

MEASURE APPLICATIONS PARTNERSHIP

Promoting Integrated and Coordinated Care that Addresses Social Risk for the Dual Eligible Beneficiary Population, 2017

FINAL REPORT
AUGUST 31, 2017



NATIONAL
QUALITY FORUM

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I, Task Order HHSM-500-T0011.

CONTENTS

EXECUTIVE SUMMARY	2
FOREWORD	4
INTRODUCTION	6
MAINTAINING THE MAP DUAL ELIGIBLE BENEFICIARIES FAMILY OF MEASURES	7
MEASUREMENT-RELATED TOPICS	13
STRATEGIC ISSUES	18
CONCLUSION	20
APPENDIX A: MAP Background	23
APPENDIX B: Rosters for the MAP Dual Eligible Beneficiaries Workgroup, MAP Coordinating Committee, and NQF Staff	24
APPENDIX C: MAP Measure Selection Criteria	27
APPENDIX D: MAP Dual Eligible Beneficiaries Family of Measures (2017 Update)	30
APPENDIX E: MAP Dual Eligible Beneficiaries Starter Set	46
APPENDIX F: Public Comments	47

EXECUTIVE SUMMARY

American citizens who are dually eligible to enroll both in Medicare and Medicaid are a growing population of more than 11 million individuals with complex needs who require high levels of services and support.¹ Improving healthcare and supportive services for dual eligible individuals has the potential to make significant differences in their health and quality of life as well as address the disproportionately high costs of their care.

Annually, dual eligible beneficiaries comprise 20 percent of Medicare beneficiaries, but account for 34 percent of Medicare spending at approximately \$187 billion. Similarly, dual eligible beneficiaries comprise 15 percent of Medicaid beneficiaries, but account for 33 percent of spending at approximately \$119 billion.² These individuals are “high-risk” because of their higher incidence of multiple disabilities, including health diagnoses and complex clinical conditions, all of which are compounded by poverty.

Performance measurement is essential to improve the quality and value of healthcare services for these vulnerable populations. The National Quality Forum (NQF) convenes the Measure Applications Partnership (MAP), a public-private collaboration of healthcare stakeholders, to provide input to the U.S. Department of Health and Human Services (HHS) on the selection of quality measures for use in public reporting and performance-based payment programs. Through the efforts of its Dual Eligible Beneficiaries Workgroup (the Workgroup), MAP builds on its previous efforts to improve care for the dual eligible population and provides updates to the MAP Dual Eligible Beneficiaries Family of Measures.

The MAP Dual Eligible Beneficiaries Family of Measures is a group of the best available measures selected and recommended to address the needs of the dual eligible population and to identify high-leverage opportunities for improvement across the continuum of care. With this year’s updates, the current MAP Dual Eligible Beneficiaries Family

of Measures now contains 71 measures that are a mixture of measure types (e.g., structure, process, and outcome) that cross both settings and levels of analysis (e.g., individual provider, facility, or population).

In its 2017 review of the MAP Dual Eligible Beneficiaries Family of Measures, MAP supports the removal of four measures.

Measure Removals from the MAP Dual Eligible Beneficiaries Family of Measures

- NQF #0043 *Pneumococcal Vaccination Status for Older Adults (PNU)*
- NQF #0557 *HBIPS-6 Post Discharge Continuing Care Plan Created*
- NQF #0558 *HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge*
- NQF #0682 *Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)*

MAP supports the addition of five measures to the MAP Dual Eligible Beneficiaries Family of Measures.

Measure Additions to the MAP Dual Eligible Beneficiaries Family of Measures*

- NQF #2775 *Functional Change: Change in Motor Score for Skilled Nursing*
- NQF #2776 *Functional Change: Change in Motor Score in Long Term Acute Care Facilities (LTACs)*

- NQF #2858 *Discharge to Community*
- NQF #2967 *CAHPS® Home- and Community-Based Services Measures**
- NQF #3086 *Population Level HIV Viral Load Suppression*

Following the in-person meeting, NQF's Consensus Development Approval Committee (CSAC) withdrew endorsement from four measures within the MAP Dual Eligible Beneficiaries Family of Measures. Among the reasons why the CSAC did not recommend continued endorsement were concerns about reliability testing and data on opportunities for improvement. As the MAP Dual Eligible Beneficiaries Family of Measures consists of currently endorsed measures, the following were removed.

Measure Removals from the MAP Dual Eligible Beneficiaries Family of Measures due to loss of NQF Endorsement*

- NQF #0646 *Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or any other Site of Care)*
- NQF #0647 *Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or any other Site of Care)**
- NQF #0648 *Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or any other Site of Care)**
- NQF #0649 *Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)*

The report also addresses strategic issues from the Workgroup about coordination and integration of various stakeholders to measure and develop dual eligible beneficiary survey instruments. They recommended that HHS develop a collaboration strategy for federal agencies and work with community-based organizations to accomplish these objectives.

In addition, the Workgroup discussed the need for a paradigm shift in measure conceptualization and development. Measure development currently uses a top-down systems approach, which insufficiently captures and assesses areas for which measures are insufficient or nonexistent for this population.

The Workgroup discussed adjusting measures for social risk factors and emphasized the need for a population-based measurement framework that recognizes and measures the effects of social risk factors on health outcomes. The Workgroup identified **11 social risk factors** that underscore the complexity of the population. The Workgroup recommended that measures should account for and address these identified factors. Of the 11 social risk factors, the most commonly cited ones included social support, residential and community context, along with socioeconomic position/status/income.

The Workgroup concluded that a change in the measurement paradigm will allow for a system view of both medical and nonmedical measures as well as address social determinants of health, which are the conditions in which people are born, grow, live, age, and work.³ However, the Workgroup emphasized that this change to the measurement paradigm must be person-focused and address what matters most from the beneficiaries' perspective.

* An asterisk (*) indicates a measure is or was in the Starter Set for dual eligible beneficiaries. For information on the Starter Set see [Appendix E](#) of the report.

FOREWORD

Dual eligible beneficiaries are a growing population of more than 11 million individuals with complex needs who require high levels of services and supports.⁴ Annually, dual eligible beneficiaries comprise 20 percent of Medicare beneficiaries but account for 34 percent of the spending at approximately \$187 billion. Similarly, dual eligible beneficiaries comprise 15 percent of Medicaid beneficiaries but account for 33 percent of spending at approximately \$119 billion.⁵ Given the burden and cost of care for these beneficiaries, these individuals are collectively referred to as “high-risk” because of their higher incidence of multiple disabilities, including mental health disabilities, and complex clinical conditions, all of which poverty compounds.

In March 2017, as co-chairs of the Measure Applications Partnership (MAP) Dual Eligible Beneficiaries Workgroup, we had the privilege and challenge of recommending measures that accurately capture what quality means to these beneficiaries, as well as their families, providers, caregivers, social workers, payers, disability communities, academic research centers, and other stakeholders. The Centers for Medicare & Medicaid Services (CMS) had the foresight six years ago to establish this Workgroup because it understood that the issues of dual eligible beneficiaries are unique. Determining what measures would best apply to dual eligible beneficiaries requires a focus for which the existing silos of MAP measurement are not well suited.

