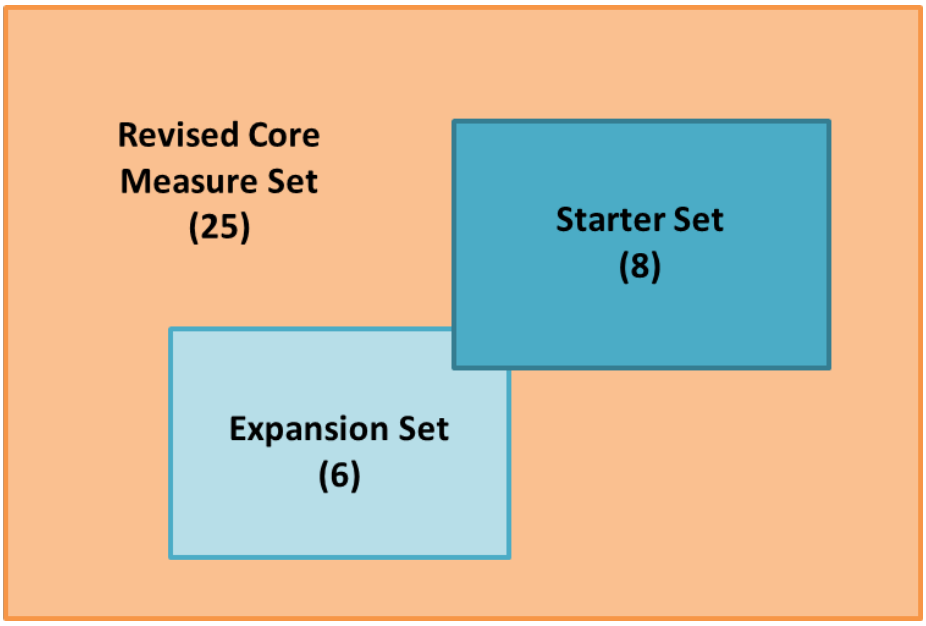
Because it was not compiled with a single application in mind, the set covers each of the five high-leverage opportunity areas, a range of measure types, and many settings of care. Some measures could be applied to all or most dual eligible beneficiaries. Others are primarily important for a significant subgroup of the population, such as individuals receiving hospice care or individuals with serious mental illness. In the future, greater fit-for-purpose might be achieved by generating a measure set with specific program goals and capabilities in mind. Until these details emerge, MAP emphasizes the importance of the quality issues addressed by each of the core measures, presented in Table 2.

Table 2. Quality Issues Addressed by Revised Core Measure Set

High-Leverage Opportunity Area	Measure Topics
Quality of Life	Functional Status Assessment Health-Related Quality of Life Palliative Care
Care Coordination	Care Transition Experience Communication With Patient/Caregiver Communication Between Healthcare Providers Hospital Readmission Medication Management
Screening and Assessment	BMI Screening Falls Management of Diabetes Pain Management
Mental Health and Substance Use	Alcohol Screening and Intervention Depression Screening Substance Use Treatment Tobacco Use Screening and Cessation Treatment
Structural Measures	Health IT Infrastructure Medical Home Adequacy Medicare/Medicaid Coordination
Other	Patient Experience

Within the revised core set, MAP identified subsets of measures with potential for either short-term (Starter Set) or phased (Expansion Set) implementation. The Starter Set suggests a starting place for measurement. The Expansion Set is intended to supplement the Starter Set once suggested modifications have been explored. Figure 2 illustrates the relationship between the three sets of measures. The following sections describe the process and results of MAP's further deliberations.

Figure 2. Appropriate Measures for Use With the Dual Eligible Beneficiary Population: 3 Related Sets



Starter Set of Measures

MAP concluded that a small number of measures within the set should be called out as the most promising for use in the short term. MAP considered measures that would work well as they are currently specified, without modification. This process balanced MAP's desire to be thorough and inclusive with its desire to provide HHS with a specific, actionable, and parsimonious list of measures. Table 3 presents MAP's recommendations for a Starter Set of Measures.

Table 3. Starter Set of Measures

Measure Name, NQF Measure Number & Status	Data Source	High-Leverage Opportunities	Setting of Care	Level of Analysis	Use in Current Programs
Screening for Clinical Depression and Follow-Up Plan #0418 Endorsed	Administrative Claims and Other Electronic Clinical Data	Screening and Assessment, Mental Health/Substance Use	Ambulatory Care, Hospital, PAC/LTC Facility	Clinician	Finalized for use in PQRS, Medicare Shared Savings Program, Medicaid Adult Core Set. Proposed for Meaningful Use Stage 2

Measure Name, NQF Measure Number & Status	Data Source	High-Leverage Opportunities	Setting of Care	Level of Analysis	Use in Current Programs
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Multiple Numbers Endorsed	Patient Survey	N/A	Various, including: • Health Plan • Clinician & Group • Experience of Care and Health Outcomes (ECHO) for Behavioral Health • Home Health Care • Hospital • In-Center Hemodialysis • Nursing Home • Supplemental Item Sets, topics including: o People With Mobility Impairments o Cultural Competence o Health IT o Health Literacy o Patient-Centered Medical Home	Clinician, Facility, Health Plan, Integrated Delivery System, Population	Multiple programs, depending on version
Medical Home System Survey #0494 Endorsed	Provider Survey, EHR, Other Electronic Clinical Data, Paper Records, and Patient Reported Data	Care Coordination, Structural	Ambulatory Care	Clinician	NCQA Accreditation
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement #0004 Endorsed	Administrative Claims, EHR, and Paper Records	Care Coordination, Mental Health/Substance Use	Ambulatory Care	Clinician, Health Plan, Integrated Delivery System, Population	Finalized for use in PQRS, Meaningful Use, Value Modifier, Medicaid Adult Core Set, and Health Homes Core
Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) #1789 In Process **OR**	Administrative Claims	Care Coordination	Hospital/Acute Care Facility	Facility	Under consideration for Inpatient Quality Reporting (MAP Supported)
Plan All-Cause Readmission #1768 In Process	Administrative Claims	Care Coordination	Hospital/Acute Care Facility, Behavioral Health/Psychiatric: Inpatient	Health Plan	Finalized for use in Medicaid Adult Core Set

Measure Name, NQF Measure Number & Status	Data Source	High-Leverage Opportunities	Setting of Care	Level of Analysis	Use in Current Programs
Falls: Screening for Fall Risk #0101 Endorsed	Administrative Claims, Other Electronic Clinical Data, and Paper Records	Screening & Assessment	Ambulatory Care, Home Health, Hospice, PAC/LTC Facilities	Clinician	Finalized for use in PQRS, Medicare Shared Savings Program, and Value Modifier. Proposed for Meaningful Use Stage 2.
3-Item Care Transition Measure (CTM-3) #0228 Endorsed	Patient Reported	Care Coordination	Hospital	Facility	Under Consideration for Hospital Inpatient Reporting (MAP Supported)
Optimal Diabetes Care #0729 Endorsed	Paper Records, Other Electronic Clinical Data, and Electronic Health Record	Screening & Assessment	Ambulatory Care	Integrated Delivery System, Clinician	Components for this composite are finalized for use in Medicare Shared Savings and Value Modifier. Under consideration for PQRS (MAP Supported)

In recommending the measures, MAP considered their suitability for addressing the heterogeneous dual eligible population. Priority measures also needed to capture complex care experiences that extend across varied settings of care and types of healthcare providers. Considered broadly, the prioritized list demonstrates concepts are of critical importance to the dual eligible population: care that is responsive to patients' experiences and preferences, the need for follow-up, treatment for behavioral health conditions, and ongoing management of health conditions and risks.

The first measure in the Starter Set is Screening for Clinical Depression and Follow-up Plan (Measure 0418). This measure addresses two high-leverage opportunity areas in the dual eligible population (screening and assessment, mental health and substance use). It can be applied to many care settings in which dual eligible beneficiaries receive services. Further, use of this measure would promote alignment with other measurement programs in which it is used, including the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and the Medicare Shared Savings Program.

MAP also recommends that CAHPS® surveys be used in every setting of care for which they are available. These patient experience surveys capture actionable feedback from patients and their families and are deemed vital to promoting a person- and family-centered measurement enterprise. Measure developers and the Agency for Healthcare Research and Quality (AHRQ) are actively enhancing CAHPS tools, including efforts to draft and test a CAHPS survey for Medicaid HCBS. Once complete, a participant experience survey of HCBS would be an important complement to more typical measures of the clinical aspects of long-term supports and services.

Other recommended measures touch on the important topics of care coordination and patient engagement. MAP has supported the concept of a health home for dual eligible beneficiaries from the outset of its deliberations. Reflecting that desire, the structural measure Medical Home System Survey (Measure 0494) was ranked highly as it is one of the only available measures to promote health homes and reflect core concepts such as the presence of a registry. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Measure 0004) was also recognized for addressing critical steps in identifying and treating substance use conditions. This measure not only encourages the initial referral to treatment, but also evaluates the individual's continued engagement in treatment over time. Finally, measures of hospital readmission rates were thought to be important proxies for the level of care coordination, communication, and community supports available to dual eligible beneficiaries. Two similar measures of readmissions are currently in the NQF endorsement process, with the recommendation that the measure developers work to harmonize these metrics (Measure 1768 and Measure 1789). MAP defers judgment about which of the measures is preferred until the endorsement process has concluded, but emphasizes the primary importance of this topic in evaluating the "connectedness" of care for dual eligible beneficiaries.

Most chronic conditions have significantly higher prevalence rates in the dual eligible beneficiary population than in the general Medicare population.[ix] Some conditions like diabetes, cardiovascular disease, and depression are especially common. Each affects more than 20 percent of dual eligible beneficiaries. Other conditions like multiple sclerosis, cerebral palsy, and end stage renal disease are less common but disproportionately affect dual eligible beneficiaries. Moreover, a majority of dual eligible beneficiaries live with multiple chronic conditions (MCCs).[x] Clinical practice guidelines that inform the development of performance measures typically focus on the management of a single disease, and strict adherence to disease-specific guidelines can potentially result in harm to patients with MCCs.[xi, xii, xiii] This heterogeneity complicates efforts to select a small number of measures that would accurately reflect duals' care experience. MAP relied on its guiding principle that a parsimonious measure set should rely primarily on cross-cutting measures and use condition-specific measures only to the extent that they address critical issues for high-need subpopulations. The Starter Set does not attempt to include all valid measures of effective clinical care for these and other chronic diseases.

While it provides a necessary starting place, evaluating the Starter Set against the NQS priorities and the MAP's own high-leverage opportunity areas reveals important shortcomings. For example, no available measures were thought to adequately address the NQS goal of affordable care for dual eligible beneficiaries. Limited availability of cost data that encompasses both Medicare and Medicaid expenditures is a major factor. Similarly, information on beneficiaries' out-of-pocket expenses is not routinely collected. While a few elements within CAHPS surveys touch on quality of life, the Starter Set may not adequately address this concept as a high-leverage opportunity area. These gaps in available measures will be more fully discussed in a later section of this report.

Expansion Set of Measures Needing Modification

MAP also sought to provide specific guidance regarding opportunities to improve existing measures. Participants voiced many suggestions for broadening and improving measures' specifications for use with dual eligible beneficiaries. Following the initial ranking exercise that yielded the Starter Set, members performed a second ranking to indicate the measures that would be preferred *if the suggested modifications could be made*. This group of measures would build on the Starter Set discussed above, expanding the range of quality issues addressed. Table 4 presents the top tier of results from this prioritization as an Expansion Set of Measures.

Table 4. Expansion Set of Measures Needing Modification

Measure Name, NQF Measure Number & Status	Measure Description	Suggested Modifications and Other Considerations
Assessment of Health-Related Quality of Life (Physical & Mental Functioning) #0260 Endorsed	Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year. • Data Source: Patient Reported • Care Setting: Dialysis Facility • Current Programs: MAP supported for ESRD Quality Improvement Program	• Emphasized for its consideration of quality of life, a rarity among available measures • Current survey is dialysis-specific; suggested expansion beyond ESRD setting to include other types of care • Construction of this concept as a process measure is not ideal
Medical Home System Survey #0494 Endorsed	Percentage of practices functioning as a patient-centered medical home by providing ongoing coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a) Improved access and communication, b) Care management using evidence-based guidelines, c) Patient tracking and registry functions, d) Support for patient self-management, e) Test and referral tracking, and f) Practice performance and improvement functions • Data Source: Provider Survey, EHR, Other Electronic Clinical Data, Paper Records, and Patient Reported Data • Care Setting: Ambulatory Care • Current Programs: None	• Care management might be appropriately conducted by other parties besides primary care physician (e.g., family member, clinical specialist, PACE site) • A health home's approach to care management must be designed for duals and consider both Medicaid and Medicare benefits • Consider broader application in shared accountability models such as ACOs and health homes • May be more important to measure whether duals have access to a usual source of primary care rather than primary care providers' ability to meet these standards
HBIPS-6: Post-Discharge Continuing Care Plan Created #0557 Endorsed	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-7: Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge • Data Sources: Administrative Claims, Paper Records, Other Electronic Clinical Data • Care Setting: Hospital, Behavioral Health/Psychiatric: Inpatient • Current Programs: Under Consideration for Inpatient Psychiatric Facility Quality Reporting (MAP Supported)	• This type of transition planning/communication is universally important • Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox

Measure Name, NQF Measure Number & Status	Measure Description	Suggested Modifications and Other Considerations
HBIPS-7: Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge #0558 Endorsed	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-6: Post-Discharge Continuing Care Plan Created • Data Sources: Administrative Claims, Other Electronic Clinical Data, and Paper Records • Care Setting: Hospital, Behavioral Health/Psychiatric: Inpatient • Current Programs: Under Consideration for Inpatient Psychiatric Facility Quality Reporting (MAP Supported)	• This type of transition planning/communication is universally important • Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox • Information should be transmitted to both nursing facility and primary care provider, if applicable
Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment #0209 Endorsed	Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours. • Data Sources: Patient Reported • Care Setting: Hospice • Current Programs: Finalized for Use in Hospice Quality Reporting	• Give consideration to operationalizing this measure as pain assessment across settings; at a minimum could be applied more broadly to other types of palliative care
Change in Daily Activity Function as Measured by the AM-PAC #0430 Endorsed	The Activity Measure for Post-Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post-acute care (PAC) patients. A Daily Activity domain has been identified which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing. • Data Sources: Other Electronic Clinical Data • Care Setting: Hospital, PAC/LTC Facilities, Home Health, Ambulatory Care • Current Programs: None	• Emphasized for its consideration of functional status, a rarity among available measures • Broaden beyond post-acute care • Include maintenance of functional status if this is all that can be realistically expected • Address floor effects observed when tool is applied to very frail/complex patients • Incorporate community services in supporting post-acute recovery • May present relatively larger data collection burden

The concepts and best practices represented within the Expansion Set measures are merely a starting point in the long path toward developing a comprehensive set of appropriate measures. MAP's discussion of the expansion set revealed a range of shortcomings in existing measures from the perspective of measuring quality in a defined population. Many of the proposed modifications related to broadening the denominator populations of measures to increase their applicability to other patient groups. MAP also proposed expansion of measures to account for multiple settings of care and community supports, as well as emphasizing functional outcomes.

Each subset of MAP's recommended measures contains one or more measures related to care transitions, a vital quality issue in the dual eligible beneficiary population. The Expansion Set contains

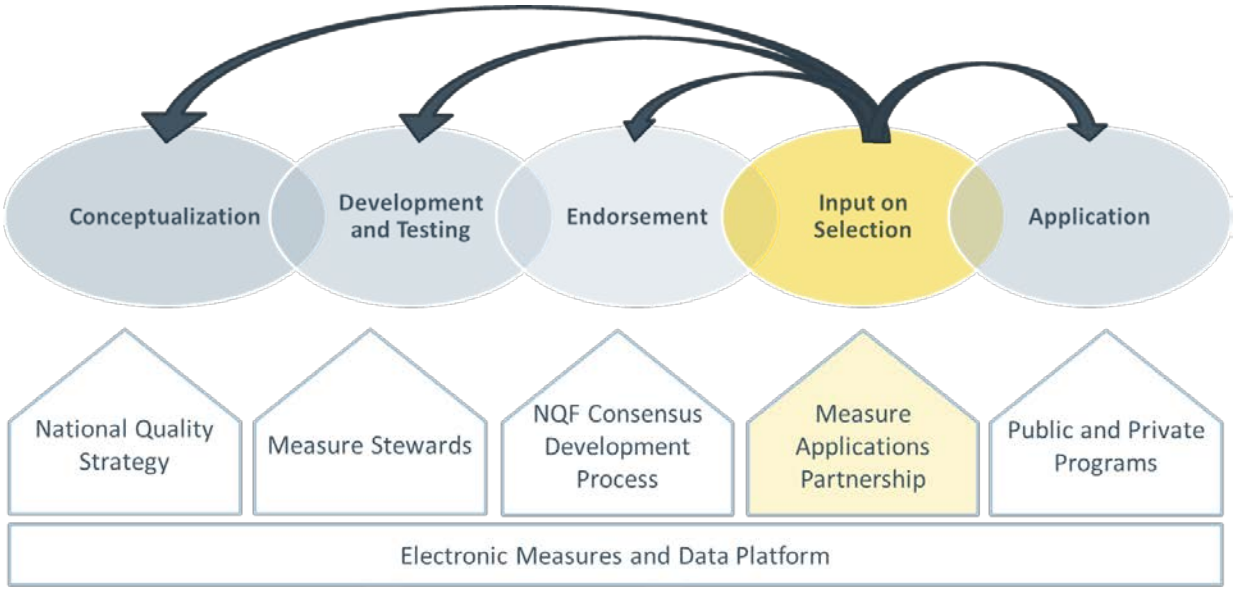
two process measures specified for use in behavioral health (Measure 0557, Measure 0558) that are conceptually similar to two measures specified for a general hospital admission (Measure 0647, Measure 0648) that appear in the larger core set. Some of these measures may be candidates for harmonization or expansion. Short of that, MAP urges that quality measures be applied to all transitions in care for which they are available, including discharges to home, to/from a nursing facility, or to/from any other setting.

Because the majority of available performance measures were developed for specific programs or purposes, there is difficulty in retrospectively applying them to care for dual eligible beneficiaries. MAP anticipates that making the suggested revisions will be challenged by shortcomings in clinical evidence and data availability. Measure developers are asked to consider MAP's suggested modifications and evaluate the feasibility of the proposed changes.

Addressing Gaps in Measurement

MAP's activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality through performance measurement. Measure development and standardization of measures are essential upstream inputs to these efforts. Figure 3 broadly depicts the pathway from the conceptualization and development of measures through their selection for specific applications by MAP.

Figure 3. Illustration of Measure Development and Application



The NQS provides national priorities and goals for quality improvement, influencing the conceptualization of measures that would evaluate progress in each area. Once measurement priorities are clear, measure developers and stewards must secure funding for development, explore the evidence base, develop numerator and denominator statements, identify data, specify the measures, and test measures to ensure reliability and validity of the measures as specified. Stewards then submit their measures to the National Quality Forum for endorsement as consensus standards. Endorsement provides an avenue for measure harmonization while enhancing measures' credibility and likelihood of adoption. Finally, recommendations from MAP influence the application of individual measures in

specific public- and private-sector programs. Gaps and suggested modifications revealed by MAP processes can also follow multiple avenues to inform preceding steps in the pathway.

MAP's effort to compile a set of performance measures appropriate for assessing and improving the quality of care for dual eligible beneficiaries was constrained by gaps in available measures. This report documents many modifications suggested to improve existing measures, but countless other concepts one might wish to evaluate cannot currently be measured.

Measure gaps identified by MAP consist of two general types:

- **Development Gaps.** Desired measures do not currently exist or are extremely limited in scope. For example, MAP would like to evaluate the quality and comprehensiveness of an individual's person-centered plan of care, but no measures are available to do so.
- **Implementation Gaps.** Appropriate measures exist but are not included in a given performance measurement program. For example, standardized measures of patient experience are available but not currently applied in many public reporting and performance-based payment programs.

Measure gaps can be found at any stage of measure development and implementation. Most gaps in measurement for dual eligible beneficiaries are development gaps. Because the dual eligible beneficiary population is defined by the happenstance of two overlapping public insurance programs, they have lacked traditional interest groups to advocate for their unique needs related to healthcare quality. This sharply contrasts with well-organized medical boards, specialty societies, providers, quality alliances, and consumer groups that have promoted and funded measurement in specific areas, such as cardiovascular care, pharmacy, and renal dialysis, to name a few. While measures have proliferated in other areas, the needs of dual eligible beneficiaries have gone unaddressed.

In considering the landscape of currently available measures applicable to dual eligible beneficiaries, MAP identified and categorized a large number of measure development gaps (Table 5).

Table 5. Categorized Measure Gaps Applicable to Dual Eligible Beneficiaries

STRUCTURAL MEASURES	Ability to capture encounter data with Health IT
	Access to services (e.g., transportation, appointment availability)
	Capacity to serve as a medical home or health home
	Cultural competence
	Frequency of change in eligibility
	Harmonization of program benefits
	Level of beneficiary assistance navigating Medicare/Medicaid
	Presence of coordinated or blended payment streams
	Rating system for level of integration between health and community services
	Workforce capacity
CARE COORDINATION	Appropriateness of hospitalization (e.g., avoidable admission/readmission)
	Effective communication (e.g., provider-to-patient, provider-to-provider)
	Fidelity to care plan
	Follow-up visit
	Goal-directed, person-centered, care planning and implementation
	System structures to connect health system and long-term supports and services
	Timely communication of discharge info to all parties
QUALITY OF LIFE	Caregiver support
	Choice of support provider
	Community inclusion/participation
	Life enjoyment
	Optimal functioning (e.g., improving when possible, maintaining, managing decline)
	Pain and symptom management
	Sense of control/autonomy/self-determination
MENTAL HEALTH AND SUBSTANCE USE	Initiation of pharmacotherapy after diagnosis of substance dependence
	Medication adherence and persistence for all behavioral health conditions
	Outcome measures for smoking cessation
	Regular assessment of weight/BMI for all patients on anti-psychotic medication
	Suicide risk assessment for any type of depression diagnosis
SCREENING AND ASSESSMENT	Assessment for rehabilitative therapies
	Appropriate follow-up intervals
	Appropriate prescribing and medication management
	Cardiovascular disease management
	More “optimal care” composite measures (e.g., NQF #0076)
	Safety risk assessment
	Screening for cognitive impairment and/or poor psychosocial health
	Screening for poor health literacy
	Screening population for diabetes and cardiovascular risks
	Sexual health screenings for disenfranchised groups
OTHER	Consideration of global costs
	Patient activation measure
	Utilization benchmarking (e.g., outpatient/ED)

The lengthy list of measure development gaps reveals that many concepts considered core to improving quality for dual eligible beneficiaries are not yet able to be measured. Very few desired measurement topics apply to specific diseases or conditions. Indeed, few desired concepts are fully within the purview of a single entity in the health system. Instead the measurement gaps reflect MAP's desire to emphasize cross-cutting aspects of high-quality care.

MAP acknowledged the resource-intensive nature of measure development and prioritized the measure gaps to provide the measure development community with more specific guidance and a sense of importance. The highest priority gaps are presented in Table 6.

Table 6: Prioritized Measure Gaps

Measure Development Gap Concepts
Goal-directed person-centered care planning/implementation
System structures to connect health system and long-term supports and services
Appropriate prescribing and medication management
Screening for cognitive impairment and poor psychosocial health
Appropriateness of hospitalization (e.g., avoidable admission/readmission)
Optimal functioning (e.g., improving when possible, maintaining, managing decline)
Sense of control/autonomy/self-determination
Level of beneficiary assistance navigating Medicare/Medicaid
Presence of coordinated or blended payment streams
Screening for poor health literacy
Utilization benchmarking (e.g., outpatient/ED)

Given that Assessing Outcomes Relative to Goals is one the guiding principles for this measurement framework, it is not surprising that MAP members prioritized measurement around goal-directed care planning and implementation of that plan of care. Similarly, MAP expressed a strong desire for structure and process measures to assess connections between the health system and the long-term supports and services system, including Medicaid HCBS. These topics are emblematic of the comprehensive, coordinated care that would benefit high-need beneficiaries. However, these types of measure gaps present particularly significant challenges to developers. In many ways, they aspire to measure aspects of integrated healthcare that are still the exception rather than the rule in clinical practice. Similarly, the evidence base may be limited, workflows may be non-standard, and the data sources may be inconsistent.

Other topics more amenable to measure development are also among the top results. For example, the concepts of appropriate prescribing behavior and medication management to reduce poly-pharmacy risks could be operationalized as process measures. MAP also recommended routine screening of dual eligible beneficiaries for cognitive impairment and psychosocial risk factors. While it may be challenging to define a denominator population for these measure topics, the experience of developing and using screening and referral measures in other areas will be instructive.

Measures of Quality in Home and Community-Based Services

MAP separately considered measures of quality in Medicaid-funded home and community-based services as a major development gap area. Nationally, more than 300 Medicaid waiver programs provide services to more than 1.2 million participants, with expenditures exceeding $27 billion annually.[xiv] More than two out of every three HCBS recipients are dual eligible beneficiaries.

Because HCBS services are largely non-medical, they necessarily operate within a different quality paradigm than the health system. Many of the primary domains of high-quality, person-centered HCBS can be traced back to the disability rights movement and the historical need to assure adequate quality of life for individuals with disabilities leaving institutional care settings. Dominant constructs include access to services, community inclusion, choice and control, respect and dignity, cultural competence, and safety.

Compared to quality measurement in clinical settings, performance measures in HCBS are in the early stages of development and standardization. Many factors contribute to the limited availability of measures. Variation across states in eligibility standards, diagnoses of enrollees, the service package each beneficiary receives, the settings in which supports are delivered, and the providers who furnish services have made it impossible to apply measures across states or across HCBS subpopulations to date.

Government and private sector research efforts are gradually pushing the field forward. For example, AHRQ has funded an effort to develop indicators of potentially avoidable hospitalizations for the HCBS population.[xv] As risk adjustment models become more sophisticated, this promising work can be taken much further. A number of prominent measure scans have also demonstrated that valid measures exist across a wide range of domains, but further development and testing will be required to broaden their applicability.

MAP suggests that HHS explore the feasibility of funding an NQF measure endorsement effort for HCBS measures. Measure developers may need significant support in broadening and standardizing current metrics. To provide more specificity around this request, MAP examined a total of 148 candidate HCBS measures from three primary sources:

- Environmental Scan of Measures for Medicaid Title XIX Home and Community-Based Services (June 2010)[xvi]
- Raising Expectations: A State Scorecard on LTSS for Older Adults, People with Disabilities, and Family Caregivers (September 2011)[xvii]
- National Balancing Indicator Contractor (October 2010)[xviii]

Following a stepwise approach that considered the five high-leverage opportunity areas, the inclusiveness of the candidate measures, and their potential applicability to dual eligible beneficiaries, MAP narrowed the universe to 24 selected measures particularly worthy of further attention (Appendix G). Though they rely on surveys and attestations as data sources, many of the measures reflect concepts that ring true for evaluating quality in the dual eligible population (Figure 4).

Figure 4. HCBS Measures Show Promise for Application to the Dual Eligible Population

Measures of Functional Status

Appropriate functional status measures comprise a second major gap area. As outcome indicators, they are fundamental to demonstrating high-quality care. MAP is interested in measuring an individual's level of ability in multiple physical, mental, and social domains. A small number of functional status measures are currently available, but they failed to gain MAP's support for use with dual eligible beneficiaries. For example, six measures are specified for use in the home health program, assessing improvement in bathing, bed transferring, management of oral medications, status of surgical wounds, dyspnea, and ambulation/locomotion. In the context of assuring home health care quality, the existing measures are adequate. However, the assumption that an individual would *improve* might be inappropriate if these home health functional status measures were broadly applied to the heterogeneous and medically complex dual eligible population. Individuals who are older and/or who have advanced diseases are likely to have care goals that emphasize maintenance of function or slowing of decline. Moreover, the home health measures of functional status rely on an assessment tool that is not intended for use in any other context.

MAP would be interested in composite measures that combine separate indicators into a single output that conveys an overall sense of functional status. Though not currently specified or endorsed as a performance measure, MedPAC has published data that approximates this concept. Using the Health Outcomes Survey (HOS) and the Medicare Advantage population, MedPAC calculated the percentage of

enrollees "Improving or maintaining physical health" and "Improving or maintaining mental health."[xix] If the data source and denominator population can be altered, this construct may be useful in broadly assessing functional status. Such global measures may be especially useful for policymakers and consumers interested in understanding patterns in duals' overall quality of care rather than any specific dimension.

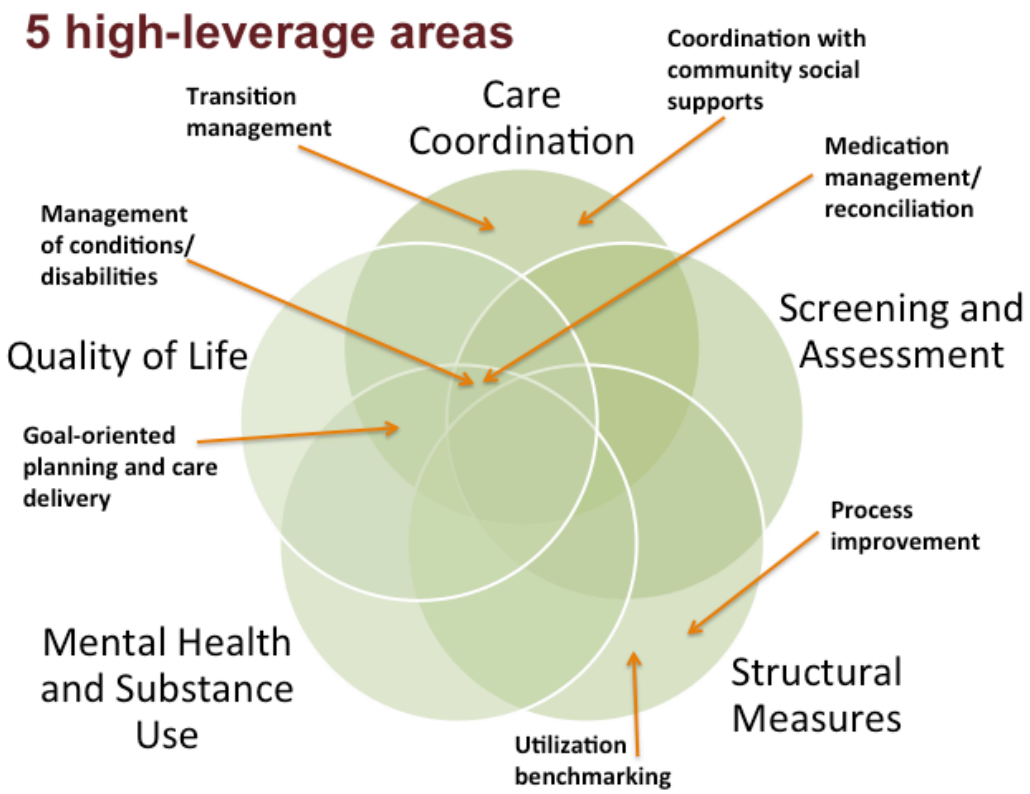
Measure Gaps Revealed by Environmental Scan

NQF contracted with Avalere Health, LLC and L&M Policy Research, LLC to conduct an environmental scan to glean further insights regarding the future direction of measurement in the dual eligible beneficiary population. This scan included a series of expert stakeholder discussions and a targeted literature review. Findings corroborated many of the themes of MAP's deliberations. Using seven areas of focus listed below, the environmental scan highlighted example measures, measure gaps, implementation barriers, and recommendations.

- **Consumer-based assessment of goal-oriented planning and care delivery**: patient/caregiver/family perception of extent to which care plan and care delivered reflect goals and desires of the individual
- **Management and monitoring of specific conditions and disabilities**: provider and patient active awareness of and engagement with signs and symptoms related to conditions to achieve care plan goals
- **Medication management/reconciliation across settings**: management of medications by both provider and patient/caregiver to optimize appropriate use of medication and minimize negative drug interactions
- **Transition management**: interactions that occur within and across care settings (between patients, families, and providers) to ensure individuals receive comprehensive and streamlined care without duplication
- **Integration and coordination of community social supports and health delivery**: ability to identify need for and ultimately integrate community social supports into care plan based on individual/caregiver needs
- **Utilization benchmarking**: ability to gauge the extent of service use among duals and their subpopulations across settings
- **Capacity for process improvement across settings**: ensure quality improvement programs are in place within and across settings and organizations that serve dual eligible beneficiaries

The seven areas of focus relate to MAP's five high-leverage opportunities as depicted in Figure 5.

Figure 5. Important Measure Gaps in MAP's Five High-Leverage Areas



Environmental scan findings are further summarized in Appendix H.

Resolving Prioritized Measure Gaps

Many measurement gaps exist because of the difficulties inherent in measurement. The field is still evolving strategies to address data reliability, risk-adjustment, small sample sizes, insufficient or evolving evidence base, reducing reporting burden, and other challenges. Resolving the gaps will require a mix of short-term and long-term strategies. NQF and MAP offer multiple avenues through which to guide the quality measurement enterprise in being more responsive to the needs of vulnerable populations. These avenues include new calls for measures through the NQF Consensus Development Process (CDP), annual measure updates, and measure maintenance reviews. Appendix I provides further information about those processes.

Levels of Analysis and Potential Applications of Measures

MAP's work in identifying appropriate measures for use with the dual eligible beneficiary population has been challenged by the fact that there are many potential ways to apply measures. Each potential use of measures has its own purpose, resource constraints, type of authority or influence, and data capabilities. While the MMCO will play a dominant role in directing large-scale quality improvement activities for the foreseeable future, no single entity is fully accountable for the delivery of care to dual eligible beneficiaries. Given the diffuse accountability, MAP has grappled with the questions of where and how measurement currently occurs and might occur in the future to align incentives and create shared accountability. A number of likely scenarios have emerged.

Federal Government

At the federal level, the MMCO has expressed multiple needs for measurement. MAP proposes the measures presented in this report as candidates for these initiatives. First, the Office will continue to pursue its Congressional mandate to improve the experience of care for dual eligible beneficiaries. They are likely to use year-over-year comparisons to monitor progress and direct continuing activities to the most fruitful areas.

Efforts have been underway at CMS to link a comprehensive database of Medicare and Medicaid claims data from which to draw measurement information. The MMCO has also proposed the addition of 13 new condition flags in the CMS Chronic Condition Warehouse (CCW). These new flags will allow for a better understanding of conditions affecting the dual eligible population, including many prominent mental illnesses, substance use, and HIV/AIDS. The MMCO may also consider stratifying information about dual eligible beneficiaries within measures reported to HHS for other programs. Current programs collect and publish quality data from nursing homes, dialysis facilities, home health agencies, and many other types of care.

The MMCO and selected states have also established demonstration grants to integrate care and improve quality for the population. As an accompaniment to a broader evaluation strategy that will assess cost-effectiveness, measures will be needed to evaluate the success of the new models and to ensure that beneficiaries are not negatively affected by the new programs. In parallel to a national evaluation, individual states are likely to use individualized sets of measures for quality assurance. Each state is expected to select measures that reflect the unique design of its demonstration and its data capabilities. This is an important opportunity for state initiatives to act as test beds for evaluating new and emerging quality measures.

National Research Entities

To date, most of the strongest research and analysis on dual eligible beneficiaries has been performed by independent national organizations. For example, MedPAC has begun to routinely publish data on duals as part of its role in advising Congress on Medicare payment policy. These rich analyses have drawn on claims data, the CCW, the HOS, site visits, and other sources. Similarly, private foundations such as The Henry J. Kaiser Family Foundation, The SCAN Foundation, and The Commonwealth Fund have also taken up the charge to monitor duals' access, quality of care, and expenditures to inform policymakers. The foundation of gray literature and background information generated by these organizations was indispensable to MAP's early deliberations and understanding of quality issues affecting the population. MAP is hopeful that the recommendations in this report will inform their future work.

State Governments

The cost-sharing and long-term care benefits provided by Medicaid are crucial to dual eligible beneficiaries. However, state governments have been particularly challenged in identifying quality measurement strategies. Resources are strictly limited and healthcare insurance and delivery systems are in the process of being thoroughly redesigned. States often have their own data collection tools, surveys, forms, and procedures. Many may even use homegrown quality measures. States also lacked the ability to access Medicare Part A, B, and D data until very recently and are beginning the process of exploring and integrating this information to facilitate care coordination for dual eligible beneficiaries.

Though each state's approach will need to be customized based on the local environment, MAP offers the information in this report as a potential framework and a starting place for measure selection. In addition, this report begins to provide a foundation for aligning improvement efforts and the ability to

benchmark outcomes. States are encouraged to focus on measures related to long-term supports and services, beginning with those that are already publicly reported before branching into other areas.

Health Plans and Providers

Private-sector entities such as health plans and provider networks work in partnership with Medicare and Medicaid to serve dual eligible beneficiaries. Emerging accountable care organizations offer promising models for serving dual eligible beneficiaries in a coordinated, integrated way. Managed care plans, particularly SNPs that target this population, are also important partners in assuring high-quality care. Current measurement activities in SNPs are focused on applying Healthcare Effectiveness Data and Information Set (HEDIS) and Structure and Process Measures established by the National Committee for Quality Assurance (NCQA). One of those measures, SNP 6: Coordination of Medicare and Medicaid Coverage, is included in the core measure set with the suggestion that the concept be examined for potential use in broader applications.

Measure Alignment Across Federal Programs

Contributions of the Dual Eligible Beneficiary Perspective to MAP's Pre-Rulemaking Deliberations

HHS identified the dual eligible beneficiary population as a priority consideration for MAP's first round pre-rulemaking deliberations. While this is just one of many populations that could greatly benefit from a purposeful person- and family-centered approach to care and quality measurement, the perspective of dual eligible beneficiaries provided an enlightening case study in promoting aligned performance measurement.