We would like to thank CMS for supporting this work for the past six years. We would also like to acknowledge and commend CMS’ commitment to improving the health and quality of life of this diverse population. Dual eligible beneficiaries include both young and old people with physical, developmental, and other disabilities who use long-term services and supports, people with a variety of health challenges, and those for whom

the social risk factors of health are as critical as the traditional healthcare system. The Workgroup has highlighted the uniqueness of this population during its deliberations, and as its work comes to an end, the Workgroup urges CMS to keep focus on the needs of this growing population.

The continued expansion of the dual beneficiary population, along with rapid changes in healthcare delivery, highlights the need for quality measurement that focuses on dual eligible beneficiaries. Therefore, as CMS focuses on specific quality measure development and testing, the Workgroup encourages CMS to keep these beneficiaries at the forefront and ensure that their voices are heard.

The members of this Workgroup have been tireless in their support of dual eligible beneficiaries and have helped shape the measurement dialogue by introducing and advocating for topics such as clinical measures, along with strategies to support improved quality-of-life outcomes, advancing person- and family-centered care, and connections across healthcare and community supports and services. Some examples of our past recommendations include:

- Emphasizing the role of community in keeping the population healthy and stable;
- Recognizing that consumers’ health outcomes and quality of life should be the primary driver of an integrated system;
- Acknowledging that delivery system should put consumers in control of setting health-related goals given that engaged consumers can achieve positive outcomes that benefit them and reduce healthcare expenditures;
- Aligning current reporting requirements by focusing on measures from the MAP Dual Eligible Beneficiaries Family of Measures ([Appendix D](#));

- Eliminating nonessential measurement, attestation, and regulatory requirements to free up the system from inefficiency while investing in innovation; and
- Stratifying measures using variables to better understand the impact of disparities in the dual eligible beneficiary population.

Recognizing the imperative to keep innovating and improving care for dual eligible beneficiaries, we hope this report provides strategic guidance that fosters collaboration, communication, and informed collective action to assure the best care and health for this important, growing segment of our country's population.

MAP Dual Eligible Workgroup Co-Chairs

Jennie Chin Hansen RN, MS, FAAN

Michael Monson, MPP

Nancy Hanrahan PhD, PN, FAAN
(Inactive March-May, 2017)

INTRODUCTION

The National Quality Forum (NQF) convenes the Measure Applications Partnership (MAP) as a public-private partnership of healthcare stakeholders. In pursuit of the [National Quality Strategy](#) goals of improving the quality, affordability, and community impact of healthcare, MAP provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. MAP also helps to identify gaps in measure development and encourages measure alignment across public and private programs, settings, levels of analysis, and populations. [Appendix A](#) provides information and background on MAP.

The MAP Dual Eligible Beneficiaries Workgroup is a 22-member, multistakeholder group that serves as one of four advisory workgroups to the MAP Coordinating Committee ([Appendix B](#)). The Workgroups advise the Coordinating Committee on the use of measures to encourage performance improvement based on the MAP Measure Selection Criteria (MSC) and other inputs ([Appendix C](#)). The MAP Dual Eligible Beneficiaries Workgroup provides guidance on performance measures to assess and improve healthcare in the population of individuals dually eligible for Medicare and Medicaid.

Dual eligible beneficiaries are a growing population of more than 11 million individuals with many complex needs who require high levels of care.⁶ Spending for dual eligible beneficiaries is disproportionately high. Annually, they comprise 20 percent of Medicare beneficiaries but account for 34 percent of the spending at approximately \$187 billion. Dual eligible beneficiaries comprise 15 percent of Medicaid beneficiaries but account for 33 percent of spending at approximately \$119 billion.⁷ The primary driver of these high costs is the higher incidence among dually eligible beneficiaries of multiple disabilities, including mental health disabilities, and complex clinical conditions, all of which poverty compounds. In this diverse and often complex population, 77 percent of individuals have diagnoses across two or more condition groups of physical or mental illness; 60 percent have diagnoses

across three or more; 41 percent have diagnoses across four or more; and 25 percent have diagnoses across five or more condition groups.⁸

In prior meetings, the Workgroup addressed strategies to support improved quality-of-life outcomes, advancing person- and family-centered care and connections across healthcare and community supports and services. Past recommendations include:

- Emphasizing the role of community in keeping the population healthy;
- Recognizing that consumers' health outcomes and quality of life should be the primary drivers of an integrated system;
- Putting consumers in control of setting health-related goals;
- Aligning current reporting requirements by focusing on measures from the MAP Dual Eligible Beneficiaries Family of Measures ([Appendix D](#));
- Eliminating nonessential measurement, attestation, and regulatory requirements to free up the system for innovation; and
- Stratifying measures using variables of interest to better understand the impact of disparities in the dual eligible population.⁹

This report describes the latest round of Workgroup-informed guidance/recommendations from MAP on the use of performance measures to assess and improve healthcare for individuals dually eligible for Medicare and Medicaid. The report includes updates to the MAP Dual Eligible Beneficiaries Family of Measures, discusses remaining measure gaps, and provides an overview of current efforts related to addressing social risk factors and health disparities. The report also discusses the potential benefit of adjusting measures for social risk factors.

As part of its commitment to transparency and collaboration, NQF invited public comments on this report, receiving 13 comments from six organizations ([Appendix F](#)).

MAINTAINING THE MAP DUAL ELIGIBLE BENEFICIARIES FAMILY OF MEASURES

The MAP Dual Eligible Beneficiaries Family of Measures is a group of the best available measures that the Workgroup selects and recommends for use to address the needs of this population and to identify high-leverage opportunities for improvement across the continuum of care. Since 2012, MAP identified families of measures across a variety of topics such as safety and affordable care. In 2013, MAP established the MAP Dual Eligible Beneficiaries Family of Measures with the goal of driving improvement in specific areas that affect healthcare quality for dual beneficiaries.¹⁰ In 2014, the MAP Dual Eligible Beneficiaries Workgroup established a Starter Set of measures meant to guide those selecting and implementing measures in the field by indicating the highest-priority measures for dual beneficiaries.¹¹

Approach

All MAP workgroups, including the MAP Dual Eligible Beneficiaries Workgroup, rely on the Measure Selection Criteria (MSC) ([Appendix C](#)) to standardize measure evaluation and recommendations across all topics. Workgroup members select measures to include in the MAP Dual Eligible Beneficiaries Family of Measures based on the MSC with particular attention to measures addressing person- and family-centered services, healthcare disparities, and cultural competence. In the absence of a specific quality measure reporting program, the MAP Dual Eligible Beneficiaries Workgroup makes recommendations about the use of measures to address the needs of the population.