Federal measurement programs have traditionally focused on a single setting or type of healthcare, such as inpatient hospital care or skilled nursing facility care, rather than a population of consumers. In recognition that numerous, isolated programs have limited ability to reflect healthcare quality across the continuum, newer initiatives such as the Medicare Shared Savings Program have expanded the scope of measurement across settings and time while promoting shared accountability for a defined population. This is the beginning of a vital shift toward integrated healthcare delivery and performance-based payment policy.

Dual eligible beneficiaries are served in every part of the health and long-term care systems, but there is not currently a dedicated federal measurement program to monitor the overall quality of their care. Many measures are applied to care provided to the dual eligible population, but they are deployed through a variety of isolated programs run by government entities and private health plans. While CMS' MMCO and state demonstration grantees explore measurement options, MAP has helped to drive alignment across existing programs by considering the population's needs across settings of care. Specifically, MAP has examined measures under consideration for addition to 18 existing programs and favored the use of those relevant to dual eligible beneficiaries. This guidance was summarized in MAP's pre-rulemaking input to HHS.[xx] In its continuing role of providing pre-rulemaking input, MAP will pursue alignment across federal programs while ensuring that the unique needs of Medicare-Medicaid dual eligible beneficiaries receive attention and measurement.

Complementing Efforts on Medicaid Adult Measures

Until recently, federal performance measurement programs have primarily related to the Medicare program. In an important step forward, ACA required HHS to establish an initial core set of health care quality measures for Medicaid-eligible adults. Seeking to complement, but not duplicate, efforts in

Medicaid measurement, MAP followed the progress of this initiative from the outset. After publication of the Medicaid adult core measure set in January 2012, MAP further considered the relationship between the two efforts.[xxi]

While any effort to measure Medicaid beneficiaries would involve the dual eligible population by definition, it is important to note that duals account for fewer than one in three Medicaid enrollees. Logically, the core measure set reflects the different healthcare needs of these low-income adults in addition to more complex dual eligible beneficiaries. For example, the set includes four measures of reproductive health services that are very important to Medicaid-only enrollees but of limited utility in the dual eligible population. In terms of overlap between the two sets of measures, six measures do appear in both the Medicaid adult core list and MAP's list of appropriate measures for dual eligible beneficiaries (NQF Measures 0418, 0576, 0006/0007, 0648, 0004, and 1768). Where possible, MAP recommends stratification of these measures to enable comparison between dual eligible beneficiaries and Medicaid-only beneficiaries.

A second consideration for the Medicaid measurement effort is that it is largely focused on ambulatory and hospital services, including prevention and health promotion, management of acute conditions, and management of chronic conditions. However, dual eligible beneficiaries generally receive coverage for those services through Medicare. Medicaid only serves as the primary payor for long-term services and supports. This benefit design complicates the availability of data to evaluate dual eligible beneficiaries' care experience through the Medicaid quality measurement program. There are no long-term care measures in the Medicaid adult core set.

Future Opportunities

Much work remains before MAP's vision for high-quality care for dual eligible beneficiaries will be fully realized. Understanding the limitations of the current environment, this report seeks to jump-start a long-term effort to ensure that all major points in the health care system accessed by dual eligible beneficiaries are using performance measures that motivate providers to address the unique needs of this population.

Going forward, MAP will seek to provide more clarity around program alignment and the current and potential uses of measures in the field, updating its guidance as necessary to inform the many stakeholders working to improve quality. MAP will continue to search for answers to implementation questions, increasing transparency around why, where, and how public- and private-sector stakeholders use measures to improve quality. With concerted effort, one day it will be possible to form a complete picture of the quality of care that dual eligible beneficiaries receive, drawing on measures from different sources and combining them in a meaningful whole.

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Appendix A: MAP Background

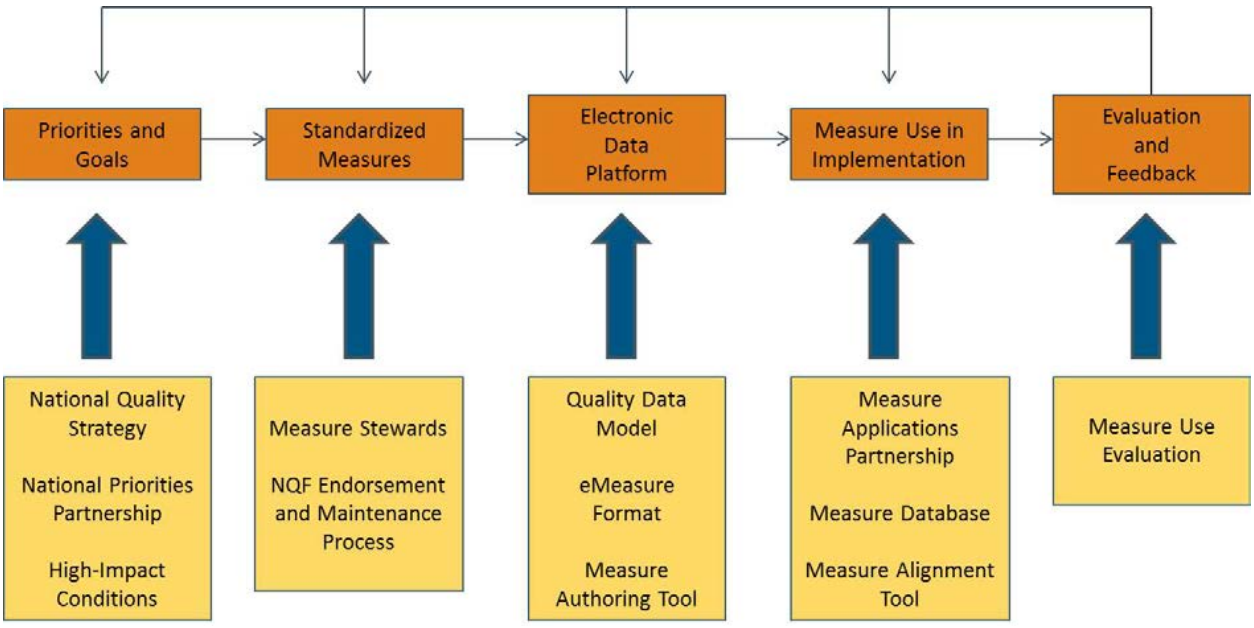
Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency, aligning payment with value, rewarding providers and professionals for using health information technology (health IT) to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare.

Foundational to the success of all of these efforts is a robust "quality measurement enterprise" (Figure A-1) that includes:

- Setting priorities and goals for improvement;
- Standardizing performance measures;
- Constructing a common data platform that supports measurement and improvement;
- Applying measures to public reporting, performance-based payment, health IT meaningful use programs, and other areas; and
- Promoting performance improvement in all healthcare settings.

Figure A-1. Functions of the Quality Measurement Enterprise



The National Priorities Partnership (NPP) is a multi-stakeholder group convened by NQF to provide input to HHS on the NQS, by identifying priorities, goals, and global measures of progress.[i] Another NQF-convened group, the Measure Prioritization Advisory Committee, has defined high-impact conditions for the Medicare and child health populations.[ii] Cross-cutting priorities and high-impact conditions provide

the foundation for all of the subsequent work within the quality measurement enterprise.

Measure development and standardization of measures are necessary to assess the baseline relative to the NQS priorities and goals, determine the current state and opportunities for improvement, and monitor progress. The NQF endorsement process meets certain statutory requirements for setting consensus standards and also provides the resources and expertise necessary to accomplish the task. A platform of data sources, with increasing emphasis on electronic collection and transmission, provides the data needed to calculate measures for use in accountability programs and to provide immediate feedback and clinical decision support to providers for performance improvement.

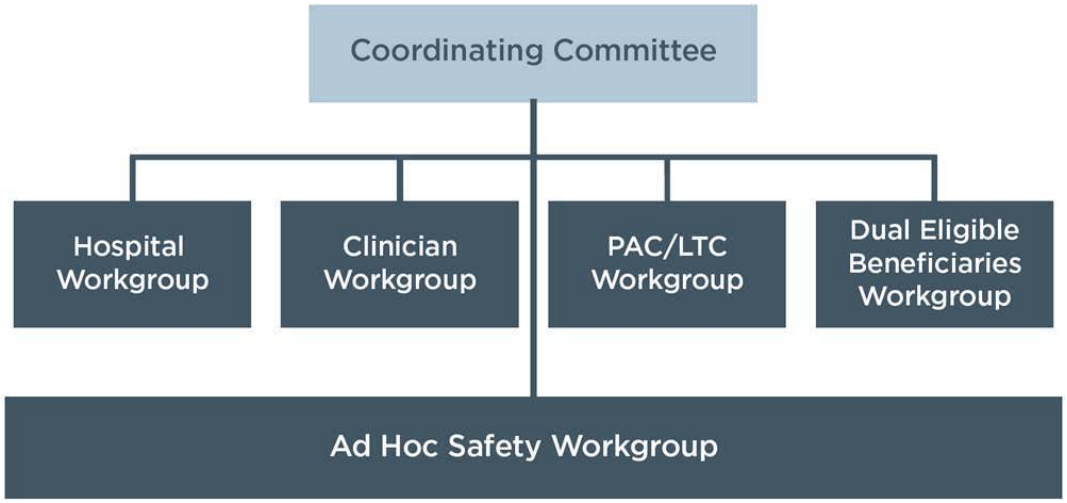
Alignment around environmental drivers, such as public reporting and performance-payment, is MAP's role in the quality measurement enterprise. By considering and recommending measures for use in specific applications, MAP will facilitate the alignment of public- and private-sector programs and harmonization of measurement efforts under the NQS.

Finally, evaluation and feedback loops for each of the functions of the quality measurement enterprise ensure that each of the various activities is driving desired improvements.[iii,iv] Further, the evaluation function monitors for potential unintended consequences that may result.

Function

Composed of a two-tiered structure, MAP's overall strategy is set by the Coordinating Committee, which provides final input to HHS. Working directly under the Coordinating Committee are five advisory workgroups responsible for advising the Committee on using measures to encourage performance improvement in specific care settings, providers, and patient populations (Figure A-2). More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies (*ex officio* members) are represented on the Coordinating Committee and workgroups.

Figure A-2. MAP Structure



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

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

MAP decision making is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the high-impact conditions determined by the NQF-convened Measure Prioritization Advisory Committee, the NQF-endorsed Patient-Focused Episodes of Care framework,[v] the HHS Partnership for Patients safety initiative,[vi] the HHS Prevention and Health Promotion Strategy,[vii] the HHS Disparities Strategy,[viii] and the HHS Multiple Chronic Conditions framework.[ix] Additionally, the MAP Coordinating Committee has developed measure selection criteria to help guide MAP decision making.

One of MAP's early activities was the development of measure selection criteria. The selection criteria are intended to build on, not duplicate, the NQF endorsement criteria. The measure selection criteria characterize the fitness of a measure set for use in a specific program by, among other things, how closely they align with the NQS's priority areas and address the High-Impact Conditions, and by the extent to which the measure set advances the purpose of the specific program without creating undesirable consequences.

Timeline and Deliverables

MAP's initial work included performance measurement coordination strategies and pre-rulemaking input on the selection of measures for public reporting and performance-based payment programs. Each of the coordination strategies addresses:

- Measures and measurement issues, including measure gaps;
- Data sources and health IT implications, including the need for a common data platform;
- Alignment across settings and across public- and private-sector programs;
- Special considerations for dual eligible beneficiaries; and
- Path forward for improving measure applications.

On October 1, 2011, MAP issued three coordination strategy reports. The report on coordinating readmissions and healthcare-acquired conditions focuses on alignment of measurement, data collection, and other efforts to address these safety issues across public and private payers.[x] The report on coordinating clinician performance measurement identifies the characteristics of an ideal measure set for assessing clinician performance, advances measure selection criteria as a tool, and provides input on a recommended measure set and priority gaps for clinician public reporting and performance-based payment programs.[xi] An interim report on performance measurement for dual eligible beneficiaries offered a strategic approach that includes a vision, guiding principles, characteristics of high-need subgroups, and high-leverage opportunities for improvement, all of which informed the content of this final report.[xii]

On February 1, 2012, MAP submitted the *Pre-Rulemaking Final Report* and the *Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement Report*. The *Pre-Rulemaking Final Report* provided input on more than 350 performance measures under consideration for use nearly 20 federal healthcare programs.[xiii] The report is part of MAP's annual analysis of measures under consideration for use in federal public reporting and performance-based payment programs, in addition to efforts for alignment of measures with those in the private sector. The *Coordination Strategy for*

Post-Acute Care and Long-Term Care Performance Measurement report made recommendations on aligning measurement, promoting common goals for PAC and LTC providers, filling priority measure gaps, and standardizing care planning tools. [xiv]

Additional coordination strategies for hospice care and cancer care will be released in June 2012, concurrent with this report.

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[i] NQF. *Input to the Secretary of Health and Human Services on Priorities for the National Quality Strategy.* Washington, DC: NQF; 2011. Available at www.quality-forum.org/Setting_Priorities/NPP/National_Priorities_Partnership.aspx. Last accessed March 2012.

[ii] NQF. *Measure Prioritization Advisory Committee Report. Measure Development and Endorsement Agenda.* Washington, DC: NQF; 2011. Available at www.qualityforum.org/Projects/i-m/Measure_Development_and_Endorsement_Agenda/Project_Fact_Sheet.aspx. Last accessed March 2012.

[iii] RAND Health. *An Evaluation of the Use of Performance Measure in Health Care.* Washington, DC: NQF; 2011. Available at www.qualityforum.org/Setting_Priorities/Measure_Use_Evaluation.aspx. Last accessed March 2012.

[iv] NQF, *Evaluation of the National Priorities Partnership Phase 1: Cross-Case Analysis Report*, Washington, DC: NQF; 2011. Available at http://www.qualityforum.org/Setting_Priorities/Evaluation_of_the_National_Priorities_Partnership.aspx. Last accessed March 2012.

[v] NQF. *Measurement Framework: Evaluating Efficiency Across Patient Patient-Focused Episodes of Care,* Washington DC: NQF; 2010. Available at www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx. Last accessed March 2012.

[vi] HHS. *Partnership for Patients: Better Care, Lower Costs.* Washington, DC: HHS; 2011. Available at www.healthcare.gov/center/programs/partnership. Last accessed March 2012.

[vii] HHS. *National Prevention, Health Promotion and Public Health Council (National Prevention Council).* Washington, DC: HHS; 2011. Available at www.healthcare.gov/center/councils/nphpphc/index.html. Last accessed March 2012.

[viii] HHS. *National Partnership for Action to End Health Disparities,* Washington, DC: HHS; 2011. Available at http://minorityhealth.hhs.gov/npa/. Last accessed March 2012.

[ix] HHS, *HHS Initiative on Multiple Chronic Conditions,* Washington, DC: HHS: 2011. Available at www.hhs.gov/ash/initiatives/mcc/. Last accessed March 2012.

[x] NQF. *Coordination Strategy for Healthcare-Acquired Conditions and Readmissions Across Public and Private Payers.* Washington, DC: NQF; 2011. Available at www.qualityforum.org/map/. Last accessed March 2012.

[xi] NQF. *Coordination Strategy for Clinician Performance Measurement.* Washington, DC: NQF; 2011. Available at www.qualityforum.org/map/. Last accessed March 2012.

[xii] NQF. *Strategic Approach to Quality Measurement for Dual Eligible Beneficiaries*. Washington, DC: NQF; 2011. Available at www.qualityforum.org/map/. Last accessed March 2012.

[xiii] NQF. *Input on Measures Under Consideration by HHS for 2012 Rulemaking*. Washington, DC: NQF; 2012. Available at www.qualityforum.org/map/. Last accessed March 2012.

[xiv] NQF. *Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement*. Washington, DC: NQF; 2012. Available at www.qualityforum.org/map/. Last accessed March 2012.

Appendix B

Roster for the MAP Dual Eligible Beneficiaries Workgroup

CHAIR (VOTING)
Alice Lind, MPH, BSN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	David Polakoff, MD, MsC
Better Health Greater Cleveland	Patrick Murray, MD, MS
Center for Medicare Advocacy	Patricia Nemore, JD
National Health Law Program	Leonardo Cuello, JD
Humana, Inc.	Thomas James, III, MD
L.A. Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National PACE Association	Adam Burrows, MD

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

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Medicare-Medicaid Coordination Office	Cheryl Powell
Health Resources and Services Administration	Samantha Wallack Meklir, MPP
HHS Office on Disability	Henry Claypool
Substance Abuse and Mental Health Services Administration	Rita Vandivort-Warren, MSW
Veterans Health Administration	Daniel Kivlahan, PhD

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

APPENDIX C:

Roster for the MAP Coordinating Committee

CHAIR (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPPs

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

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

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

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

APPENDIX D: MAP MEASURE SELECTION CRITERIA AND INTERPRETIVE GUIDE

1. Measures within the program measure set are NQF endorsed or meet the requirements for expedited review

Measures within the program measure set are NQF endorsed, indicating that they have met the following criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. Measures within the program measure set that are not NQF endorsed but meet requirements for expedited review, including measures in widespread use and/or tested, may be recommended by MAP, contingent on subsequent endorsement. These measures will be submitted for expedited review.

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree

Measures within the program measure set are NQF endorsed or meet requirements for expedited review (including measures in widespread use and/or tested)

Additional Implementation Consideration: Individual endorsed measures may require additional discussion and may be excluded from the program measure set if there is evidence that implementing the measure would result in undesirable unintended consequences.

2. Program measure set adequately addresses each of the National Quality Strategy (NQS) priorities

Demonstrated by measures addressing each of the National Quality Strategy priorities:

Subcriterion 2.1	Safer care
Subcriterion 2.2	Effective care coordination
Subcriterion 2.3	Preventing and treating leading causes of mortality and morbidity
Subcriterion 2.4	Person- and family-centered care
Subcriterion 2.5	Supporting better health in communities
Subcriterion 2.6	Making care more affordable

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree:

NQS priority is adequately addressed in the program measure set

3. Program measure set adequately addresses high-impact conditions relevant to the program's intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)

Demonstrated by the program measure set addressing Medicare High-Impact Conditions; Child Health Conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s). (Refer to Tables 1 and 2 for Medicare High-Impact Conditions and Child Health Conditions determined by the NQF Measure Prioritization Advisory Committee.)

Response option: Strongly Agree / Agree / Disagree / Strongly Disagree:

Program measure set adequately addresses high-impact conditions relevant to the program.