The Workgroup periodically reviews the MAP Dual Eligible Beneficiaries Family of Measures to ensure that it contains the best measures currently available. Periodic reviews are important as the dual beneficiary population continues to grow, and as measurement science evolves and produces new measures with the potential to address

the population's needs. To maintain the MAP Dual Eligible Beneficiaries Family of Measures, Workgroup members evaluate measures with changes to endorsement, review newly available measures, and work to achieve consensus on any changes to measures included in the MAP Dual Eligible Beneficiaries Family of Measures.

The Starter Set of measures is a subset of measures in the MAP Dual Eligible Beneficiaries Family of Measures that are most ready for implementation as currently specified. Generally, these measures demonstrate the Workgroup's preference for cross-cutting measures and condition-specific measures that address critical clinical issues across the population. The Workgroup periodically reviews this set in tandem with the other measures in the MAP Dual Eligible Beneficiaries Family of Measures. Although the Workgroup reviewed the Starter Set during the previous MAP cycle, it voted off-cycle to add a newly endorsed measure to the Starter Set.

Building Consensus

NQF staff completed the preliminary analysis that took into consideration the MSC, including measure alignment with population characteristics, and the Workgroup's input on high-leverage opportunities for improvement and priority gap areas from previous in-person deliberations.

Workgroup members discussed removing measures from the MAP Dual Eligible Beneficiaries Family of Measures if they had endorsement status changes such as endorsement removal since the Workgroup's last in-person meeting in the spring of 2016. Members also considered measures that received NQF endorsement since the Workgroup's last in-person deliberations. In doing so, members reflected on whether these newly endorsed measures address the priorities for measurement and/or gap areas. The Workgroup approved changes to the MAP Dual Eligible Beneficiaries

Family of Measures by a consensus vote in which more than 60 percent of votes supported a change.

Measures with Changes to Endorsement Status

The MAP Dual Eligible Beneficiaries Workgroup considered four measures in the MAP Dual Eligible Beneficiaries Family of Measures that have had changes in endorsement status since its last meeting. Harmonization with another measure, placement on reserve status due to limited opportunities for improvement, or endorsement removal are all causes for changes to endorsement. Concerns about measure reliability, validity, other **Measure Evaluation Criteria**, or discontinuation of maintenance by the measure steward are among the reasons NQF removes endorsement. When stewards do not maintain measures, the measures are not updated and do not have current specifications or current data on reliability, validity, and performance. The Workgroup voted to remove the measures that are no longer NQF-endorsed from the MAP Dual Eligible Beneficiaries Family of Measures. As a rationale for removing measures no longer endorsed, the Workgroup emphasized the importance of measures that represent the most up-to-date care guidelines.

Measures Removed from the MAP Dual Eligible Beneficiaries Family of Measures

The Workgroup voted to remove two pneumococcal vaccination and two continuing care planning measures from the MAP Dual Eligible Beneficiaries Family of Measures. Additionally, following the in-person meeting, NQF's CSAC withdrew endorsement of four measures within the MAP Dual Eligible Beneficiaries Family of Measures.

Pneumococcal Vaccination

The Workgroup removed NQF #0043 *Pneumococcal Vaccination Status for Older Adults (PNU)* because the developer did not submit the

measure for required NQF maintenance review.

The Workgroup also removed NQF #0682 *Percent of Residents or Patients Assessed and Appropriately Given the Pneumococcal Vaccine (Short-Stay)* because the developer is no longer maintaining the measure.

The Workgroup discussed the importance of measuring pneumococcal vaccination for the duals population. The updated Centers for Disease Control and Prevention (CDC) guidelines now recommend a two-step vaccination process of both 3-Valent Pneumococcal Conjugate vaccine and 23-Valent Pneumococcal Polysaccharide vaccine among adults aged 65 years or older.¹² NQF #0043 and NQF #0682 do not reflect this update. The Workgroup recommended that, when available, the MAP Dual Eligible Beneficiaries Family of Measures include a measure that reflects the updated guidelines.

Continuing Care Planning

The Workgroup removed NQF #0558 *HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge* and NQF #0557 *HBIPS-6 Post Discharge Continuing Care Plan Created* because the developer withdrew both measures from required NQF maintenance review.

Following the Workgroup in-person meeting, the CSAC removed endorsement from four measures from NQF's Care Coordination portfolio during the 2016-2017 review.

- NQF #0646 *Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or any other Site of Care)*. The CSAC supported the Standing Committee's recommendation not to endorse the measure due to the absence of performance scores and disparities data.
- NQF #0647 *Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or any other Site of Care)*. The CSAC

removed endorsement because it did not accept the reliability testing.

- NQF #0648 *Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or any other Site of Care)*. The CSAC agreed with the Standing Committee that the measure lacked current data on the opportunity for improvement, and it did not accept the reliability testing.
- NQF #0649 *Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)*. The CSAC agreed with the Standing Committee's decision not to support the measure because it could not determine if the measure addresses a quality problem in healthcare.

The removal of these six measures that assess transitions of care leave the MAP Dual Eligible Beneficiaries Family of Measures with only one other measure that addresses this issue which is NQF #0228 *3-Item Care Transition Measure (CTM-3)*. This creates a potential measurement gap within the MAP Dual Eligible Beneficiaries Family of Measures.

Consideration of Newly Endorsed Measures

The Workgroup only considered measures relevant to the dual eligible beneficiary population that NQF newly endorsed since the last in-person meeting in April 2016. The Workgroup did not review measures that did not specifically address a priority gap area or high-leverage opportunity for improvement. Generally, public comments received supported the Workgroup's changes to the MAP Dual Eligible Beneficiaries Family of Measures.

Measures Added to the MAP Dual Eligible Beneficiaries Family of Measures

NQF #2775 Functional Change: Change in Motor Score for Skilled Nursing Facilities

The Workgroup voted to include NQF #2775 *Functional Change: Change in Motor Score for Skilled Nursing Facilities*. NQF #2775 is an outcome measure and complements the other functional change measure currently in the MAP Dual Eligible Beneficiaries Family of Measures, NQF #2624 *Functional Outcome Assessment*, a process measure. The developer for NQF #2775 adjusted the measure's risk model by category/subgroup, which the Workgroup noted is important due to the large mix of individuals in skilled nursing facilities. The risk adjustment allows for comparison among dissimilar facilities, for example, a facility in a rural area where there may be only one which primarily sees very ill people and a facility in a metropolitan area which have multiple facilities, some of which have a wealthy population. The Workgroup expressed concern that the measure lacked testing in the dual beneficiaries population but supported the measure because it will allow for the measurement and tracking of functional score changes reflecting improvement in motor skills while at a nursing facility.