4. Program measure set promotes alignment with specific program attributes, as well as alignment across programs

Demonstrated by a program measure set that is applicable to the intended care setting(s), level(s) of analysis, and population(s) relevant to the program.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 4.1	Program measure set is applicable to the program's intended care setting(s)
Subcriterion 4.2	Program measure set is applicable to the program's intended level(s) of analysis
Subcriterion 4.3	Program measure set is applicable to the program's population(s)

5. Program measure set includes an appropriate mix of measure types

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, and structural measures necessary for the specific program attributes.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 5.1	Outcome measures are adequately represented in the program measure set
Subcriterion 5.2	Process measures are adequately represented in the program measure set
Subcriterion 5.3	Experience of care measures are adequately represented in the program measure set (e.g., patient, family, caregiver)
Subcriterion 5.4	Cost/resource use/appropriateness measures are adequately represented in the program measure set
Subcriterion 5.5	Structural measures and measures of access are represented in the program measure set when appropriate

6. Program measure set enables measurement across the person-centered episode of care[1]

Demonstrated by assessment of the person's trajectory across providers, settings, and time.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 6.1	Measures within the program measure set are applicable across relevant providers
Subcriterion 6.2	Measures within the program measure set are applicable across relevant settings
Subcriterion 6.3	Program measure set adequately measures patient care across time

1 National Quality Forum (NQF), *Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care,* Washington, DC: NQF; 2010.

7. Program measure set includes considerations for healthcare disparities[2]

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, age disparities, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 7.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Subcriterion 7.2 Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8. Program measure set promotes parsimony

Demonstrated by a program measure set that supports efficient (i.e., minimum number of measures and the least effort) use of resources for data collection and reporting and supports multiple programs and measurement applications. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

Response option for each subcriterion: Strongly Agree / Agree / Disagree / Strongly Disagree

Subcriterion 8.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)

Subcriterion 8.2 Program measure set can be used across multiple programs or applications (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

2 NQF, *Healthcare Disparities Measurement*, Washington, DC: NQF; 2011.

Table 1: National Quality Strategy Priorities

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

Table 2: High-Impact Conditions

Medicare Conditions
1. Major Depression
2. Congestive Heart Failure
3. Ischemic Heart Disease
4. Diabetes
5. Stroke/Transient Ischemic Attack
6. Alzheimer's Disease
7. Breast Cancer
8. Chronic Obstructive Pulmonary Disease
9. Acute Myocardial Infarction
10. Colorectal Cancer
11. Hip/Pelvic Fracture
12. Chronic Renal Disease
13. Prostate Cancer
14. Rheumatoid Arthritis/Osteoarthritis
15. Atrial Fibrillation
16. Lung Cancer
17. Cataract
18. Osteoporosis
19. Glaucoma
20. Endometrial Cancer

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese (≥85th percentile BMI for age)
3. Risk of Developmental Delays or Behavioral Problems
4. Oral Health
5. Diabetes
6. Asthma
7. Depression
8. Behavior or Conduct Problems
9. Chronic Ear Infections (3 or more in the past year)
10. Autism, Asperger's, PDD, ASD
11. Developmental Delay (diag.)
12. Environmental Allergies (hay fever, respiratory or skin allergies)
13. Learning Disability
14. Anxiety Problems
15. ADD/ADHD
16. Vision Problems Not Corrected by Glasses
17. Bone, Joint, or Muscle Problems
18. Migraine Headaches
19. Food or Digestive Allergy
20. Hearing Problems
21. Stuttering, Stammering, or Other Speech Problems
22. Brain Injury or Concussion
23. Epilepsy or Seizure Disorder
24. Tourette Syndrome

MAP MEASURE SELECTION CRITERIA INTERPRETIVE GUIDE

Instructions for applying the measure selection criteria:

The measure selection criteria are designed to assist MAP Coordinating Committee and workgroup members in assessing measure sets used in payment and public reporting programs. The criteria have been developed with feedback from the MAP Coordinating Committee, workgroups, and public comment. The criteria are intended to facilitate a structured thought process that results in generating discussion. A rating scale of *Strongly Agree, Agree, Disagree, Strongly Disagree* is offered for each criterion or sub-criterion. An open text box is included in the response tool to capture reflections on the rationale for ratings.

The eight criteria areas are designed to assist in determining whether a measure set is aligned with its intended use and whether the set best reflects "quality" health and healthcare. The term "measure set" can refer to a collection of measures—for a program, condition, procedure, topic, or population. For the purposes of MAP moving forward, we will qualify all uses of the term measure set to refer to either a "program measure set," a "core measure set" for a setting, or a "condition measure set." The following eight criteria apply to the evaluation of program measure sets; a subset of the criteria apply to condition measure sets.

FOR CRITERION 1—NQF ENDORSEMENT:

The optimal option is for all measures in the program measure set to be NQF endorsed or ready for NQF expedited review. The endorsement process evaluates individual measures against four main criteria:

1. **Importance to measure and report**—how well the measure addresses a specific national health goal/priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus.
2. **Scientific acceptability of the measurement properties**—evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.
3. **Usability-** the extent to which intended audiences (e.g., consumers, purchasers, providers, and policymakers) can understand the results of the measure and are likely to find the measure results useful for decision-making.
4. **Feasibility**—the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

To be recommended by MAP, a measure that is not NQF endorsed must meet the following requirements, so that it can be submitted for expedited review:

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use.
- whether the scope of the project/measure set is relatively narrow.
- time-sensitive legislative/regulatory mandate for the measure(s).
- Measures that are NQF endorsed are broadly available for quality improvement and public accountability

programs. In some instances, there may be evidence that implementation challenges and/or unintended negative consequences of measurement to individuals or populations may outweigh benefits associated with the use of the performance measure. Additional consideration and discussion by the MAP workgroup or Coordinating Committee may be appropriate prior to selection. To raise concerns on particular measures, please make a note in the included text box under this criterion.

FOR CRITERION 2—PROGRAM MEASURE SET ADDRESSES THE NATIONAL QUALITY STRATEGY PRIORITIES

The program's set of measures is expected to adequately address each of the NQS priorities as described in criterion 2.1-2.6. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. This assessment should consider the current landscape of NQF-endorsed measures available for selection within each of the priority areas.

FOR CRITERION 3—PROGRAM MEASURE SET ADDRESSES HIGH-IMPACT CONDITIONS

When evaluating the program measure set, measures that adequately capture information on high-impact conditions should be included based on their relevance to the program's intended population. High-priority Medicare and Child Health Conditions have been determined by NQF's Measure Prioritization Advisory Committee and are included to provide guidance. For programs intended to address high-impact conditions for populations other than Medicare beneficiaries and children (e.g., adult non-Medicare and dual eligible beneficiaries), high-impact conditions can be demonstrated by their high prevalence, high disease burden, and high costs relevant to the program. Examples of other ongoing efforts may include research or literature on the adult Medicaid population or other common populations. The definition of "adequate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria.

FOR CRITERION 4—PROGRAM MEASURE SET PROMOTES ALIGNMENT WITH SPECIFIC PROGRAM ATTRIBUTES, AS WELL AS ALIGNMENT ACROSS PROGRAMS

The program measure sets should align with the attributes of the specific program for which they intend to be used. Background material on the program being evaluated and its intended purpose are provided to help with applying the criteria. This should assist with making discernments about the intended care setting(s), level(s) of analysis, and population(s). While the program measure set should address the unique aims of a given program, the overall goal is to harmonize measurement across programs, settings, and between the public and private sectors.

- **Care settings include:** Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services—Ambulance, Home Health, Hospice, Hospital- Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.
- **Level of analysis includes:** Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.
- **Populations include:** Community, County/City, National, Regional, or States.
- **Population includes:** Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

FOR CRITERION 5—PROGRAM MEASURE SET INCLUDES AN APPROPRIATE MIX OF MEASURE TYPES

The program measure set should be evaluated for an appropriate mix of measure types. The definition of "appropriate" rests on the expert judgment of the Coordinating Committee or workgroup member using the selection criteria. The evaluated measure types include:

1. **Outcome measures**—Clinical outcome measures reflect the actual results of care.[3] Patient-reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[4]
2. **Process measures—**Process denotes what is actually done in giving and receiving care.[5] NQF endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[6]
3. **Experience of care measures**—Defined as patients' perspective on their care.[7]
4. **Cost/resource use/appropriateness measures—**

   a. Cost measures—Total cost of care.

   b. Resource use measures—Resource use measures are defined as broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).[8]

   c. Appropriateness measures—Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[9]
5. **Structure measures**—Reflect the conditions in which providers care for patients.[10] This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure.

3 NQF, 2011, The right tools for the job. Available at http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx.

4 Consumer-Purchases Disclosure Project, 2011. Ten Criteria for Meaningful and Usable Measures of Performance

5 Donabedian, A., The quality of care, *JAMA*, 1998; 260: 1743-1748.

6 NQF, 2011, Consensus development process. Available at http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx.

5 NQF, 2011, The right tools for the job. Available at http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx.

6 NQF, 2009, National voluntary consensus standards for outpatient imaging efficiency. Available at http://www.qualityforum.org/Publications/2009/08/National_Voluntary_Consensus_Standards_for_Outpatient_Imaging_Efficiency__A_Consensus_Report.aspx

7 NQF, 2011, The right tools for the job. Available at http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx.

8 NQF, 2011, The right tools for the job. Available at http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx.

Appendix E: Guiding Principles

In considering how to achieve the desired vision, MAP established guiding principles for the approach to measurement. Measurement programs can be designed for many purposes, and at many levels of accountability and analysis. Individual measures are also generally designed for specific uses. Defining a purpose, goals, data platform, and levels of analysis for a measurement initiative are precursors to the selection and application of specific measures within a program. Individual measures must be chosen with the program goals and capabilities in mind. This concept of fit-for-purpose is so fundamental that MAP was limited in its ability to fully define federal and state-level measure sets for dual eligible beneficiaries. To do so, MAP would require detailed information about the aspects of the measurement programs that are still in the process of being established. Despite these constraints, MAP's Measure Selection Criteria (Appendix D), and the guiding principles below can assist in evaluating the appropriateness of potential measures to meet the goals of any initiative.

The guiding principles regarding measurement in the dual eligible beneficiary population fall into three general categories: desired effects of measurement, measurement design, and data platform principles.

Desired Effects of Measurement

Promoting Integrated Care. Measurement has the ability to drive clinical practice and provision of community supports toward desired models of integrated, collaborative, and coordinated care. Improving the health of dual eligible beneficiaries will require wide-scale cooperation, systematic communication, and shared accountability.

Ensuring Cultural Competence. The measurement approach also should promote culturally competent care that is responsive to dimensions of race, ethnicity, age, functional status, language, level of health literacy, environmental factors, and accessibility of the environment for people with different types of disability.

Health Equity. Stratifying measures by such factors as race, ethnicity, or socio-economic status allows for identification of potential healthcare disparities and related opportunities to address them. Moreover, it is important to measure the experiences of dual eligible beneficiaries year-over-year and in contrast to Medicare-only and Medicaid-only beneficiaries in order to assess any differences in program access.

Measurement Design

Assessing Outcomes Relative to Goals. The measurement approach should evaluate person-level outcomes relative to goals that are defined in the process of developing a person- and family-centered plan of care. Such goals might include maintaining or improving function, longevity, palliative care, or a combination of factors. It also is vital to include outcome measures related to the individual's or family's assessment of the care and supports received.

Parsimony. To minimize the resources required to conduct performance measurement and reporting, a core measure set should be parsimonious. The set should include the smallest possible number of measures to achieve the intended purpose of the measurement program.

Cross-Cutting Measures. The heterogeneity of the dual-eligible population complicates efforts to select a small number of measures that would accurately reflect their care experience. Thus,

a parsimonious measure set should rely primarily on cross-cutting measures and use condition-specific measures only to the extent they address critical issues for high-need subpopulations.

Inclusivity. The measurement strategy should span the continuum of care and include both Medicare and Medicaid services. It should include measures that are broadly applicable across age groups, disease groups, or other cohorts, as opposed to measures with narrowly defined denominator populations.

Avoiding Undesirable Consequences. The methodology should anticipate and mitigate potential undesirable consequences of measurement. This might include overuse or underuse of services as well as adverse selection. For example, the measurement approach could use strategies such as stratification or risk adjustment to account for the increased difficulty of caring for complex patients and to ensure that such individuals would have access to providers willing to treat them.

Data Platform Principles

Data Sharing. The measurement strategy should encourage dynamic data exchange and shared accountability. Interoperable health records that enable portability of information across providers can assist greatly in delivering timely, appropriate services that are aligned with a shared plan of care.

Using Data for Multiple Purposes. A robust data exchange platform also would assist providers in gathering information from the individual receiving care or his or her caregivers, and circulating feedback, as appropriate, to improve quality. Tracking data over time also enables longitudinal measurement and tracking “delta measures” of change in outcomes of interest.

Making the Best Use of Available Data. While our nation’s health IT infrastructure develops, the measurement strategy must make the best use of all available data sources, including administrative claims, registries, and community-level information.

Appendix F: MAP Dual Eligible Beneficiaries Workgroup
Revised Core Set of Measures

NQF Measure # and Status	Measure Name	Measure Description	Potential Modifications	MAP High-Leverage Opportunities
0004 Endorsed (eMeasure specification available)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	• Suggested to represent identification of dependence, initiation of treatment, and engagement in treatment as separate elements in a composite measure	Care Coordination, Mental Health and Substance Use
0028 Endorsed (eMeasure specification available)	Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period		Screening & Assessment, Mental Health and Substance Use
0097 Endorsed (eMeasure specification available)	Medication Reconciliation	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	• Suggested that the time window in which patient should see physician after discharge be condensed, potentially to 30 days or fewer	Care Coordination, Screening & Assessment
0101 Endorsed	Falls: Screening for Fall Risk	Percentage of patients aged 65 years and older who were screened for fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months	• Suggested that the measure be expanded to include anyone at risk for a fall (e.g. individuals with mobility impairments), not just individuals older than 65 • Suggested that patients could report if they received counseling on falls rather than relying on claims data	Screening & Assessment
0208 Endorsed	Family Evaluation of Hospice Care	The survey measures family members perception of the quality of hospice care for the entire enrollment period, regardless of length of service.		Quality of Life
0209 Endorsed	Comfortable Dying	Percentage of patients who were uncomfortable because of pain on admission to hospice whose pain was brought under control within 48 hours	• Give consideration to operationalizing this measure as pain assessment across settings, at a minimum could be applied more broadly to other types of palliative care	Quality of Life
0228 Endorsed	3-Item Care Transition Measure (CTM-3)	Uni-dimensional self-reported survey that measure the quality of preparation for care transitions.	• Broaden to additional settings beyond inpatient, such as ER and nursing facility discharges	Care Coordination
0260 Endorsed	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	Percentage of dialysis patients who receive a quality of life assessment using the KDQOL-36 (36-question survey that assesses patients' functioning and well-being) at least once per year.	• Suggested expansion beyond ESRD setting to include other types of care • Construction of this concept as a process measure is not ideal	Quality of Life
0418 Endorsed	Screening for Clinical Depression and Follow-up Plan	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented		Screening & Assessment, Mental Health and Substance Use
0421 Endorsed (eMeasure specification available)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented Normal Parameters: Age 65 and older BMI ≥23 and <30; Age 18 – 64 BMI ≥18.5 and <25		Screening & Assessment

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NQF Measure # and Status	Measure Name	NQS Priority	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0004 Endorsed (eMeasure specification available)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement	Effective Communication and Care Coordination, Health and Well-Being	Administrative Claims, Electronic Health Record, Paper Records	Process	Ambulatory Care, Hospital/ Acute Care Facility	Clinician, Health Plan, Integrated Delivery System, Clinician, Population	NCQA	Finalized for use in PQRS, Meaningful Use, Value Modifier, Medicaid Adult Core Measures
0028 Endorsed (eMeasure specification available)	Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	Prevention and Treatment of Leading Causes of Mortality, Health and Well-Being	Administrative Claims	Process	Ambulatory Care	Clinician	AMA-PCPI	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier
0097 Endorsed (eMeasure specification available)	Medication Reconciliation	Effective Communication and Care Coordination, Patient Safety	Administrative Claims, Other Electronic Clinical Data, Paper Records	Process	Ambulatory Care	Clinician, Integrated Delivery System, Population	NCQA	Finalized for use in PQRS, Medicare Shared Savings Program, VBPM and proposed for the Stage 2 Meaningful Use Program
0101 Endorsed	Falls: Screening for Fall Risk	Patient Safety, Health and Well-Being	Administrative Claims, Other Electronic Clinical Data	Process	Ambulatory Care, Home Health, Hospice, PAC/LTC Facility	Clinician	NCQA	Finalized for use in PQRS, Medicare Shared Savings Program, Value Modifier and proposed for the Stage 2 Meaningful Use Program
0208 Endorsed	Family Evaluation of Hospice Care	Person- and Family-Centered Care	Patient Reported Survey	Composite	Hospice	Facility, Population	National Hospice and Palliative Care Org.	Under consideration for Hospice Quality Reporting (MAP Supported)
0209 Endorsed	Comfortable Dying	Effective Communication and Care Coordination, Person- and Family-Centered Care	Patient Reported Survey	Outcome	Hospice	Facility, Population	National Hospice and Palliative Care Org.	Finalized for use in Hospice Quality Reporting
0228 Endorsed	3-Item Care Transition Measure (CTM-3)	Effective Communication and Care Coordination, Person- and Family-Centered Care	Patient Reported Survey	Patient Engagement/ Experience	Hospital	Facility	University of Colorado Health Sciences Center	Under consideration for Hospital Inpatient Reporting (MAP Supported)
0260 Endorsed	Assessment of Health-related Quality of Life (Physical & Mental Functioning)	Person- and Family-Centered Care	Patient Reported Survey	Process	Dialysis Facility	Facility	RAND	MAP Supported for ESRD Quality Reporting
0418 Endorsed	Screening for Clinical Depression and Follow-up Plan	Health and Well-Being	Administrative Claims	Process	Ambulatory Care, Hospital, PAC/LTC Facility	Clinician	CMS/QIP	Finalized for use in PQRS, Medicare Shared Savings Program, Medicaid Adult Core and proposed for the Stage 2 Meaningful Use Program
0421 Endorsed (eMeasure specification available)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up	Health and Well-Being	Administrative Claims, Other Electronic Clinical Data	Process	Ambulatory Care	Clinician, Population	CMS/QIP	Finalized for use in PQRS, Meaningful Use, Medicare Shared Savings Program, and Value Modifier

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NQF Measure # and Status	Measure Name	Measure Description	Potential Modifications	MAP High-Leverage Opportunities
0430 Endorsed	Change in Daily Activity Function as Measured by the AM-PAC:	The Activity Measure for Post Acute Care (AM-PAC) is a functional status assessment instrument developed specifically for use in facility and community dwelling post acute care (PAC) patients. A Daily Activity domain has been identified which consists of functional tasks that cover in the following areas: feeding, meal preparation, hygiene, grooming, and dressing.	• Broaden beyond post-acute care • Include maintenance of functional status if this is all that can be realistically expected • Address floor effects observed when tool is applied to frail/complex patients • Incorporate community services in supporting post-acute recovery	Quality of Life
0490 Endorsed	The Ability to use Health Information Technology to Perform Care Management at the Point of Care	Documents the extent to which a provider uses a certified/qualified electronic health record (EHR) system capable of enhancing care management at the point of care. To qualify, the facility must have implemented processes within their EHR for disease management that incorporate the principles of care management at the point of care which include: a. The ability to identify specific patients by diagnosis or medication use b. The capacity to present alerts to the clinician for disease management, preventive services and wellness c. The ability to provide support for standard care plans, practice guidelines, and protocol	• Could also capture this concept as a % of providers in a defined area or network achieving Meaningful Use incentives	Care Coordination, Structural
0494 Endorsed	Medical Home System Survey	Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: a. Improved access and communication b. Care management using evidence-based guidelines c. Patient tracking and registry functions d. Support for patient self-management e. Test and referral tracking f. Practice performance and improvement functions	• A health home's approach to care management must be designed for duals and consider both Medicaid and Medicare benefits • Care management might be appropriately conducted by other parties besides primary care physician (e.g., family member, clinical specialist) • Consider broader application in shared accountability models such as ACOs and health homes • Survey is long, complex, and not widely used. Potential starting place to address this concept would be to evaluate duals' access to a usual source of primary care	Care Coordination, Structural
0523 Endorsed	Pain Assessment Conducted	Percent of patients who were assessed for pain, using a standardized pain assessment tool, at start/resumption of home health care	• Suggested expansion beyond home health care • Outcome measure of pain management would be preferred	Quality of Life, Screening & Assessment
0557 Endorsed	HBIPS-6 Post discharge continuing care plan created	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge.	• Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox.	Care Coordination, Mental Health and Substance Use
0558 Endorsed	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity.	• Suggested expansion to all discharges, not just psychiatric. At a minimum, the measure should include inpatient detox. • Information should be transmitted to both nursing facility and primary care provider, if applicable.	Care Coordination, Mental Health and Substance Use

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NQF Measure # and Status	Measure Name	NQS Priority	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0430 Endorsed	Change in Daily Activity Function as Measured by the AM-PAC:	N/A	Electronic Health Record	Outcome	Ambulatory Care, Home Health, Hospital, PAC/LTC Facility	Facility, Clinician	CREcare	None
0490 Endorsed	The Ability to use Health Information Technology to Perform Care Management at the Point of Care	N/A	Administrative Claims, Electronic Health Record	Structure	Ambulatory Care	Clinician	CMS	None
0494 Endorsed	Medical Home System Survey	Effective Communication and Care Coordination, Person- and Family-Centered Care	Provider Survey, patient reported Survey, Other Electronic Clinical Data, Electronic Health Record, Paper Records	Structure	Ambulatory Care	Facility, Clinician	NCQA	None
0523 Endorsed	Pain Assessment Conducted	Effective Communication and Care Coordination	Other Electronic Clinical Data	Process	Home Health	Facility	CMS	Finalized for use in Home Health
0557 Endorsed	HBIPS-6 Post discharge continuing care plan created	Effective Communication and Care Coordination	Administrative Claims, Paper Records, Other Electronic Clinical Data	Process	Hospital, Behavioral Health/ Psychiatric (Inpatient)	Facility	The Joint Commission	Under consideration for Inpatient Psychiatric Facility Quality Reporting (MAP Supported)
0558 Endorsed	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	Effective Communication and Care Coordination	Administrative Claims, Paper Records, Other Electronic Clinical Data	Process	Hospital, Behavioral Health/ Psychiatric (Inpatient)	Facility	The Joint Commission	Under consideration for Inpatient Psychiatric Facility Quality Reporting (MAP Supported)

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NQF Measure # and Status	Measure Name	Measure Description	Potential Modifications	MAP High-Leverage Opportunities
0576 Endorsed	Follow-up after hospitalization for mental illness	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.	• Suggested expansion to incorporate substance use disorders/detox	Care Coordination, Mental Health and Substance Use
0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements.	• Do not limit to certain transition sites/settings	Care Coordination
0648 Endorsed	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	• Do not limit to certain transition sites/settings	Care Coordination
0729 Endorsed	Optimal Diabetes Care	The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes. Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated. Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component.		Screening & Assessment
Multiple Numbers Endorsed	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys	Many versions of CAHPS patient experience surveys have been endorsed for use across the health system. Surveys are available for: Health Plan, Clinician & Group Practice, Experience of Care and Health Outcomes (ECHO) for Behavioral Health, Home Health Care, Hospital, In-Center Hemodialysis, Nursing Home Supplemental Item Sets, topics including: People with Mobility Impairments, Cultural Competence, Health IT, Health Literacy, Patient-Centered Medical Home		N/A

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NQF Measure # and Status	Measure Name	NQS Priority	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
0576 Endorsed	Follow-up after hospitalization for mental illness	Effective Communication and Care Coordination	Administrative Claims, Electronic Health Record	Process	Ambulatory Care, Behavioral Health/ Psychiatric Outpatient, Inpatient)	Health Plan, Integrated Delivery System, Clinician, Population	NCQA	Finalized for use in Medicaid Adult Core Measures, CHIPRA Core Measures
0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Effective Communication and Care Coordination	Paper Records, Electronic Health Record, Administrative Claims	Process	Hospital, PAC/LTC Facility, Ambulatory Care	Facility, Integrated Delivery System	AMA-PCPI	None
0648 Endorsed	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self Care or Any Other Site of Care)	Effective Communication and Care Coordination	Administrative Claims, Paper Records, EHR	Process	Hospital, PAC/LTC Facility, Ambulatory Care	Facility, Integrated Delivery System	AMA-PCPI	Finalized for use in Medicaid Adult Core Measures
0729 Endorsed	Optimal Diabetes Care	Effective Communication and Care Coordination, Prevention and Treatment of Leading Causes of Mortality	Paper Records, Other Electronic Clinical Data, Electronic Health Record	Outcome	Ambulatory Care	Integrated Delivery System, Clinician	MN Community Measurement	Components for this composite are finalized for use in Medicare Shared Savings and Value Modifier, Under consideration for PQRS (MAP Supported)
Multiple Numbers Endorsed	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys	Person- and Family-Centered Care	Patient Reported Survey	Patient Engagement/ Experience	Ambulatory Care	Clinician, Facility, Health Plan, Integrated Delivery System, Population	AHRQ	Finalized for use in Medicare Shared Savings Program

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NQF Measure # and Status	Measure Name	Measure Description	Potential Modifications	MAP High-Leverage Opportunities
1768 In Process	Plan all-cause readmissions	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/Denominator) 5. Total Variance Note: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	Measures #1768 and #1789 are currently undergoing review for endorsement. MAP recommends use of either measure, depending on the desired unit of analysis, if endorsement is received.	Care Coordination
1789 In Process	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology, each of which will be described in greater detail below. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts. We developed the measure for patients 65 years and older using Medicare fee-for-service (FFS) claims and subsequently tested and specified the measure for patients aged 18 years and older using all-payer data. We used the California Patient Discharge Data (CPDD), a large database of patient hospital admissions, for our all-payer data.		Care Coordination
Not Endorsed	SNP 6: Coordination of Medicare and Medicaid coverage.	Intent: The organization helps members obtain services they are eligible to receive regardless of payer, by coordinating Medicare and Medicaid coverage. This is necessary because the two programs have different rules and benefit structures and can be confusing for both members and providers.	• Measure currently applies to Medicare Advantage Special Needs Plans only. Suggest expansion to other entities if possible.	Structural
Not Endorsed	Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment	a. Patients screened annually for alcohol misuse with the 3-item AUDIT-C with item-wise recording of item responses, total score and positive or negative result of the AUDIT-C in the medical record. B. Patients who screen for alcohol misuse with AUDIT-C who meet or exceed a threshold score who have brief alcohol counseling documented in the medical record within 14 days of the positive screening.	Beyond just a single condition/setting	Screening & Assessment, Mental Health and Substance Use

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NQF Measure # and Status	Measure Name	NQS Priority	Data Source	Measure Type	Setting	Level of Analysis	Measure Steward	Current Programs
1768 In Process	Plan all-cause readmissions	Patient Safety, Effective Communication and Care Coordination	Administrative Claims	Outcome	Hospital, Behavioral Health/ Psychiatric (Inpatient)	Health Plan	NCQA	None
1789 In Process	Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Patient Safety, Effective Communication and Care Coordination	Administrative Claims	Outcome	Hospital	Facility	CMS, Yale	Under consideration for Inpatient Quality Reporting (MAP Supported)
Not Endorsed	SNP 6: Coordination of Medicare and Medicaid coverage.	Effective Communication and Care Coordination	(not available)	Structure	(not available)	Health Plan	NCQA	None
Not Endorsed	Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment	Effective Communication and Care Coordination, Health and Well-Being	(not available)	Process	(not available)	(not available)	(not available)	None

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Appendix G: MAP Dual Eligible Beneficiaries Workgroup
Selected Measures for Medicaid Home and Community-Based Services (HCBS)

Framework	Domain	Sub-domain	Measure	Source	Notes	High-Leverage Opportunities
HCBS Scan (AHRQ, Thomson Reuters)	Client Functioning	Change in daily activitiy function	Degree to which consumers experience an increased level of functioning	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disabilities populations	Quality of Life, Screening/ Assessment
HCBS Scan (AHRQ, Thomson Reuters)	Client Functioning	Availability of support with everyday activities when needed	Unmet need in ADLs/IADLs (11 measures total)	Participant Experience Survey	Item present in all three versions (elderly/disabled, mental retardation/developmental disabilities, and acquired brain injury); additional money management item in brain injury tool.	Quality of Life, Structural
HCBS Scan (AHRQ, Thomson Reuters)	Client Functioning	Presence of friendships	Degree to which people express satisfaction with relationships	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disabilities populations	Quality of Life
HCBS Scan (AHRQ, Thomson Reuters)	Client Functioning	Presence of friendships	Satisfaction with close friends	Quality of Life Scale (modified by Burkhardt)	Developed and tested with populations with chronic illness	Quality of Life
HCBS Scan (AHRQ, Thomson Reuters)	Client Functioning	Maintenance of family relationships	Satisfaction with relationships with parents, siblings, and other relatives	Quality of Life Scale (Burkhardt version for chronic illness)	Developed and tested with populations with chronic illness	Quality of Life
HCBS Scan (AHRQ, Thomson Reuters)	Client Functioning	Community integration	Participants reporting unmet need for community involvement	Participant Experience Survey	Item supported by all three versions; additional community involvement measures related to specific activities such as shopping present in brain injury and mental retardation/developmental disabilities versions	Quality of Life
HCBS Scan (AHRQ, Thomson Reuters)	Client Functioning	Receipt of recommended preventive health care services	Degree to which people with identified physical health problems obtain appropriate services and degree to which health status is maintained and improved	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disabilities populations	Screening/ Assessment, Structural
HCBS Scan (AHRQ, Thomson Reuters)	Client Experience	Respectful treatment by direct service providers	Degree to which consumers report that staff are sensitive to their cultural, ethnic, or linguistic backgrounds and degree to which consumers felt they were respected by staff	Commission on Accreditation of Rehabilitation Facilities	Developed and tested with multiple disability populations	Care Coordination
HCBS Scan (AHRQ, Thomson Reuters)	Client Experience	Opportunities to make choices about Services	Degree of active consumer participation in decisions concerning their treatment	Commission on Accreditation of Rehabilitation Facilities	Tested with multiple disability populations	Care Coordination, Structural
HCBS Scan (AHRQ, Thomson Reuters)	Client Experience	Satisfaction with case management services	Case manager helpfulness	Participant Experience Survey	Item present in all three survey versions	Care Coordination
HCBS Scan (AHRQ, Thomson Reuters)	Client Experience	Client perception of quality of care	Degree to which consumers were satisfied with overall services	Commission on Accreditation of Rehabilitation Facilities	Developed and tested with multiple disability populations	Quality of Life
HCBS Scan (AHRQ, Thomson Reuters)	Client Experience	Client perception of quality of care	Service satisfaction scales: home worker; personal care; home-delivered meals	Service Adequacy and Satisfaction Instrument	Developed and tested with service recipients age 60 and older	Quality of Life

AHRQ: http://www.ahrq.gov/research/ltc/hcbsreport/
AARP: http://www.aarp.org/relationships/caregiving/info-09-2011/ltss-scorecard.html
NBIC: http://nationalbalancingindicators.com/

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Selected Measures for Medicaid Home and Community-Based Services (HCBS)

Framework	Domain	Sub-domain	Measure	Source	Notes	High-Leverage Opportunities
HCBS Scan (AHRQ, Thomson Reuters)	Program Performance	Access to case management services	Ability to identify case manager	Participant Experience Survey	Supported by all three survey versions	Care Coordination, Structural
HCBS Scan (AHRQ, Thomson Reuters)	Program Performance	Access to case management services	Ability to contact case manager	Participant Experience Survey	Supported by all three survey versions	Care Coordination, Structural
LTSS Scorecard (AARP)	Choice of Setting and Provider	N/A	Tools and programs to facilitate consumer choice (composite indicator, scale 0-4)	AARP conducted a state survey to collect information about states' single entry point systems and various functions that facilitate consumer choice. Data from State LTSS Scorecard Survey (AARP PPI, Scorecard 2010).	States were scored from 0 (no use of tool or program) to 1 (full use of tool or program) in each of four categories: 1. Presumptive eligibility (scoring: 1 point) 2. Uniform assessment (scoring: proportion of Medicaid and state-funded programs that use a uniform assessment tool, with multiple HCBS waivers counting as two programs regardless of the number of waivers) 3. Money Follows the Person and other nursing facility transition programs (scoring: 1/3 point if a program exists, 1/3 point if statewide, 1/3 point if it pays for one-time costs to establish community residence) 4. Options counseling (scoring: whether offered to individuals using each of five types of payment source)	Quality of Life, Structural
LTSS Scorecard (AARP)	Quality of Life and Quality of Care	N/A	Percent of adults age 18+ with disabilities in the community usually or always getting needed support	Data from 2009 BRFSS (NCCDPHP, BRFSS 2009)	Percent of adults limited in any way in any activities because of physical, mental, or emotional problems who usually or always received needed social and emotional support.	Structural
LTSS Scorecard (AARP)	Quality of Life and Quality of Care	N/A	Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life	Data from 2009 BRFSS (NCCDPHP, BRFSS 2009)	Percent of adults limited in any way in any activities because of physical, mental, or emotional problems who were satisfied or very satisfied with their life.	Quality of Life, Structural
LTSS Scorecard (AARP)	Support for Family Caregivers	N/A	Percent of caregivers usually or always getting needed support	Institute analysis of 2009 BRFSS (NCCDPHP, BRFSS 2009)	Percent of adults who provided regular care or assistance to a friend or family member during the past month and who usually or always received needed social and emotional support.	Structural
National Balancing Indicators (Abt, IMPAQ)	Sustainability	N/A	Proportion of Medicaid HCBS Spending of the Total Medicaid LTC Spending	NBIC using Thomson Reuters	The proportion of Medicaid HCBS spending of the total Medicaid long-term care spending	Structural
National Balancing Indicators (Abt, IMPAQ)	Self-determination/ Person-centeredness	N/A	Availabilityof Self-Direction Options	NBIC using CMS Medicaid Waiver Database, and State Self-Assessment	Does the State have one or more Medicaid waivers that offer participant-directed services? If yes, what is the employer status of participant? • Employer authority –Yes/No; Co-employer option, common law employer option • Budget authority –Yes/No; participant exercises decision-making authority and management responsibility; participant afforded flexibility to shift funds; participant authorizes purchase of approved waiver goods and services.	Quality of Life, Structural

AHRQ: http://www.ahrq.gov/research/ltc/hcbsreport/
AARP: http://www.aarp.org/relationships/caregiving/info-09-2011/ltss-scorecard.html
NBIC: http://nationalbalancingindicators.com/

Appendix G: MAP Dual Eligible Beneficiaries Workgroup
Selected Measures for Medicaid Home and Community-Based Services (HCBS)

Framework	Domain	Sub-domain	Measure	Source	Notes	High-Leverage Opportunities
National Balancing Indicators (Abt, IMPAQ)	Community Integration & Inclusion	N/A	Waiver Waitlist	NBIC using CMS Medicaid Waiver Database, and State Self-Assessment	There is a process for tracking people who are unable to gain access to services (e.g., waiting list management and protocols).	Structural
National Balancing Indicators (Abt, IMPAQ)	Prevention	N/A	Proportion of People with Disabilities Reporting Recent Preventive Health Care Visits(Individual-level)	NBIC calculations using the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS) data	The proportion of individuals with disabilities who report having had a preventive health care visit within the past year	Screening/ Assessment
National Balancing Indicators (Abt, IMPAQ)	Coordination & transparency	N/A	Proportion of People Reporting That Service Coordinators Help Them Get What They Need (Individual-level)	NBIC using National Core Indicators (NCI) Data	The proportion of people reporting that service coordinators help them get what they need	Care Coordination, Structural
National Balancing Indicators (Abt, IMPAQ)	Coordination & transparency	N/A	Coordination Between HCBS and Institutional Services	State Self-Assessment	Coordinated Policymaking: The State coordinates budgetary, programmatic, and oversight responsibility for institutional and home and community-based services	Care Coordination

AHRQ: http://www.ahrq.gov/research/ltc/hcbsreport/
AARP: http://www.aarp.org/relationships/caregiving/info-09-2011/ltss-scorecard.html
NBIC: http://nationalbalancingindicators.com/

Appendix H

Analytic Support for the Measure Application Partnership

Final Report – FINAL

March 29, 2012

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EXECUTIVE SUMMARY

When the U.S. Congress passed the Patient Protection and Affordable Care Act (ACA) in March 2010, it established the Federal Coordinated Health Care Office (FCHCO) to more effectively integrate benefits under Medicare and Medicaid and improve federal and state coordination for the nation's 9.2 million dual-eligible beneficiaries (duals) (Clemans-Cope and Waidmann, 2011). Such legislation emphasized the need to provide better coordinated and, in turn, higher quality care to a subpopulation of notoriously underserved and chronically ill individuals. In general, duals are among the most vulnerable beneficiaries: Most face multiple and severe chronic conditions that require complex and intense care. And because they receive both Medicare and Medicaid coverage, they must navigate two separate health care programs, often yielding fragmented, inefficient, and costly care. Although duals account for just 18 percent of Medicaid and 20 percent of Medicare enrollment, they represent 46 percent of Medicaid and 28 percent of Medicare program spending (Kasper, Watts & Lyons, 2010). Much of this phenomenon can be attributed to the average health status of duals – three in five dual eligibles have multiple chronic conditions, and two-fifths of those with multiple physical or physical and mental conditions were hospitalized in the previous year – coupled with the lack of coordination between the Medicare and Medicaid programs (Kasper, Watts & Lyons, 2010).

The literature clearly documents the population-level spending trends and poor health status of the dually eligible population, but in conjunction with the new mandates of the ACA related to coordination of care for duals, there is a need for additional research around measure development that will enable tracking of quality care for duals. As part of its larger contract with Avalere Health, LLC (Avalere), the National Quality Forum (NQF) has subcontracted L&M Policy Research, LLC (L&M), to focus on Task 3 of the project, Analytic Support for the Measure Applications Partnership (MAP). In particular, this task focuses on identifying quality issues for duals and related measures across all settings of care, organized around the five high-leverage domains defined by the MAP to guide measure development:

- Quality of life
- Care Coordination
- Screening and assessment
- Mental health and substance use
- Structural measures

The research team undertook an environmental scan that included nine discussions with experts, a focused literature scan that built upon the MAP activities and interaction/feedback from the MAP workgroup itself. The goal of this scan was to winnow a broad set of potential measures (and possible gaps) into a prioritized subset of measures that address the five high-leverage domains and informs the broader MAP goals of drafting a core measure set.