NQF #2776 Functional Change: Change in Motor Score in Long Term Acute Care Facilities

In addition to NQF #2775, the Workgroup voted to include another functional measure, NQF #2776 *Functional Change: Change in Motor Score in Long Term Acute Care Facilities (LTACs)*. The Workgroup discussed the importance of measuring functional improvement in LTACs, a care setting that previously did not measure functional status. The Workgroup noted that the target population was not clearly stated, which created confusion and led to discussion about the relevance and impact of the measure, especially for the dual beneficiaries. Ultimately, the Workgroup agreed that an

outcome measure that assesses functional change, regardless of measure ambiguity, is important for the dual eligible beneficiaries population.

NQF #2858 Discharge to Community

The Workgroup voted to include NQF #2858 *Discharge to Community* because the measure addresses the high-priority gap area—quality measures that evaluate system level coordination of acute care, long-term services and supports (LTSS), and nonmedical community resources. This measure assesses whether or not individuals discharged into the community remain in the community, which the Workgroup emphasized as an important aspect of care quality.

NQF #2967 CAHPS® Home- and Community-Based Services Measures

The Workgroup voted to include NQF #2967 *CAHPS® Home- and Community-Based Services Measures* in the MAP Dual Eligible Beneficiaries Family of Measures. The Workgroup agreed that NQF #2967 is a much-needed experience-of-care measure for individuals in home and community-based services (HCBS). The Workgroup noted that a significant number of dual beneficiaries receive HCBS in several state dual eligible demonstration programs. For individuals enrolled in such programs, this measure allows states to compare the quality of services and support across programs and providers. Workgroup members emphasized that NQF #2967 will support dual eligible beneficiaries who receive HCBS and allow them to experience the best life possible while remaining in the community. Similarly, public commenters strongly supported the addition of NQF #2967 to the MAP Dual Eligible Beneficiaries Family of Measures and Starter Set.

NQF #3086 Population Level HIV Viral Load Suppression

The Workgroup also added NQF #3086 *Population Level HIV Viral Load Suppression* to the MAP Dual Eligible Beneficiaries Family of Measures. NQF #3086 is an intermediate outcome measure that will compliment NQF #2079 *HIV Medical Visit Frequency*, a process measure

currently included in the MAP Dual Eligible Beneficiaries Family of Measures. Workgroup members noted that a significant percentage of Medicaid enrollees with HIV are dually eligible and that NQF #3086 addresses the critical issue of HIV care and management.

Update to the Starter Set of Measures

Measure Included in the Starter Set

The Starter Set ([Appendix E](#)) is a subset of measures in the MAP Dual Eligible Beneficiaries Family of Measures that are ready for implementation as currently specified. Measures in the Starter Set cover the spectrum of cross-cutting to condition-specific measures and address critical clinical issues across the dual beneficiaries population.

The Workgroup voted to add one measure to the Starter Set: NQF #2967 *CAHPS® Home- and Community-Based Services Measures*. The addition was done off-cycle since updates to the Starter Set are performed every couple of years and the last update was completed in 2016. The Workgroup stated that the measure addresses a critical need in the Starter Set to measure experience of care for people in home and community-based services.

The CSAC removed endorsement of NQF #0647 *Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or any other Site of Care)* and NQF #0648 *Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or any other Site of Care)*. Consequently, these measures were removed from the Starter Set since it consists of currently endorsed measures.

Additional Measures Considered

Three CoreQ Measures: NQF #2614 Short Stay Discharge, NQF #2615 Long-Stay Resident, and NQF #2616 Long-Stay Family

The Workgroup also discussed three CoreQ measures on individual satisfaction as part of its review of newly endorsed measure deliberations. Generally, the Workgroup supported the intent behind these patient-reported outcome measures, but had significant concerns about their readiness for implementation. The Workgroup noted that measure specification exclusions for both NQF #2614 and NQF #2615 included individuals with cognitive impairment and individuals who used a proxy to complete the surveys. Members voiced their concern that this would exclude many dual eligible beneficiaries. Further, it noted that NQF #2614 and NQF #2615 did not adequately accommodate for literacy and/or health literacy. The Workgroup concluded that NQF #2614, NQF #2615, and NQF #2616 would be unable to capture and derive meaningful outcomes for the dual beneficiaries population. The Workgroup acknowledged the importance of the measures, especially NQF #2616, as families are often unable to provide meaningful input regarding their loved one's care.

High-Priority Gaps

While the Workgroup did not explicitly discuss gaps, discussions and gaps lists from previous years are still relevant.

Below is a list of the gaps emphasized by the Workgroup during past deliberations:

- Goal-directed, person-centered care planning and implementation
- Shared decision making
- Systems to coordinate acute care, long-term services and supports (LTSS), and nonmedical community resources
- Beneficiary sense of control/autonomy/self-determination
- Psychosocial needs
- Community integration/inclusion and participation
- Optimal functioning
- Home and community-based services (HCBS)
- Affordable and cost-effective care

NQF Updates on Projects of Interest

In the spirit of communication and collaboration, the MAP Dual Eligible Beneficiaries Workgroup received updates on two projects/topics of relevance to the dual beneficiaries population. Below is the summary of these presentations.

Behavioral Health Project

The Workgroup received an update on the Behavioral Health Standing Committee's recent activities. The work of this Committee is of particular interest to the Workgroup as dual eligible beneficiaries have a higher incidence of mental health conditions compared with Medicare only beneficiaries.¹³ There are several measures within the MAP Dual Eligible Beneficiaries Family of Measures that the Committee reviewed during the most recent endorsement review cycle, NQF #0008 *Experience of Care and Health Outcomes (ECHO) Survey*, NQF #0027 *Medical Assistance with Smoking and Tobacco Use Cessation*, and NQF #0576 *Follow-Up After Hospitalization for Mental Illness*.

The Committee recommended the continued endorsement of #0027 and #0576 but deferred a decision on continued endorsement for NQF #0008 since there were not enough data on performance score and use. Consequently, the developer is updating these data and the Committee will reconsider the measure for endorsement during its next review cycle.

The Workgroup noted that the NQF behavioral health portfolio lacks outcome measures related to

employment, relationships, and independent living. Therefore, the Workgroup recommended that the Committee look for outcome measures in its future work. Additionally, the Workgroup recommended including measures that expand upon the definition of “mental health practitioner” to include a more diverse field of providers. The Workgroup also suggested the inclusion of measures that address co-occurring disorders such as substance use disorder or intellectual disability, as well as measures that evaluate support structures for individuals who suffer from behavioral health issues.

NQF Disparities Project and Social Risk Trial Update

The MAP Dual Eligible Beneficiaries Workgroup has a particular interest in addressing healthcare disparities because dual beneficiaries are, by definition, economically disadvantaged as evidenced by their eligibility for Medicaid supports and services. The MAP Dual Eligible Beneficiaries Workgroup received an update on the progress of NQF’s social risk trial period during the March 2017 in-person meeting. During the trial period,

measure submissions for NQF endorsement review were allowed to include risk adjustment for factors related to social risk. Measure submissions with risk adjustment for social risk factors had to include a conceptual rationale that explains why risk adjustment is necessary, test results based on risk adjustment methodology, and develop specifications with stratification in addition to risk adjustment for these factors. NQF presented the final results of the [trial period evaluation](#) to the NQF Board of Directors in July 2017. The Board voted to launch a new initiative focused on social risk factors.

Workgroup members expressed concern that developers did not always adjust for Medicare-Medicaid dual eligible status. The Workgroup commented that measuring social risk factors individually might not capture how these factors influence each other and affect an individual’s health. The Workgroup encouraged NQF to continue the exploration of social risk factor adjustment. Public commenters also agreed that additional guidance is needed to appropriately adjust for social risk factors within the population.

MEASUREMENT-RELATED TOPICS

ASPE Reports Addressing Social Risk Factors

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act charged the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) with addressing the role of social risk factors on health outcomes.¹⁴ Workgroup members received an overview of three of the four mandated areas of work by the IMPACT Act that include:

- A study of the impact of social risk factors and its effect on beneficiary outcomes. ASPE shared the results in the December 2016 *Report to Congress*.¹⁵
- A study of the impact of socioeconomic status (SES) on quality and resource use within Medicare. The study is ongoing.
- A qualitative analysis of data sources and context to define SES. The National Academies of Sciences, Engineering, and Medicine (NASM) reported their findings in its 2016 publication of *Accounting for Social Risk in Medicare Payment*.¹⁶

In the *Report to Congress*, ASPE identified five social risk factors in its conceptual framework that affect health and their effects on beneficiaries. ASPE's analysis revealed two main findings. First, it identified a patient effect—beneficiaries with social risk factors had worse outcomes regardless of which providers they saw. Among the five risk factors evaluated, dual enrollment in Medicare and Medicaid was the most powerful predictor of poor outcomes. The second finding highlighted the provider effect and revealed that providers who disproportionately served beneficiaries with social risk factors provided a lower quality of care.

ASPE concluded the report with three recommendations for HHS and policymakers to consider how to address social risk factors

in value-based payment programs: (1) measure and report quality for beneficiaries with social risk factors; (2) set high fair quality standards for all beneficiaries; and (3) reward and support better outcomes for beneficiaries with social risk factors within value-based purchasing programs. The Medicare Advantage program trial and an ongoing physician value-based payment modifier pilot program served as examples of programmatic changes and initiatives based on the recommendations discussed above.

ASPE then reviewed Study B, which is currently underway. Study B will build upon the first report's framework to assess the impact of SES on quality and resource use within Medicare. The study will explore new measures of social risk and evaluate both medical and social risk factors that are prevalent in the dual beneficiaries population.

The NASM reports were the final items that ASPE reviewed. These reports identified five social risk factors in the Medicare population: socioeconomic position, race/ethnicity/cultural context, gender, social relationships, and residential/community context. In addition to social risk factors, the reports identified two major data sources for measuring social risk using Medicare claims data: the Medicare Current Beneficiary Survey (MCBS) and the American Community Survey (ACS). The goal of this effort was to assess which social risk factors are the strongest predictors of poor outcomes by exploring the intersectionality of individual and community measures of social risk and beneficiary outcomes.

The Workgroup discussed the merits of comparing different subpopulations, within dual eligible beneficiaries, against each other in performance and reporting, to obtain a more accurate analysis of the impact of social risk factors. In its previous work, the Workgroup identified four high-need subpopulation groups: adults aged 18-64 with physical or sensory disabilities, medically

complex adults aged 65 and older with functional limitations and co-occurring chronic conditions, beneficiaries with serious mental illness (SMI) and/or substance use disorders, and beneficiaries with cognitive impairment (e.g., dementia, intellectual/developmental disability).¹⁷ The Workgroup recommended that ASPE consider this work as it illustrates the heterogeneous nature of the population.

The Workgroup also recommended several sources and programs that contain information related to beneficiary specific clinical and social risk factors. For example, the Programs for All-Inclusive Care for the Elderly (PACE) includes a clinical frailty adjustment which includes social risk factors such as age, sex, and dual enrollment status. Other sources such as the National Core Indicators™ (NCI) and Person Outcome Measures® are used in many publicly operated programs and can measure social relationships as well as residential/community context.

Further, Workgroup members listed other data repositories within state home and community-based services (HCBS) programs as additional data sources. The Workgroup acknowledged challenges in linking state Medicaid and Medicare data. However, it confirmed that linked data exist in programs such as the Medicare-Medicaid Plans (MMP) and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs).

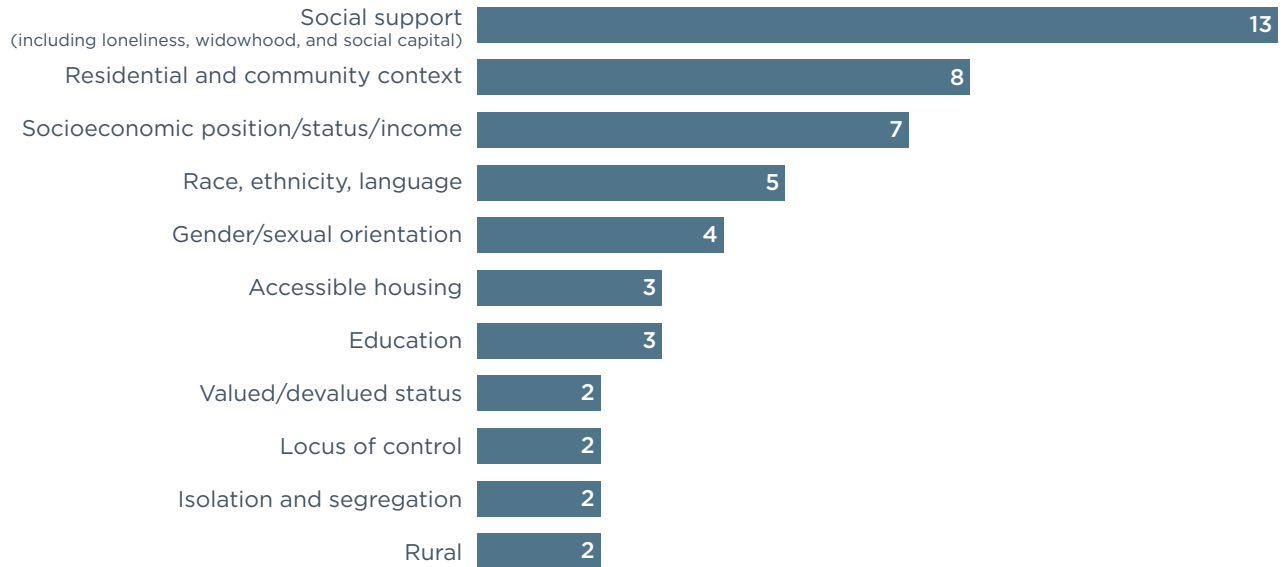
The Workgroup suggested several frameworks that address the relationship between social risk factors and health. In particular, Dr. Linda Fried's seminal work illuminating the interconnectedness of the concepts of disability, frailty, and comorbidity, along with the more recent work of Dr. Raj Chetty that examines how health, behavioral, and local (i.e., geographical) area characteristics influence the relationship between income and life expectancy.^{18,19}