The key gaps in existing quality measures the team reviewed and discussed with interviewees are the lack of cross-setting, cross-organization applicability and the general clinical orientation of the measures. Interviewees across the board emphasized that ongoing, person-centered care that focuses resources on those most in need is the paramount goal. More specifically, interviewees

said, a duals-focused measure set should capture: 1.) the extent that "high-touch" person-centered care planning and management occurs when needed and 2.) the extent to which the processes and structures in place support this as an on-going activity.

Using person-centered health and well-being as the focal point of duals-specific measures, interviewees generally expressed the importance of seven key areas vital to creating a robust set of measures for duals:

- **Consumer-based assessment of goal-oriented planning and care delivery** – Patient/caregiver/family perception of extent to which care plan (if needed) and care delivered reflect goals and desires of the individual and/or care plan[1]
- **Management and monitoring of specific conditions and disabilities** – Provider and patient active awareness of and engagement with signs and symptoms related to conditions (and clusters of them) to achieve individual's care plan goals
- **Medication management/reconciliation across settings** – Shared management of medications among provider and patient/caregiver focusing on goals of care plan to optimize appropriate use of medication and minimize negative drug interactions
- **Transition management** – Interactions that occur within and across settings among providers with patients and their families to ensure individuals receive comprehensive and streamlined care without duplication
- **Integration and coordination of community social supports and health delivery** – Ability to identify need for and ultimately integrate community social supports into care plan based on individual/caregiver needs
- **Utilization benchmarking** – Ability to gauge the extent of service use among duals and their subpopulations across settings
- **Process improvement across settings** – Ensure quality improvement programs are in place within and across settings and organizations that serve duals and their subpopulations

Ultimately, to deliver high-quality care, the literature and interviewed stakeholders noted having an integrated delivery system as the key. To gauge the success of that system, measures must examine the extent to which processes occur across settings, at appropriate times, and in meaningful ways. This approach to measure development requires an evolution beyond the existing array of single-setting, single-condition measures. In doing so, measure developers could consider:

- Identify key components of "system-ness" that are critical to capture in a measure set

[1] Multiple interviewees emphasized the importance of not "over-medicalizing" this assessment process for duals, given their many non-medical priorities.

- Limit the number of measures so those responsible for focusing on improving quality have particular areas of focus
- Develop clear and specific criteria so that each measure gauges “apples to apples”
- Identify the particular sub-population each measure applies to
- Account for the data source of each measure because pulling and merging data from different agencies can be difficult if not impossible
- Apply consistent requirements across programs that account for meaningful use requirements, as stipulated in the Health Information Technology for Economic and Clinical Health Act (HITECH), to minimize duplication

INTRODUCTION

When the U.S. Congress passed the Patient Protection and Affordable Care Act (ACA) in March 2010, it established the Federal Coordinated Health Care Office (FCHCO) to more effectively integrate benefits under Medicare and Medicaid and improve federal and state coordination for the nation's 9.2 million dual-eligible beneficiaries (duals) (Clemans-Cope and Waidmann, 2011). Such legislation emphasized the need to provide better coordinated and, in turn, higher quality care to a subpopulation of notoriously underserved and chronically ill individuals. In general, duals are among the most vulnerable beneficiaries: Most face multiple and severe chronic conditions that require complex and intense care. And because they receive both Medicare and Medicaid coverage, they must navigate two separate health care programs, often yielding fragmented, inefficient, and costly care. Although duals account for just 18 percent of Medicaid and 20 percent of Medicare enrollment, they represent 46 percent of Medicaid and 28 percent of Medicare program spending (Kasper, Watts & Lyons, 2010). Much of this phenomenon can be attributed to the average health status of duals – three in five dual eligibles have multiple chronic conditions, and two-fifths of those with multiple physical or physical and mental conditions were hospitalized in the previous year – coupled with the lack of coordination between the Medicare and Medicaid programs (Kasper, Watts & Lyons, 2010).

The literature clearly documents the population-level spending trends and poor health status of the dually eligible population, but in conjunction with the new mandates of the ACA related to coordination of care for duals, there is a need for additional research around measure development that will enable tracking of quality care for duals. As part of its larger contract with Avalere Health, LLC (Avalere), the National Quality Forum (NQF) has subcontracted L&M Policy Research, LLC (L&M), to focus on Task 3 of the project, Analytic Support for the Measure Applications Partnership (MAP). Specifically, this task focuses on identifying quality issues for duals and related measures, and measure gaps, across all settings of care. The following five high-leverage domains defined by the MAP served as the overarching framework for this research task: quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures.

METHODS

The research team undertook an environmental scan that included nine discussions with experts, a focused literature scan that built upon the MAP activities and interaction/feedback from the MAP workgroup itself. The goal of this scan was to winnow a broad set of potential measures (and possible gaps) into a prioritized subset of measures that address the five high-leverage domains and informs the broader MAP goals of drafting a core measure set. Figure 1 below includes a depiction of the major research activities associated with this task, followed by a description of each.

Figure 1. Task 3 Research Approach

Literature review

To ground this task in an evidence base, we reviewed the NQF-supplied literature and began culling additional sources to improve our understanding of the relevant information published around quality metrics concerning duals. This literature review addressed a wide range of topics the team refined based on feedback from informant interviews and under consultation with NQF. Given the considerable amount of work the Duals Workgroup had already accomplished and the preceding research conducted under Task 2, the intent of this literature review was to build upon this body of work, not duplicate it.

As a first step, we reviewed the Duals Workgroup products and Avalere's Task 2. These sources included the current database of NQF-endorsed standards and the following:

- MAP Duals Work Group Measure Table
- MAP Duals Interim Report
- MAP Clinician Coordination Strategy Report
- MAP Safety Coordination Strategy Report
- National Priorities Partnership Input to HHS on the National Quality Strategy

As a second step, L&M created a list of terms and/or relevant combinations of terms and inclusion/exclusion criteria (e.g., publication years, etc.) for use in the search of the extant literature. Search terms mapped to the described aims of the task, and the team systematically tried to address the key research aims through the literature review.

These terms included:

- Quality of life
- Care coordination
- Screening and assessment
- Mental health and substance use
- Structural measures
- Duals, Medi-Medi, Dual eligible
- Spend down
- Disability
- Functional status
- Frail elderly
- Vulnerable population
- Coordination of Medicare/Medicaid
- Fragmentation of care
- Coverage gaps
- Quality of care
- Quality measures
- Quality benchmarks
- Outcomes measures
- Disparities
- Self-directed care

Because the subject of duals is so broad and there is a multiplicity of terms that could have been used during this search to find relevant material, we created a tracking worksheet that included the combination of terms used and the number of relevant sources found in each database (see Appendix C). We refined our search terms throughout the process based on the combination of terms that proved most successful. Using the criteria described above, L&M conducted searches using a combination of databases as well as targeted searches of articles published by relevant organizations and journals as well as the databases/search engines Academic Search Premier, PubMed, and Google Scholar.

To inform the measure development process, the team focused on literature associated with the best practices and challenges related to caring for the population of beneficiaries dually eligible for Medicare and Medicaid. There is sparse literature focusing on the intersection of measures development and caring for the dually eligible: The MAP workgroup reflects an innovative shift in thinking – the need for measures that specifically cater to the needs of this population. For background associated with the development of measures, the research team relied on NQF's reports as well as findings from the MAP workgroup, informant interviews, and the AHRQ Clearinghouse, which provided an additional source of specific measures beyond those initially provided by NQF. For an additional understanding of the most important facets of care delivered to the dually eligible individual, the research team relied on the literature search, its previous research experience around duals, and discussions with key informants.

Measures inventory, review, and prioritization

The team began the task by reviewing a compendium of more than 150 NQF-endorsed measures that each fell into at least one of the five high-leverage domains the MAP workgroup had previously identified as of particular importance to duals: quality of life, care coordination, screening and assessment, mental health and substance use, and structural measures. To create a working set of measures manageable enough to review with stakeholders in one to one-and-a-half hour discussions, while still meaningfully representing the scope of available measures, the research team developed a five-step filtering process. The project team selected measures that fell into the areas of care delivery deemed most relevant to duals (i.e. discharges and follow-ups, transitions, medication management/reconciliation, end-of-life planning, etc.), as guided by the literature and previous relevant research conducted by the team. Within each of those groups, the

team identified measures that best represented coordinated and comprehensive care. For example, the team selected a measure that included identification of a condition, documentation, management, and follow-up rather than one that just measured the frequency for which providers screened for a condition.

Key informant interviews

Following review of the initial measure cull with NQF, the team solicited the expertise of key informants to further explore the existing, as well as ideal or potential, measures. In doing so, the team presented each interviewee with a table of the measures identified through the filtering process and used a protocol with open-ended questions (see Appendix A). Discussions solicited the informant's insights about the areas most relevant to capture when measuring the quality of care delivered to duals, as well as the strengths and weaknesses of the currently available measures. As directed and specified by NQF, the project team conducted nine interactions with key informants representing a range of perspectives during December 2011 and January 2012. Table 1 below lists interviewees, their organizations, and the perspective they offered. The team spoke with a range of interviewees representing different backgrounds so as to acquire a more robust picture of current gaps and barriers in measurement as well as areas that should be emphasized when targeting with duals.

Table 1: Expert discussions

Organization	Individuals	Perspective
Health Management Associates	Jack Meyer	Access issues for special needs populations
State of Minnesota	Pam Parker, Jeff Schiff, Scott Leitz	State concerns
Senior Whole Health/Special Needs Plan (SNP)	John Charde, M.D.	Medical director, SNP, NY
National Program for All-Include Care for the Elderly (PACE) Association	Adam Burrows, M.D., Maureen Amos	Medical director and VP of quality and performance
National Committee for Quality Assurance (NCQA)	Sarah Scholle, Jennifer French	Measurement expertise
State of North Carolina	Denise Levis and team	State concerns
Centers for Medicare & Medicaid Services (CMS)	Cheryl Powell and team.	Federal policy priorities
Kaiser Family Foundation	MaryBeth Musumeci, Barbara Lyons	Data expertise
National Academy for State Health Policy (NASHP)	Neva Kaye, Diane Justice	State health policy expertise

FINDINGS

This section presents a literature summary the team utilized to frame the environmental scan, followed by integrated findings from the scan, identifying the major gaps in the currently

available measures as well as the areas key informants most frequently cited as intrinsic to gauging the nature of care delivered to duals.

Literature summary

Duals have been at the forefront of the push within the last decade to reduce disparities in care through an increased emphasis on quality improvement approaches (Weinick and Hasnain-Wynia, 2011). In December 2010, the Center for Medicare & Medicaid Innovation (CMMI) and the FCHCO together released a Request for Proposals (RFP) for "State Demonstrations to Integrate Care for Dual Eligible Individuals," which ultimately seeks to test a variety of payment system and delivery models that integrate care for duals (Families USA, 2011). The release of this RFP – in addition to the ACA's creation of the FCHCO office itself – signifies an increased nationwide understanding that the opportunity to integrate cross-setting care and funding streams offer great potential in terms of improving the quality and cost of care delivered to this particularly vulnerable population (Bella and Palmer, 2009).

Currently, there are only a few models that represent the kind of cross-setting care integration these demonstrations seek to encourage: special needs plans (SNPs), The Program of All-Inclusive Care for the Elderly (PACE), and Medicaid managed care (MMC) (Bella and Palmer, 2009). SNPs are specialized Medicare Advantage (MA) plans that operate off of capitated premiums to provide Medicare-covered services; they covered just one million enrollees nationwide in 2009. PACE serves only an estimated 20,000 people nationwide, integrating Medicare and Medicaid services through capitated payments through each program (Fontenot and Stubblefield, 2011). Because the program is limited to people who need a nursing home level of care, it serves only a small number of duals (Jacobson, Neuman, Damico, and Lyons, 2010). MMC models vary widely but generally include fee-for-service (FFS) arrangements in conjunction with additional capitated payments to further coordinate care (Fontenot and Stubblefield, 2011).

Although integrated Medicare-Medicaid programs serve a small minority of duals, the literature clearly documents a number of elements needed for integration to be successful. According to the Center for Health Care Strategies (CHCS), these elements include:

- Comprehensive assessment to determine needs, including screening for cognitive impairment/dementia;
- Personalized (person-centered) plan of care, including a flexible range of benefits;
- Multidisciplinary care teams that put the individual beneficiary at the center;
- Involvement of the family caregiver, including an assessment of his or her needs and competency;
- Comprehensive provider networks, including a strong primary care base;
- Strong home- and community-based service options, including personal care services;
- Adequate consumer protections, including an ombudsman;
- Robust data-sharing and communications system; and
- Aligned financial incentives (Gore, Lind, & Somers, 2010).

Studies by Komisar and Feder (2011) and Thorpe (2011) suggest a similar list of elements as well as the importance of their simultaneous presence. In 2010, a study published by Burwell and

Saucier that reviewed the practices of four care management plans for duals noted that all possessed several elements that served as a framework for providing care: supportive services, primary care, medical management, behavioral health management, and member services.

In reality, however, providing quality care through these means is, at the very least, challenging. The traditional barriers to providing quality care for duals still hold true: Across the continuum, providers face fragmentation of financing and care, a lack of integration between medical services and social supports, and a need for more effective measures to gauge the quality of care being delivered (Brookings, 2010). A 2009 CHCS policy brief noted that the challenges associated with integration with SNPs as well as alternative integrated care models included:

- *Administrative/operational challenges* – integration of benefits is difficult due to the lack of alignment between Medicare and Medicaid
- *Financial misalignment* – savings achieved through Medicare are not felt on the Medicaid side and vice versa
- *Low enrollment* – SNPs do not draw large numbers of beneficiaries
- *Forging state-SNP relationships* – there are few contracts established between states and SNPs
- *Developing and bringing model SNPs to scale* – most SNPs do not have experience as Medicare insurers (typically born out of provider-sponsored organizations)

Among the four care management plans Burwell and Saucier (2010) studied, all faced challenges related to overlapping roles, non-comprehensive HIT, and administrative duplication.

As states begin to develop models of care that more consistently cater to the needs of dually eligible populations, overcoming some of these classic challenges, the available measures must reflect the specific needs of this vulnerable population. According to a 2010 report released by the Brookings Institution, performance measures should begin to target the distinct needs and goals of chronically ill patients through "patient- and family-focused" measures, which specifically stress continuity of relationships between patients and providers. The report also noted that while outcome measures provide information crucial to assessing quality, they are oftentimes problematic when it comes to sample sizes, variations in inputs, and risk adjustment. As a first step in developing measures specifically targeting the chronically ill, the focus should be on structure and process measures. Regardless of the approach, the message is clear: the development of an altered approach to measures so they target the needs of this particular population should coincide with the development of innovative integrated care delivery systems themselves.

Potential measures or measure concepts

In general, the notable gaps in the existing measures are the lack of cross-setting, cross-organization applicability and the general clinical orientation of the measures. While certain measures gauge key components of health care delivery, to truly measure the extent of person-centered care delivered to duals, they must be expanded to cover more than one patient condition or multiple settings, including behavioral health as well as non-medical social supports. Furthermore, this population is not homogenous – at the very least there are three distinct groups (frail elderly, younger adults with disabilities, and individuals with behavioral health issues) –

and some measures must be considered differently from one strata to the next. The ultimate compendium of core measures would ideally reflect this heterogeneity. For example, the goal of a frail elderly individual may not be to avoid falls but, rather, to achieve the best quality of life possible, therein staying mobile and possibly enduring falls. To the extent possible, it is important to incorporate the individual's goals, level of functionality, and level of cognition, which vary significantly depending on the individual's personal circumstances.

Interviewees across the board emphasized that, when caring for this highly vulnerable population with complex needs, ongoing person-centered care that focuses resources on those most in need is the paramount goal. And when creating a compendium of measures best suited to gauge the quality of care delivered to duals, the compendium must be structured with this in mind. More specifically, interviewees said, it must measure: 1.) the extent that "high-touch" person-centered care planning and management occurs when needed and 2.) the extent to which the processes and structures in place support this as an ongoing activity. Using person-centered health and well-being as the focal point of measures relevant to duals, interviewees generally expressed the importance of seven key measures areas vital to creating a robust set of measures for duals:

- **Consumer-based assessment of goal-oriented planning and care delivery** – Patient/caregiver/family perception of extent to which care plan (if needed) and care delivered reflect goals and desires of the individual and/or care plan[2]

- **Management and monitoring of specific conditions and disabilities** – Provider and patient active awareness of and engagement with signs and symptoms related to conditions (and clusters of them) to achieve individual's care plan goals

- **Medication management/reconciliation across settings** – Shared management of medications among provider and patient/caregiver focusing on goals of care plan to optimize appropriate use of medication and minimize negative drug interactions

- **Transition management** – Interactions that occur within and across settings among providers with patients and their families to ensure individuals receive comprehensive and streamlined care without duplication

- **Integration and coordination of community social supports and health delivery** – Ability to identify need for and ultimately integrate community social supports into care plan based on individual/caregiver needs

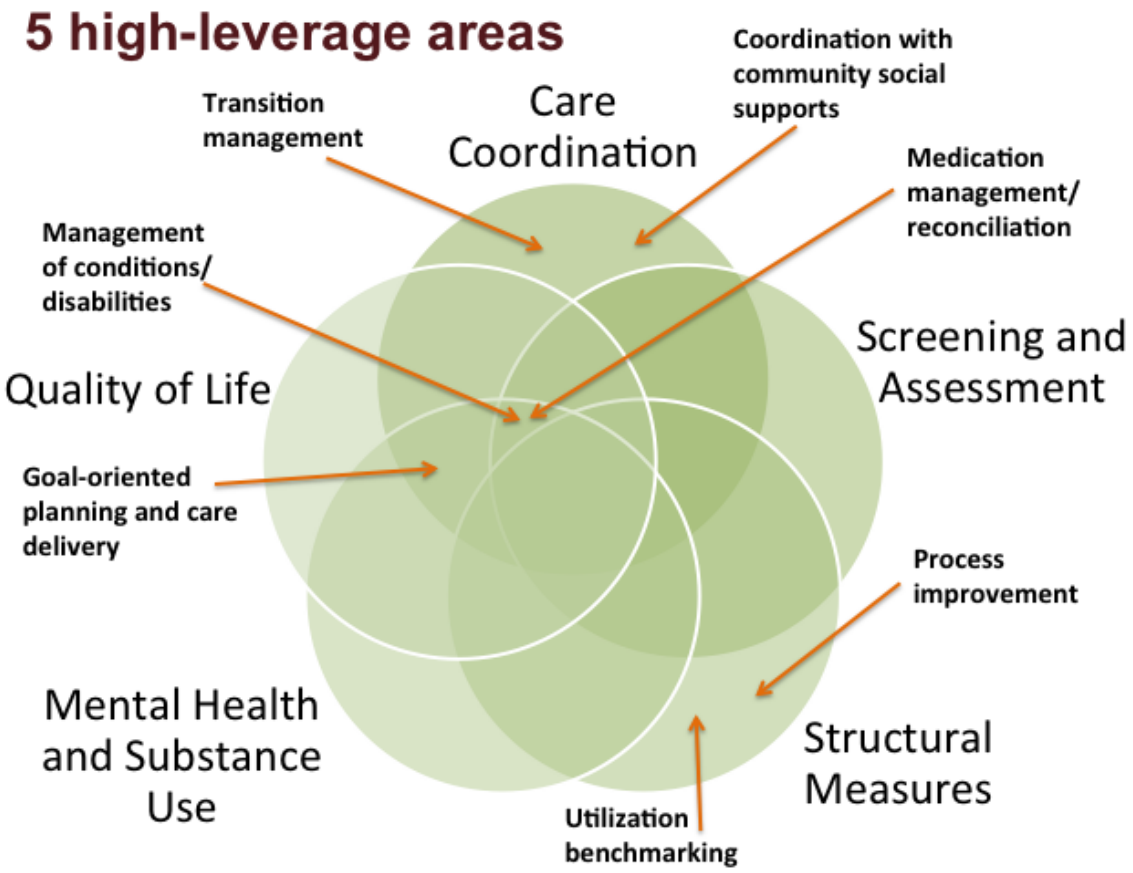
- **Utilization benchmarking** – Ability to gauge the extent of service use among duals and their subpopulations across settings

- **Process improvement across settings** – Ensure quality improvement programs are in place within and across settings and organizations that serve duals and their subpopulations

[2] Multiple interviewees emphasized the importance of not "over-medicalizing" this assessment process for duals, given their many non-medical priorities.

It is important to note that while not all of these focus areas speak directly to quality, the interviewees emphasized the importance of considering some indirect indicators of the status of services delivered to duals to highlight the importance of focusing on the improvement of service delivery across the continuum for this vulnerable population. Taken together, such areas represent a more robust and interconnected picture of the desired delivery system that will encourage "system-ness" with a team of primary service providers continuously recognizing and focusing on individuals' goals. Still, all seven areas fit within the five-high leverage areas the MAP developed as a framework to assess measures of particular importance to duals, as shown in Figure 2 below.

Figure 2. Relationships across five high-leverage areas and key measure areas



To capture all aspects of care delivery, it is important to recognize the focus of measures by dividing them into national-, state-, and provider-level areas. This approach can help clarify which entity is responsible for capturing and monitoring particular aspects of care delivery. Interviewees emphasized that a specific measure captured at the state level could look drastically different from a measure captured at the regional level or even the county or provider level, each telling a different story about the nature of care delivery.

To get a sense of how the existing measures (NQF-endorsed and others from the AHRQ Clearinghouse) fit into the measure areas informants highlighted, the research team created the

table in Appendix B. For each of the seven measure areas, the team chose a combination of measures most reflective of findings from discussions with key informants and pointed out their limitations for future application, therein suggesting areas that require further evolution in quality measurement. Although the team included non-NQF-endorsed measures in the table, it, first, reviewed and used NQF measures pulled from the initial filtering process. Second, it pulled additional measures as needed to round out the picture of currently available measures that fit within each of the seven measure areas.

Appendix B does not represent an exhaustive list of measures that must be applied to duals. Rather, it enumerates examples of selected existing measures related to the seven areas interviewees identified as key to gauging the extent of person-centered care delivery as well as the limitations and gaps that currently exist. Measures related to a specific condition/disability are meant to illustrate the limits of a single-condition measure and are not meant to suggest that one condition is more important to monitor than another. For this exercise, the research team chose measures reflective of the conversations with interviewees, which included a focus on mental health conditions, substance use issues, and diabetes.

Consumer-based assessment of goal-oriented planning and care delivery

Of the seven areas interviewees identified as intrinsic to capturing the quality of care delivered to duals, consumer-based assessment of goal-oriented planning and care delivery was emphasized most prominently. Key informants noted that to truly capture this area, measures must include the presence (or absence) of care plans that focus on the goals of the consumers and/or their families. This aspect of consumer involvement is central to gauging whether quality care is being delivered because oftentimes the goals of the individual are not necessarily the same as those of the clinician – and it is imperative that the individual play a central role in care-related decisions. "When we sit down to develop participant-centered plan with goals, we think of what's important with this person's life – and it's not necessarily medical at all," one informant said. "It may have to do with establishing meaning in life, and we don't have much to assess."

Although interviewees uniformly agreed that care planning should ideally play a central role in duals' experience in the health care system, they also noted that it is challenging to develop meaningful measures that capture more than merely a "yes" or a "no" but, rather, the complexity of components that truly make a care plan useful to the individual. One interviewee noted that when he reviews care plans, he looks for multidimensional assessment across a number of domains – medical, social, functional, and nutritional – that identify patient goals and include an interdisciplinary team. Still, because not all dually eligible beneficiaries are in need of a care plan, measures that are developed to capture this area of care delivery must be flexible in their application.

The currently available measures related to this aspect of care delivery are for the most part limited to Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey measures as well as other sporadically applied consumer and quality-of-life surveys. Appendix B shows a subset of measures that generally fit under the umbrella of this measure area. Still, they all have limitations, either as a result of their application in only a single setting, their lack of consumer input, or their application to a limited population.

Management and monitoring of specific conditions and disabilities

When discussing this measure area, interviewees noted that there currently exist a broad array of measures that fit under this umbrella category, but for the most part they are single-setting, single-condition measures, that do not truly capture the needs of the dually eligible population. As a majority of duals have multiple chronic conditions, it is important to capture the type of care provided to manage and monitor those conditions together across settings. For example, one interviewee noted that his studies have shown that diabetes and cardiovascular disease tend to present together and are also oftentimes accompanied by depression, making them logical to combine into one larger composite measure. "I think the conversation points to the fact that the science of disease-related quality measurement is not caught up with the complex dual population," one interviewee said. "We can measure entities that are measureable – A1C control, etc. – but that constellation of care is probably not as important as other things we should measure. I think it's a difficult area." Approaching disease-related measures in this way – by grouping conditions and monitoring them across settings – promotes a more "whole-person" approach to care that moves beyond viewing single conditions in a vacuum.

Medication management/reconciliation across settings

Interviewees considered this measure area to be "one of the lowest hanging fruits for this population." It is crucial to capture documentation and continued management of medications across settings, which includes communication among multiple providers and continued awareness and engagement of patients/caregivers. Measures must extend well beyond walls of hospitals and primary care physician offices, especially given the number of specialists with whom duals typically interact, interviewees said. As Appendix B shows, there are currently a number of measures that target medication management/reconciliation upon discharge from an acute care setting. While this scenario is clearly important to capture, interviewees emphasized that the measures need to go beyond that – to account for the movement of duals through multiple different settings, not just upon discharge from the hospital. "We simplify medication management a bit too much," one interviewee said. "Hospitals might be doing a good job, but a lot of times they don't know what drugs the patients are on when they come in, then the patients leave with new drugs. It's a much more complex problems we're getting at right now." Of course, the type of measures that can be developed are dependent on the type of data collected: In many cases it is impossible for a provider to know if his or her patient filled a prescription and whether or not the patient takes that medication as directed. Still, the currently available measures can be built upon to focus not just on medication reconciliation within 30 days of discharge (see measure 0554 in Appendix B) to include follow-up and management across multiple settings of care.

Transition management

While there is a plethora of measures associated with transition measurement, many of which focus on key areas such as communication among providers, they are still limited in their scope. Like the currently available measures for medication management/reconciliation, transition measures focus on the acute care setting – from an inpatient facility to the home (see measures 0646, 0647, 0648 in Appendix B), or an emergency department (ED) to an ambulatory setting (measure 0649), or even from one acute care setting to another (measures 0291 through 0297).

Because duals frequently receive care in other settings, such as nursing homes, the limited nature of these measures does not capture the full spectrum of care and the number of equally important transitions that require the same type of management and communication that occurs upon discharge from an acute care setting. According to one informant: "The quality measurement approach tends to work within a setting. That ignores critical handoffs that happens between settings."

Integration and coordination of community social supports and health delivery

Due to the profile of the dually eligible population – poor, elderly, disabled – the integration and coordination of community social supports and health delivery is integral to their receiving quality care. Naturally, though, it may be the most difficult area to measure. As Appendix B shows, there is a paucity of measures that fit into this category, and those that do are generally limited to measures that assess the use of checklists that numerate patient needs for social supports. As this gap in the measures suggests, the development of such measures is problematic because the supports that are particularly important to duals are frequently not covered benefits, and is difficult to determine who should be held accountable.

Ideally, however, a measure set for duals would incorporate such integral elements as: transportation services to and from appointments, safe and clean low-income housing, translation services for non-English speakers, and employment counseling/training. Oftentimes these elements prove larger barriers to quality care than any of the other areas previously discussed. For example, without transportation, duals may be unable to get to their physician appointments, making the management and monitoring of their chronic conditions virtually impossible. Even if an individual has the means to arrive at an appointment, if he or she does not speak English, it may be difficult or impossible to understand a prognosis and how best to manage it.

In the case of some covered benefits, such as home- and community-based services (HCBS) waivers, there is also often little integration. Providers frequently do not alert their patients to the availability of HCBS services because they do not know they exist. When providers are aware of the HCBS system, they may still encounter difficulty in knowing which of their patients receive those services and supports, and how to coordinate them with medical care. In general, this area of the delivery system represents a major gap in measurement for duals: "The measures out there don't capture what's important in lives of individual families we serve. The gaps far dwarf what's actually available to measure quality for this population," one informant said.

Utilization benchmarking

The concept of utilization benchmarking is not traditionally discussed within the context of quality measurement because utilization is not a direct indicator of quality. Still, interviewees emphasized the importance in developing state and national benchmarks that promote a more robust picture of the status of service delivery to duals. Utilization trending at each level would ideally offer a profile of patterns that states, regions, and providers could use when comparing their own care delivery against national and state norms for important areas of service use beyond merely spending per beneficiary (Medicare and Medicaid), hospital days, and length of stay. Interviewees suggested that other high-leverage areas are also important to capture, such as: readmissions, ED visits, number of primary care physician (PCP) and specialty visits, number of

specialists per beneficiary, condition-specific costs, etc. Interviewees said that tracking utilization trends for duals in particular is crucial to understanding the system entry and exit points for duals and gauging utilization trends against established norms so as to target outlier areas for improvement.

Process improvement across settings

Structural measures of capacity for process improvement are also important. Similar to utilization benchmarking, these types of measures are indirect indicators of actual quality of care. Because this measure area generally occurs at the organizational level to inform internal process improvement, it is challenging to measure these types of structures on a widespread basis. But without process improvement, there is no guarantee that any of the direct quality measures will see improvement over time. This measure area would ideally incorporate multiple provider settings and human service settings/organizations and gauge the extent to which they identify and solve problems within and across the continuum of care. As Appendix B shows, measures are trending toward process improvement – to gauge the intricacies of a person-centered medical home structure or the entrenchment of health information technology (HIT) – but there is still work remaining, particularly in determining the appropriate entity to be measured.

Practical issues

When discussing the ideal delivery system areas that should be captured to appropriately gauge the quality of care delivered to duals, interviewees mentioned three areas of practical hurdles that must be accounted for when developing new measures: population, data, and adoption. In terms of population concerns, interviewees emphasized that the current approach to viewing all duals as a single population is inaccurate. There are three distinct populations: frail elderly, younger adults with disabilities, and individuals with behavioral health needs. Because the populations differ drastically in their needs and health statuses, they should not be measured together and in the same way.

In terms of data hurdles, interviewees expressed a number of oft-repeated concerns: 1) the separate Medicare and Medicaid datasets make it nearly impossible to track duals in the data, 2) states have difficulty getting Part D claims in a timely fashion from CMS, which makes medication management challenging, 3) states have difficulty accessing substance abuse data without patient consent, and 4) electronic medical records (EHRs) vary in their state of development and ability to capture advanced data.

Interviewees also expressed concern around the methods associated with adopting new measures targeting duals. Because the population of duals is diverse in its care needs, many measures may suffer from their small sample size, as few duals will meet the criteria for inclusion. Interviewees also warned that because Medicaid programs differ from state to state, the profile of duals receiving certain services may differ across state lines, which will make it difficult to compare "apples to apples." "I would have a checklist for [measure developers] that would ask questions for these measures – is it something that everyone can gather? Is the definition accepted equally? If no on either, I'd drop the measure," one interviewee said. "This is something they are holding people accountable for. There are a minority of measures we can do."

RECOMMENDATIONS

Ultimately, to deliver high-quality care, the literature and interviewed stakeholders noted having an integrated delivery system as the key. To gauge the success of that system, measures must examine the extent to which processes occur across settings, at appropriate times, and in meaningful ways. This approach to measure development requires an evolution beyond the existing array of single-setting, single-condition measures. In doing so, measure developers could consider:

- Identify key components of "system-ness" that are critical to capture in a measure set
- Limit the number of measures so those responsible for focusing on improving quality have particular areas of focus
- Develop clear and specific criteria so that each measure gauges "apples to apples"
- Identify the particular sub-population each measure applies to
- Account for the data source of each measure because pulling and merging data from different agencies can be difficult if not impossible
- Apply consistent requirements across programs that account for meaningful use, as stipulated in the Health Information Technology for Economic and Clinical Health Act (HITECH), requirements to minimize duplication

Ideally, rather than backing into a measure set by incorporating a number of individual, "off the shelf" measures, the process of developing a measure set would begin with the availability and use of primary care providers within some form of a "medical home" and span outward. From, there, the measures set could subsequently include screening and evaluation to determine those most in need of a care plan, the use of a care plan for those individuals, and, ultimately, improved outcomes in relation to the individuals' goals as identified through assessment and screening and outlined in the care plan when needed. Of course, these measures would ideally cover all settings and the full continuum of care provided to duals. This approach would recognize the importance of duals having an identified primary service provider who is acknowledged as their lead advisor and team member, helping them achieve their individual goals – in essence, ensuring that each dual (or ideally all beneficiaries) has a "primary home." Additionally, the approach would even go beyond a "medical home" since the team would take into account more than just medical needs – the focal point of this primary service provider would be the first proxy for quality care.

On the medical side, this would signal an ideal shift to a broader perspective on quality, one that focuses on routine check-ups, management, monitoring, and prevention, which, in turn, avoids frequent cycling in and out of the ED, a pattern that oftentimes impacts duals in greater numbers than other populations. Interviewees recognized that this desired outcome is not currently supported by current health system design or, in some instances, mandated benefits. Nonetheless, an evolving and more sophisticated measure set would view the use of this primary care giving

team in the context of the system as a whole, gauging its frequency of use and availability related to other care settings.

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APPENDIX A: DISCUSSION GUIDE

Introduction

Thank you for speaking with us today. I work for L&M Policy Research, a health policy research firm in Washington, D.C. My research team is working with Avalere Health on behalf of the National Quality Forum (NQF) to provide analytic support for NQF's Measure Applications Partnership (MAP).

As you read in your invitation for this call, NQF convenes MAP to provide multi-stakeholder input to the Department of Health and Human Services (HHS) on the selection of performance measures for use Federal programs. L&M is assisting the MAP in identifying measures of particular importance to Medicare-Medicaid dual-eligible beneficiaries (duals). L&M is tasked with helping NQF review and vet the MAP's initial list of current measures which are potentially appropriate for use in assessing the quality of care delivered to dual eligible beneficiaries.

Today we would like to hear your perspective on measures that may especially pertain to this population group. Additionally, we will ask for your feedback on the list of potential measures. The measures are grouped by five categories that MAP has identified as "high-leverage" in framing quality and the care experience for the duals population. We sent you this list in advance of our call – and for the purposes of this conversation, it will be helpful if you have the list in front of you and can refer back to it, since we will be discussing specific measures. *[Confirm they have it in front of them or help them retrieve it from an email before proceeding with the interview. The interviewee will have the list accessible in the event that the e-mail needs to be sent again.]* Essentially, we are seeking your insight into the top measures identified by the MAP Duals Workgroup as well as your perspective on the gaps in measures available.

We are soliciting input from a range of individuals and appreciate your perspective on these issues. Your honest opinions and comments will be extremely helpful. The information you share today will not be linked to you or your agency/office in any identifiable way in our report. Instead, your comments will summarized in combination with other interviewees by subject matter, without attribution, to provide NQF perspective on the measures under review.

Before we begin, do you have any questions?

General Background

I'd like to start by asking you a few questions about your background and your current role within [insert name of organization].

1. What is your current position and what are your responsibilities? Can you tell me about your experience, particularly as it relates to dual eligible beneficiaries or related issues in healthcare quality?

As I mentioned, the purpose of today's discussion is to discuss a series of quality measures identified by an NQF work group on duals. We are interested in your thoughts on which measures would be most effective given your experience in or with _____

(tailor what you say here to the individual interviewee's description of their relevant experience).

Measure Prioritization

2. The five domains identified by NQF as high-priority for the dual eligible population include:

    - Quality of life
    - Care coordination
    - Screening and assessment
    - Mental health and substance use
    - Structural measures

    Which of these domains seem particularly important to measure? Why? Are any major domains missing? *[Prior to reviewing any measures]*

3. For domain X *[go through all five domains if you have time, starting with the most important domain]* what issues would you consider the most important indicators of quality? Put another way, what are the most important aspects of the care experience for duals and their caregivers/families? Can you provide examples?

4. When considering the group of measures under domain X *(refer to the list developed by taking the best combination of the duals work group and L&M's filtering exercise sent to them in advance of the call),* do any measures seem particularly good or bad to use in assessing the quality of care provided to dual eligible beneficiaries?

Measure Implementation

5. For each of the measures in domain X, what barriers to use do you foresee? For example, is it feasible for providers, health plans, state agencies, and other stakeholders to use the suggested measures?

    a. Would data be readily available, or be retrievable without undue burden? *[Probe: availability of electronic information, reporting requirements, etc.]*

    b. Do you have any concerns related to the potential use of the measures on the list? *[Probe: high risk of unintended consequences]*

    c. Would any of the measures need to be modified before they could be used widely for the purpose of assessing the quality of care for dual eligible beneficiaries?

Gaps in Measures for Duals

6. Considering the list as a whole, do you believe there are important conditions or quality issues for which measures are missing? Do you know of specific measures that are available which could be added to the list to fill those gaps? 7. Do you have any insights related to how measures could be more rapidly developed in order to fill pressing gaps?

For example, we would like to ensure that measures are available at multiple levels of analysis and that there is a mix of process, outcome, structure, patient experience, and resource use measures.

Closing

Finally, do you have any closing comments or questions for us?

We appreciate your taking the time to speak with us and discuss your perspectives. If you have further thoughts or questions after this interview, feel free to contact me or Sarah Lash at NQF. Thank you.