Workgroup Discussion

In preparation for the in-person meeting, Workgroup members identified social risk factors most relevant to the dual beneficiaries population, as well as data sources that contain information on these risks factors. The goal of the exercise was to enrich the in-person meeting discussion and help inform HHS concerning its healthcare disparities work. Figure 1 illustrates the Workgroup responses for relevant social risk factors. The highest priority social risk factor the Workgroup identified was social support, including loneliness, widowhood, and social capital. Sources that capture these data include CAHPS®, HCBS programs, MPP, and the National Core Indicators™. Two additional high-priority categories of relevant social risk factors were residential and community context and socioeconomic position/status/income. The Workgroup also recommended HIPxChange—a program that creates area deprivation index datasets, county infrastructure data, and Medicare-Medicaid Plans (MMPs) as sources for residential and community context.²⁰ Full Benefit Dual Eligible (FBDE) status and census tract proxies are sources for information on socioeconomic position/ status/ income. The Workgroup noted that the Medicare Star Health Outcome Survey (HOS) is an additional resource that provides information on many social risk factors identified by the group such as income, sex, age, and functional status.²¹

The Workgroup acknowledged that the social risk factors identified by the Workgroup homework exercise underscore the complexity of this population. The Workgroup noted the close relationship between social risk factors and medical health issues and recommended that measures should account for and address the identified social risk factors. Public comments recommended adding functional impairment to the list of important social risk factors, especially given the physical limitations of the most vulnerable within this population.

FIGURE 1. IMPORTANT SOCIAL RISK FACTORS BASED ON DUAL ELIGIBLE BENEFICIARIES WORKGROUP RESPONSES



To account for these factors, the Workgroup recommended testing measures within a diverse group of dual eligible beneficiaries. It also recommended using the smallest geographic area as a unit of analysis. Specifically, it suggested the nine-digit zip code instead of the five-digit zip code, since the five-digit code is not granular enough and may inadvertently mask variation between subpopulations.

Measure Development— From Concept to Measurement

Presentation by University of Minnesota

The University of Minnesota’s Institute on Community Integration (ICI) presented its work related to the development of HCBS outcome measures within its Rehabilitation Research and Training Center. The goal of the Research and Training Center is to develop HCBS relevant measures with risk adjusters. Additionally, the Center will provide technical assistance to stakeholders and implementers on HCBS-related outcome measurement. Divided into six studies, the work builds upon NQF’s framework for HCBS

outcome measurement.²² Of the six studies, researchers have concluded study 1 and are concurrently conducting studies 2, 3, and 6. The results of study 6 will inform the work of studies 4 and 5.

Study 1

Researchers convened stakeholders to weigh the various domains and subdomains identified in the NQF HCBS framework as well as modify, remove, and/or add additional domains/subdomains as needed. Stakeholders agreed on the importance of the overall domains identified by the NQF HCBS Committee. However, researchers noted variations among stakeholders concerning the importance of subdomains. For example, stakeholders did not agree on the level of importance for the choice and control subdomain. Stakeholders also expressed similar sentiments for the consumer leadership in system development subdomain among others.

Study 2

After considering the domains/subdomains of the NQF HCBS framework, researchers conducted an environmental scan, which reviewed and cataloged numerous instruments using the expanded,

modified, and relevant framework domains. Researchers coded approximately 100 national and state-based instruments during this phase of the study.

Workgroup members expressed concern that there was no threshold of use for instruments that the researchers reviewed. The Workgroup noted that researchers assigned nationally implemented instruments the same weight as highly specialized and/or less utilized instruments. At the March 2017 in-person meeting, presenters from the University of Minnesota explained that the purpose of the environmental scan is not to recommend instruments for use, but to identify measures/measure concepts that will inform the measure development later on in the project.

Study 3

The goal of the third study is to identify existing outcome measurement programs that currently implement HCBS-focused outcome measures. Subsequently, researchers will conduct case studies to assess the fidelity of administration and implementation of these measurement programs. The ultimate goal is to identify factors that either facilitate or serve as barriers to effective implementation.

Study 4

Researchers will leverage their gap analysis and identify areas where there is the greatest need for further measure development. During this phase, researchers will pilot promising measure concepts.

Study 5

Study 5 will build upon the work on study 4 and will be a large-scale study to test concepts identified in the previous phase across a national audience.

Based on the discussion on measure development, the Workgroup underscored several points. First, it warned against the creation of measures that pull from proprietary sources, as this will limit the ability for broad implementation. Second,

it encouraged parsimony for new instruments. Instead of a multiplication of new measures, the Workgroup would like to see measure developers focus on a couple of key issues relevant across the population at large. Third, it expressed concern that the researchers would pull out specific measures from instruments in cases where the instrument developer believes that the value of the tool lies in using the measures collectively rather than pulling out specific measures of interest.

Throughout their five-year process, researchers will work closely with measure developers. During the presentation at the in-person meeting, the researchers highlighted their work with developers who specialize in patient-reported outcomes (PRO). The Workgroup commended the researchers' commitment to people and PROs; however, it encouraged an expansion of scope to allow for input from developers who specialize in other key elements of care quality such as transition of care and functional improvement.

Study 6

The work of study 6 is ongoing. Currently, researchers are reviewing and identifying variables for adjustment in populations of interest and highlighting the most promising ones across the NQF HCBS framework. To date, they identified 42 promising variables for risk adjustment. The researchers will narrow this list prior to the testing phase.

Workgroup members emphasized the need to have a standard set of observational questions in order to properly risk adjust for functional disability. Several members advised against using diagnoses as a risk adjuster, especially since multiple interrelated and/or confounding illnesses could contribute to an individual beneficiary's functional disability. The presenters noted this concern and expressed interest in sources of information regarding the relationship between multiple diagnoses and functional disability.

CAHPS® Home and Community-Based Services Survey and Related NQF-Endorsed Measures

CMS presented to the Workgroup on the development, testing, and piloting of the recently endorsed CAHPS® HCBS Survey. The presentation reviewed the need for the survey, key features of the survey, along with its intended use. The rationale behind developing this instrument is the increasing growth of HCBS within the population who receive LTSS. Within the past couple of years, over 50 percent of Medicaid funding for LTSS went to community-based supports, which exemplifies the growth of HCBS.²³ Therefore, it is essential to assess the quality and impact of these services. It is important to note that the CAHPS® HCBS Survey differs from other HCBS surveys currently in the field. Developers often create surveys for use in specific populations and subpopulations, but the Agency for Healthcare Research and Quality (AHRQ) designed the CAHPS® HCBS Survey to be completed by a broad range of beneficiaries including individuals who are frail/elderly and individuals who have a physical disability, an intellectual or developmental disability, a brain injury, or a serious mental illness.

During the presentation, CMS presenters highlighted some of the key aspects of the survey:

- The unit of analysis is either the HCBS program or the accountable entity that the survey defines as the operating entity responsible for managing and overseeing a specific HCBS program within a given state.

- AHRQ developed the CAHPS® HCBS survey so that people can make comparisons about the quality of services and support across programs or between managed care organizations or other subgroups.
- Average administration time is 30 minutes.
- Administration procedures allow a proxy to complete the survey following an initial cognitive assessment. As there are no uniform naming conventions for providers across care programs, AHRQ designed the survey to incorporate program-specific terms.

Seven states are currently demonstrating the use of the survey to assess program performance, document successes, identify areas for improvement, assess impacts of program improvement, as well as provide information to stakeholders on program performance.

Following the conclusion of the presentation, the Workgroup voted to include NQF #2967 CAHPS® Home- and Community-Based Services Measures in both the MAP Dual Eligible Beneficiaries Family of Measures and the Starter Set. Several Workgroup members expressed their appreciation for the measures' ability to provide a standardized method to evaluate the experience of care across varying home and community-based service settings.

STRATEGIC ISSUES

The Dual Eligible Beneficiaries Workgroup discussed the need for better coordination and integration of efforts to include various stakeholders such as federal agencies, community organizations, and available measurement tools. All participants agreed that a lack of integration and coordination results in duplication of efforts and wastes the limited resources available for this population. Therefore, a paradigm shift in how measurement is undertaken, as well as a methodological shift in how programs implement and calculate measures, is necessary for improved care delivery and quality for the dual eligible beneficiaries. Public comments supported the strategic issues discussed by the Workgroup, in particular, the paradigm shift towards a person-centered approach to measurement. They encouraged continued focus on dually eligible individuals within NQF's work.

Organizational Coordination and Integration

The Workgroup discussed the need to organize, coordinate, and integrate current efforts related to measurement and survey instrument development. It acknowledged the number and variety of federal initiatives currently underway at both the local and federal levels. However, it also voiced concern that these siloed, duplicative efforts lead to fragmentation and resource waste.

Many different federal agencies have some level of policy and/or operational oversight of healthcare programs and providers that serve the dual eligible beneficiaries population. However, these agencies do not synchronize the focus, data collection tools, requirements and/or methodologies, thereby creating burden through duplication of processes. As a result, differing program requirements lead to misaligned data collection and reporting for a population where many needs remain unaddressed. For example,

agencies both large and small are involved in activities that include community services and supports along with measure and measurement instrument development. These entities rarely confer with each other or collaborate to maximize opportunities and funding. The Workgroup noted that this issue pervades community-based organizations as well. Each entity focuses on its individual efforts, and a lack of integration and coordination of efforts results in a loss of economies of scale.

Based on these concerns, the Workgroup members recommended that federal agencies collaborate with each other as well as with community-based organizations. This would allow for efficient use of resources, coordinated and aligned program requirements, as well as a reduction in data collection and reporting burden. Furthermore, Workgroup members recommend that HHS develop a strategy for coordination and integration that covers all agencies and standardizes the process of collaboration and integration. The MAP Coordinating Committee acknowledged and reiterated the need for further integration among federal partners.

Measurement Coordination and Integration

Workgroup members noted that this issue is prevalent in measurement development as well, specifically related to survey instruments and tools. Instead of focusing on currently available and widely used tools, entities and institutions constantly modify and develop new tools, which duplicate existing ones. Specifically, the Workgroup perceives a lack of coordination between efforts at the Administration for Community Living and NCI™.^{24,25} Within CMS, coordinated efforts related to HCBS quality are underway, though challenges remain to sustain meaningful coordination among the

many different components. The Workgroup recommended using one instrument with a core set of elements and a modifiable adjunct section to address the needs and nuances of the dual beneficiary subpopulations.

The multiplication of instruments leads to instrument and data collection burden for both providers and individuals receiving care. The Workgroup members recommended a way to reduce burden related to survey response, reporting, and collection: Create a crosswalk of all measurement systems and move towards a universal survey, with the option of appending subpopulation questions based on needs and goals. Additionally, the Workgroup discussed making use of pre-existing tools like the comprehensive assessment completed on every Managed Long Term Services and Supports (MLTSS) and MMP beneficiary to gather data to minimize duplication and beneficiary confusion.

Measurement Paradigm Shift

The Dual Eligible Beneficiaries Workgroup members noted that beyond integration and coordination the fundamental paradigm in measure conceptualization and development needs to shift. Current measure development focuses on a top down system where measures are developed and then tested and implemented within the duals population. Workgroup members suggested that future measure development should start at the individual beneficiary level to address the population's needs and gap areas.

Changes in data collection, specifically what is collected, is an example of this paradigm shift. For example, the Workgroup noted that it is customary to collect information on healthy days as a proxy for quality of life. However, for the duals population with multiple conditions, the concept of healthy days may not be appropriate, especially if the goal of care is maintenance instead of health improvement. A frame shift for the duals population would manifest as the collection of information on “functional day” versus “healthy

day,” based on the need to address quality of care and, more importantly, quality of life.

The Workgroup members also noted that the dual beneficiaries population is diverse and consists of many subpopulations including people with disabilities, behavioral health issues, cognitive impairment, and complex older adults. Therefore, the shift in measurement needs to include and address corollary measures that help connect medical and social care. These corollary measures should focus on specific subpopulations, whereas most measures currently in use focus on broad population characteristics. Furthermore, these subpopulations have overlapping issues that require measures with an expanded focus and population in a system that mostly develops narrowly focused quality measures. These narrowly focused measures invariably disregard individual needs, heterogeneity, and the uniqueness of the dual beneficiaries population.

In considering a paradigm shift, the Workgroup recommended that the issue of data collection and reporting burden—including a disconnect between data collection and abstraction—be part of the discussion. The goal for doing so is both to address the need for data specific to dual beneficiaries and to consider currently collected data available through various instruments and programs. Workgroup members noted that requisite data are not always available in a single, confined system, but usually across multiple sources. Echoing previous Workgroup recommendations, the members reiterated the need for interoperability of electronic data systems and repositories, as well as improved electronic data abstraction capabilities. They also emphasized the need to balance data collection requirements with what is truly meaningful and measurable.

The Workgroup members suggested reframing the quality measurement community's perspective through a population-based measurement lens while addressing the differing needs of subsets within the dual eligible population with separate measures.

Risk Adjustment for Social Risk Factors

The discussion around a paradigm shift in measurement also included social risk factors and risk adjusting for social risk factors.

Workgroup members emphasized the need for a population-based measurement framework that recognizes and measures the effects of social risk factors on health outcomes. The Workgroup noted that this framework should highlight, address, and synthesize the interconnectedness of care complexity, social risk factors, and health outcomes for dual eligible beneficiaries. Additionally, Workgroup members stressed the need to develop a standard methodology to capture the impact of social risk factors and perform comparative analysis across localities, regions, and groups. However, the discussion also highlighted the need to balance standardization of methodology with the flexibility to allow for

modifications based on the reason for and goal of measurement.