APPENDIX B: DELIVERY SYSTEM AREAS AND MEASURES RELATED TO DUALS

Measure area	Measures	Sample gaps, barriers, & challenges	Comments
Consumer-based assessment of goal-oriented planning in care delivery	****0557-0558 NQF Endorsed:** Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created/ provided to the next level of care clinician or entity.	• Does not include patient perspective in creation of care plan; does not take into account that not all discharged patients may not need care plan • Only gauges whether or not care plan exists – not what it is composed of and to what extent it is referenced	• Ideally, a measure set for this area would gauge consumer satisfaction with cross-setting care and/or of the care plan (if needed) to meet quality of life and quality of service needs • To have measures that include goal planning documented in care plan, one must first identify population in need of care plan. • Such measures run the risk of providers simply checking off the box rather than developing meaningful care plans. Important to have consumer perspective to reflect extent to which individual feels care needs are being met. • Importance of including "goal-oriented planning" because personal desires/goals may be different from what physician deems "clinically correct" or "appropriate." Such goals and priorities may be driven by healthy literacy of patient, circumstances of patient/family/caregiver, patient's age and medical and home conditions • *"When we sit down to develop participant-centered plan with goals, we think of what's important with this person's life – and it's not necessarily medical at all. It may*
	****CAHPS NQF Endorsed** (NQMC:000849, ECHO® Survey 3.0 Adult Questionnaire): Behavioral health care patients' experiences: percentage of adult patients who reported whether someone talked to them about including family or friends in their counseling or treatment.	• Does not include Medicare (only commercial and Medicaid members) and only includes those in an MCO or MBHO • Not available at the provider level	
	****CAHPS NQF Endorsed** (NQMC:000843, ECHO® Survey 3.0 Adult Questionnaire): Behavioral health care patients' experiences: percentage of adult patients who rated how much improvement they perceived in themselves.	• Includes behavioral health patients – large group of duals. But denominator only includes those in an MCO or MBHO • Patients' perceived improvement – but does not necessarily imply existence of care plan that outlines goals	
	****CAHPS NQF Endorsed** (NQMC:006293, CAHPS® Health Plan Survey 4.0H, Adult	• Only includes those in MCO – limited population	

	Questionnaire): Health plan members' experiences: percentage of adult health plan members who reported whether a doctor or other health provider included them in shared decision making	• Not available at the provider level or for specific settings	• *have to do with establishing meaning in life – and we don't have much to assess."* • *"There are ways I look at care plans to see they are multidimensional ... The broad domains are medical, social, functional, and nutritional. I'm looking to see that it's member-centered, it identifies patient goals, and then I want to see some reflection of interdisciplinary medication, problem solving – contributions from multiple disciplines… And the participant signs off on it. That's the real work of interdisciplinary care."*
	****CAHPS NQF Endorsed** (NQMC:004536, CAHPS® Health Plan Survey 4.0, Adult Questionnaire): Health plan members' satisfaction with care: adult health plan members' overall ratings of their health care**.**	• Purely based on 1 to 10 rating of general care received. Lacking in specific areas of care (i.e. individualized care planning) that would really indicate the nature of satisfaction with care • Only includes those in MCO – limited population • Not available at the provider level or for specific settings	
	PSS-HIV (NQMC:002046): HIV ambulatory care satisfaction: percentage of HIV positive adolescent and adult patients who reported how often their case manager went over their service plan and updated it with them every 3 months.	• Limited to one setting (ambulatory) for one patient population (HIV) • Worthwhile to couple measure with measure gauging contents and "meaningfulness" of service plan	
	PSS-HIV (NQMC:002046): HIV ambulatory care satisfaction: percentage of HIV positive adolescent and adult patients who reported how often they wanted to be more involved in making decisions about their service plan and goals.	• Limited to one setting (ambulatory) for one patient population (HIV)	
	PSS-HIV (NQMC:002077): HIV ambulatory care satisfaction: percentage of HIV positive adult	• Concept of measure is important – but is limited to one patient population in one	

	patients who reported whether their substance use counselors helped them to achieve their substance use treatment plan goals.	setting. • Measure could be coupled with existence of "meaningful" care plan that is includes goals of individual	
	Non-U.S., Ministry of Health, Spain (NQMC:004978, AHRQ Clearinghouse) End-of-life care: percentage of healthcare professionals who affirm that in their unit or area enquiries are always made about terminal patients' preferences regarding life-support procedures and treatment.	• Limited to one provider's perspective – process measure as opposed to experience measure. But concept of including documentation of inquiries around end-of-life preferences in individualized care plan is important • Measure limited to "terminal patients" – in ideal world, would extend beyond that population to include advanced care planning • Non-U.S. measure	
	Non-U.S., British Medical Association (NQMC:005100, AHRQ Clearinghouse): Mental health: the percentage of patients on the mental health register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate**.**	• Sentiment of measure is important (existence of care plan agreed upon by individual/family/caregiver) • U.S. has no mental health register. Emphasizes importance of first having a designated patient population in need of care plan before developing a measure gauging extent of care plans' existence • Does not include patient perspective • Only measures the existence of care plan – not its component parts or the extent	

		to which it is followed • Non-U.S. measure	
Management and monitoring of specific conditions and disabilities	**0105 NQF Endorsed:** Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner during the 84-day (12-week) Acute Treatment Phase. b. Percentage of patients who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day Acute Treatment Phase. c. Percentage of patients who were diagnosed with a new episode of depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days.	• Single-condition process measure – no sense of whether course of treatment was correct for individual patient or whether patient adhered to treatment plan; no sense of patient improvement as result of treatment	• Ideally, a measure set for this area would consist of a tailored compendium of measures (composites when feasible) that focus on person-centered care planning (when needed) • The compendium would not only include single-conditions/diseases but also composites that couple screening of multiple conditions or condition clusters – that often present themselves together – at once. • Measures will also ideally integrate management and monitoring of physical, behavioral and social risk factors and conditions • For duals, particularly important conditions and risk factors to assess/measure include but are not limited to: o COPD o Cardiovascular disease o Diabetes o Depression and other serious mental illnesses o Substance use disorders o Intellectual/developmental disabilities or conditions o Multiple chronic conditions/polymedicine • *"Take cardiovascular disease and diabetes. I'm finding that in the poor*
	****0418 NQF Endorsed:** Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented	• Limited to single condition – useful to screen for depression and other conditions that often present with it, particularly for duals	
	0544 NQF Endorsed: Assess the use of and the adherence of antipsychotics among members with schizophrenia during the measurement year	• Limited – better to base on care plan (if it exists) and adherence to all medications taken based on goals of plan	
	0111 NQF Endorsed: Percentage of patients with bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of	• No sense of follow-up across settings, communication with other providers and development of plan with	

	suicide.	patient moving forward	*people with Medicaid, there's a huge cross-over between diabetes and cardiovascular disease – and those two and depression. So it would be nice if we were measuring whether people who have diabetes and cardiovascular disease are evaluated for depression."*
	0112 NQF Endorsed: Percentage of patients treated for bipolar disorder with evidence of level-of-function evaluation at the time of the initial assessment and again within 12 weeks of initiating treatment	• Limited to the evaluation – does not include goals of patient related to function	
	0110 NQF Endorsed: Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use	• No sense of follow-up across settings, communication with other providers and development of plan with patient moving forward	
	0077 NQF Endorsed: Percentage of patient visits for those patients aged 18 years and older with a diagnosis of heart failure with quantitative results of an evaluation of both current level of activity and clinical symptoms documented	• Single-condition measure with no sense of follow-up or long-term management	
	0076 NQF Endorsed: Percentage of adult patients ages 18 to 75 who have ischemic vascular disease with optimally managed modifiable risk factors (LDL, blood pressure, tobacco-free status, daily aspirin use).	• Single-condition measure with only one standard for "optimally managed" – no sense that patients vary in needs and goals	
	****CAHPS NQF Endorsed** (NQMC:000850, ECHO® Survey 3.0) Behavioral health care patients' experiences: percentage of adult patients who reported whether they were given enough information to manage their condition.	• Does not account for whether the information given to them was in line with care goals	
Medication management	**0554 NQF Endorsed:** Percentage of discharges from January 1 to December 1 of the measurement	• Limited to single act of "reconciliation" – no sense of whether patients have a plan	• Ideally, a measure set for this area would focus on management of medications across providers and

/reconciliation across settings	year for patients 65 years of age and older for whom medications were reconciled on or within 30 days of discharge.	for managing or understanding of how to manage medications; no sense of provider follow-up in management	settings so as to ensure appropriate use of medications and avoid duplications/unnecessary side effects • It is important to capture documentation and continued management of medications across settings, which includes communication among multiple providers and continued awareness and engagement of patients/caregivers. Measures must extend well beyond walls of hospitals and primary care physician offices, especially given the number of specialists with whom duals typically interact. • *"We simplify medication management a bit too much. Hospitals might be doing a good job, but a lot of times they don't know what drugs patients are on when they come in, then the patients leave with new drugs. It's a much more complex problem we're getting at right now."*
	0419 NQF Endorsed: Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verified with the patient or authorized representative documented by the provider.	• No sense of whether patient actually takes the medications and whether that list is communicated to all relevant providers	
	0553 NQF Endorsed: Percentage of adults 65 years and older who had a medication review	• Does not cross settings/providers or measure the extent to which medications are actually managed following review – no sense of follow-up beyond initial review	
	0520 NQF Endorsed: Percent of patients or caregivers who were instructed during their episode of home health care on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems	• No patient perspective – important to gauge whether patient actually understood instructions so as to manage own medications	
	****CAHPS NQF Endorsed** (NQMC:002460, CAHPS Hospital Survey (HCAHPS)): Hospital inpatients' experiences: percentage of adult inpatients who reported how often the hospital staff communicated well about medications.	• Limited to experience in hospital setting	

	NCQA (NQMC:002922) Geriatrics: percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.	• No sense of whether medication list was explained to and understood by patient and whether there was follow-up to make sure patient was managing medications. Documentation does not signal adherence to medication list	
Transition management	**0646-**0647 NQF Endorsed:** Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a reconciled medication list/ transition record/ at the time of discharge including, at a minimum, medications in the specified categories	• Limited to measuring transition from acute care setting but stops there. • Missing component of reinforcement – either a visit to home to make sure management of medications is occurring properly or, at least, reinforcement through communication with PCP	• Ideally, a measure for this area would track a patient's transition within and across multiple settings, throughout the full continuum of care - noting communication among providers, services agencies, and patients/families/caregivers; documentation of conditions; and follow-up • Transition management tends to stop when patient is discharged from hospital and not extend to other settings. Measures for this area must encourage and capture whether communication and documentation occur among multiple providers in various settings.
	0648 NQF Endorsed: Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	• Important in that it measures level of communication among providers and follow-up but only focuses on movement from inpatient facility	
	0649 NQF Endorsed: Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their	• Limited to transition from hospital setting; no sense of whether follow-up regularly occurs (despite existence of	

	caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements	transition record) • Still, important measure for duals because many enter system through ED	
	0291-0297 NQF Endorsed: Percentage of patients transferred to another acute hospitals whose medical record documentation indicated that administrative information/ vital signs/ medication information/ patient information/ physician information/ nursing information/ procedures and tests was communicated to the receiving hospital within 60 minutes of departure.	• Does not include Medicare (only commercial and Medicaid members)	
	0291-0297 NQF Endorsed: Percentage of patients transferred to another acute hospitals whose medical record documentation indicated that administrative information/ vital signs/ medication information/ patient information/ physician information/ nursing information/ procedures and tests was communicated to the receiving hospital within 60 minutes of departure.	• Only focuses on transfer of information in acute care setting	
	****CAHPS NQF Endorsed** (NQMC:006296, CAHPS® Health Plan Survey 4.0H, Adult Questionnaire): Health plan members' experiences: percentage of adult health plan members who reported how often their personal doctor seemed informed and up-to-date about care they got from other	• Limited to those in MCO (might mean a limited group of physicians as well as patient population)	

	doctors or other health providers.		
Integration and coordination of community social supports and health delivery	**Non-U.S., British Medical Association** (NQMC:003014) Management: the practice has a protocol for the identification of [caregivers] and a mechanism for the referral of [caregivers] for social services assessment.	• Only applies to one practice at a time – no sense of larger community presence and integration of community social supports • Non-U.S. measure	• Ideally, a measure set for this area would gauge the extent of community and social supports available and the ease with which an individual can access those services • Examples include availability of and connections with: o Transportation services to and from appointments o Safe and clean low-income housing o Translation services for non-English speakers o Employment counseling/training
	PSS-HIV (NQMC:002031): HIV ambulatory care satisfaction: percentage of HIV positive adolescent and adult patients who reported whether their providers or case managers asked them how they were feeling emotionally and made a referral to a mental health provider, counselor, or support group if needed.	• Limited to HIV patients in ambulatory setting and only includes a couple specific types of supports; additionally, no sense that the patient actually accessed the service or that there was follow-up	
Utilization benchmarking	****0329 NQF Endorsed:** Overall inpatient 30-day hospital readmission rate	• Need state and national benchmarks for this to be useful and translate into actionable process improvements	• Ideally, a measure set for this area would track overall utilization trends and those for subpopulations across all settings and develop comprehensive set of national benchmarks for states, regions, and providers • Utilization trending at each level would offer a profile of patterns which states and providers could use in comparing their own care delivery for important areas of service use beyond overall spending per beneficiary (Medicare and Medicaid) hospital days and length of stay but also focusing on high leverage areas such as: readmissions, ED visits, number of
	0330 NQF Endorsed: Hospital-specific, risk-standardized, 30-day all-cause readmission rates for Medicare fee-for-service patients discharged from the hospital with a principal diagnosis of heart failure (HF).	• Need state and national benchmarks for this to be useful and translate into actionable process improvements	
	NCQA HEDIS (NQMC:006257): Ambulatory care: summary of utilization of ambulatory care in the following categories: outpatient visits and emergency department visits.	• Only includes outpatient and ED visits • Medicaid, Medicare, commercial managed care	

	NCQA HEDIS (NQMC:006258, AHRQ Clearinghouse): Inpatient utilization--general hospital/acute care: summary of utilization of acute inpatient care and services in the following categories: total inpatient, medicine, surgery, and maternity.	• Only includes managed care plans and not duals who may have no medical home	PCP and specialty visits, number of specialists per beneficiary, condition-specific costs, etc. • *"There's a huge unmet need for meaningful measures…In an effort like this I'd be more inclined to get coordination around the ultimate outcomes – institutionalization, end-of -life care costs, cost utilization measures. I think I feel more passionate about needing that for benchmarking rather than micro-managing process measures within a program."*
Process improvement across settings	****0490 NQF Endorsed:** Documents the extent to which a provider uses a certified/qualified electronic health record (EHR) system capable of enhancing care management at the point of care. To qualify, the facility must have implemented processes within their EHR for disease management that incorporate the principles of care management at the point of care which include: (a.) The ability to identify specific patients by diagnosis or medication use (b.) The capacity to present alerts to the clinician for disease management, preventive services and wellness (c.) The ability to provide support for standard care plans, practice guidelines, and protocol	• Process improvement measures generally need to be pinpointed by and tailored to individual organizations/settings • Must determine which types of organizations are required to undertake certain processes and determine which types of processes are most important for which kinds of organizations	• Ideally, a measure set for this area would incorporate multiple provider settings and human service settings/organizations to ultimately address population health • Measures in this set represent areas where there is room for innovation and improvement in and among individual settings • Challenging measure area because process improvement is oftentimes identified by a single organization or even within a single hospital or social service department. Represents importance of identifying and solving problems across, among, and within a setting, but needs to be encouraged across

	****0494 NQF Endorsed:** Percentage of practices functioning as a patient-centered medical home by providing ongoing, coordinated patient care. Meeting Medical Home System Survey standards demonstrates that practices have physician-led teams that provide patients with: (a.) Improved access and communication (b.) Care management using evidence-based guidelines (c.) Patient tracking and registry functions (d.) Support for patient self-management (e.) Test and referral tracking (f.) Practice performance and improvement functions	• *"Measuring the number of practices in there that have a medical home is not the way to go. People are not equally distributed among all practices. There are some other proxies. Some things around identifying usual sources of care – softer areas – might get at the patient perspective."* • *"Yes, this is what the medical home should do, but the question is how do you check it?"*	the full continuum of duals care delivery.

**MAP core measure for dual eligible beneficiaries

APPENDIX C: LITERATURE TRACKING SHEET

Database	Term used	Other filters	Hits	Pulled
Academic Search Premier	Quality measures +duals		11	0
Academic Search Premier	Measures + duals + quality of care		3	0
Academic Search Premier	Quality benchmarks + duals		0	0
Academic Search Premier	Benchmarks + duals +quality		19	0
Academic Search Premier	Benchmarks + dual eligible +quality		0	0
Academic Search Premier	Measuring +dual eligibles		1	0
Academic Search Premier	Quality of care + dual eligibles		1	0
Academic Search Premier	Quality of care + vulnerable populations		15	0
Academic Search Premier	Quality of care + disparities +measures		65	5
Academic Search Premier	Coverage gaps + disparities + measures		0	0
Academic Search Premier	Quality of care + disparities + benchmarks		3	0
Google Scholar	Quality measures + duals	since 2002	127	1
Google Scholar	Quality of care + duals + benchmarks	since 2002	35	1
Google Scholar	Measuring + dual eligibles	since 2002	312	0
Google Scholar	Best practices + dual eligibles	since 2002	202	1
PubMed	Dual eligibles + measures		4	0
PubMed	Dual eligibles + best practices		0	0
PubMed	Dual eligibles + quality		0	0
PubMed	Benchmarks + duals		0	0
PubMed	Quality measures + duals		0	0
PubMed	Quality of care + measures + disparities	Full text	129	1
PubMed	Dual eligible		46	0
MedPAC	Dual eligible		Culled site	0
NCQA	Dual eligible		124	1
Robert Wood Johnson Foundation	Dual eligible		8	0
The Commonwealth fund	Dual eligible		133	0
Kaiser Family Foundation	Dual eligible		Culled site	0
New England Journal of Medicine	Dual eligible		111	1
CHCS	Dual eligible		28	4
Mathematica Policy Research	Dual eligible		35	0
Health Affairs	Dual eligible + quality measures		352	2
SCAN Foundation	Dual eligible		Culled site	0

AHRQ	(culled the measures)		N/A	N/A

L&M POLICY RESEARCH

Appendix I: Measure Endorsement and Maintenance

NQF offers three primary opportunities for communication with measure developers to improve the applicability of measures to the dual eligible population. These opportunities include new calls for measures, annual measure updates, and measure maintenance reviews.

NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry. NQF's measure endorsement activities are standardized in a regular cycle of topic-based measure evaluation. NQF follows a three year schedule that outlines the review and endorsement of measures in 22 topic areas such as cardiology, behavioral health, and functional status. As the need arises, the topic areas may be revised to account for measures that may require a new or more appropriate topic area.

As an endorsing body, NQF is committed to ensuring the performance measures it endorses continue to meet the rigorous NQF measure evaluation criteria. Every three years, endorsed measures are re-evaluated against these criteria and are reviewed alongside newly submitted (but not yet endorsed) measures. This head-to-head comparison of new and previously endorsed measures fosters harmonization and helps ensure NQF is endorsing the best available measures.

NQF also facilitates a process through which measures can be updated on an annual basis. Prior to the scheduled three-year maintenance review, stewards of endorsed measures provide NQF with any modifications to the measure specifications, current evidence supporting the measure, data supporting use of the measure, testing results, and other relevant information. NQF also solicits stakeholder input on implementation and use of the measure, changes in evidence, scientific soundness, and feasibility.

In the two years when an endorsed measure is not being re-evaluated for continued endorsement, measure stewards will submit a status report of the measure specifications to NQF. This report will either reaffirm that the measure specifications remain the same as those at the time of endorsement or last update, or outline any changes or updates made to the endorsed measure. An ad hoc review will be conducted if the changes materially affect the measure's original concept or logic.