The **ASPE presentation** at the in-person meeting noted that for dual beneficiaries, social risk is a proxy for poverty. Accordingly, social risk factors and adjusting for them is not about medical care, but about considering the care spectrum including wrap around services such as community-based care and social services. The Workgroup members cautioned that the use of risk adjustment be balanced with the complexities of providing care to dual eligible beneficiaries, especially for providers who face high caseload burdens to begin with.

The Dual Eligible Beneficiaries Workgroup members supported the concept of addressing social risk factors and encouraged continued support for both ASPE's work as well as NQF's social risk trial period.

CONCLUSION

Acknowledging the evolution of conversations regarding social risk factors, the Dual Eligible Beneficiaries Workgroup members recommend focusing future measurement efforts primarily on the needs of individual beneficiaries, such as shared decision making, social support, and locus of control.

Topics highlighted at the in-person meeting included data availability and interoperability, social determinants of health, person-centered care, integration and coordination, as well as the need for simplicity in measurement.

The Workgroup members noted that while data infrastructure challenges like interoperability exist, harvesting data from multiple sources and programs can circumvent data availability

challenges. The Workgroup suggested that future quality improvement efforts should focus on integration and coordination at both measurement and organizational levels.

Ultimately, a change in the measurement paradigm will help evolve the measurement perspective and allow for a system view of both medical and nonmedical measures, as well as address social determinants of health. The discussion of the Dual Eligible Beneficiaries Workgroup can be summed up this way: How best can existing and new measures be used to improve the quality of care for the dual eligible beneficiaries population while measuring what matters most from the beneficiaries' perspective?

ENDNOTES

- 1 Centers for Medicare & Medicaid Services (CMS). *People Enrolled in Medicare and Medicaid Fact Sheet*. Baltimore, MD: CMS, Medicare-Medicaid Coordination Office; 2017. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf. Last accessed April 2017.
- 2 Medicare Payment Advisory Commission (MedPAC), Medicaid and CHIP Payment and Access Commission (MACPAC). *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*. Washington, DC: MACPAC; 2017. Available at https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf. Last accessed April 2017.
- 3 CMS. About CMS website. <https://www.cms.gov/About-CMS/Agency-Information/OMH/Resources/OMH-Resources.html>. Last accessed August 2017.
- 4 Centers for Medicare & Medicaid Services (CMS). *People Enrolled in Medicare and Medicaid Fact Sheet*. Baltimore, MD: CMS, Medicare-Medicaid Coordination Office; 2017. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf. Last accessed April 2017.
- 5 Medicare Payment Advisory Commission (MedPAC), Medicaid and CHIP Payment and Access Commission (MACPAC). *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*. Washington, DC: MACPAC; 2017. Available at https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf. Last accessed April 2017.
- 6 CMS. *People Enrolled in Medicare and Medicaid Fact Sheet*. Baltimore, MD: CMS, Medicare-Medicaid Coordination Office; 2017. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf. Last accessed April 2017.
- 7 Medicare Payment Advisory Commission (MedPAC), Medicaid and CHIP Payment and Access Commission (MACPAC). *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*. Washington, DC: MACPAC; 2017. Available at https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf. Last accessed April 2017.
- 8 CMS. *Physical and Mental Health Condition Prevalence and Comorbidity among Fee-for-Service Medicare-Medicaid Enrollees*. Baltimore, MD: CMS; 2014. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidity_2014.pdf. Last accessed April 2017.
- 9 National Quality Forum (NQF). MAP Final Recommendations 2017. Slide presented at Measure Applications Partnership Dual Eligible Beneficiaries Workgroup In-Person Meeting; March 28-29, 2017; Washington, DC. Available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=84850>. Last accessed May 2017.
- 10 NQF. *Families of Measures: Safety, Care Coordination, Cardiovascular Conditions, Diabetes*. Washington, DC: NQF; 2012. Available at http://www.qualityforum.org/Publications/2012/10/MAP_Families_of_Measures.aspx. Last accessed May 2017.
- 11 NQF. *2014 Input on Quality Measures for Dual Eligible Beneficiaries*. Washington, DC: NQF; 2014. Available at http://www.qualityforum.org/Publications/2014/08/2014_Input_on_Quality_Measures_for_Dual_Eligible_Beneficiaries.aspx. Last accessed May 2017.
- 12 Centers for Disease Control and Prevention (CDC). Use of 13-valent pneumococcal conjugate vaccine and 23-valent pneumococcal polysaccharide vaccine among adults aged ≥ 65 Years: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2014;63(37):822-825. Available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm>. Last accessed June 2017.
- 13 Kasper J, O'Malley Watts M, Lyons B. *Chronic Disease and Co Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*. Washington, DC: Kaiser Family Foundation; 2010. Available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8081.pdf>. Last accessed May 2017.
- 14 CMS. Post-acute care quality initiatives website. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html>. Last accessed May 2017.

- 15** HHS, Office of the Assistant Secretary for Planning and Evaluation (ASPE). *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*. Washington, DC: ASPE; 2016. Available at <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicare-value-based-purchasing-programs>. Last accessed May 2017.
- 16** Institute of Medicine (IOM). *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*. Washington, DC: National Academies Press; 2016.
- 17** NQF. *Measure Applications Partnership: Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*. Washington, DC: NQF; 2012. Available at http://www.qualityforum.org/Publications/2012/06/MAP_Dual_Final_Report_to_HHS.aspx. Last accessed May 2017.
- 18** Fried LP, Ferrucci L, Darer J, et al. Untangling the concepts of disability, frailty, and comorbidity: implications for improved targeting and care. *J Gerontol A Biol Sci Med Sci*. 2004;59(3):255-263.
- 19** Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. *JAMA*. 2016;315(16):1750-1766.
- 20** HIPxChange. About HIPxChange website. <https://www.hipxchange.org/about>. Last accessed May 2017.
- 21** Medicare Health Outcome Survey. Medicare health outcomes survey (HOS) website. <http://www.hosonline.org/>. Last accessed May 2017.
- 22** NQF. *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*. Washington, DC: NQF; 2016. Available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=83433>. Last accessed May 2017.
- 23** CMS. Medicaid home & community based services website. <https://www.medicaid.gov/medicaid/hcbs/>. Last accessed May 2017.
- 24** NQF. MAP Final Recommendations 2017. Slide presented at Measure Applications Partnership Dual Eligible Beneficiaries Workgroup In-Person Meeting; March 28-29, 2017; Washington, DC. Available at <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=84850>. Last accessed May 2017.
- 25** NQF. Measure Applications Partnership Dual Eligible Beneficiaries Workgroup In-Person Meeting [transcript]; March 28-29, 2017; Washington, DC.

APPENDIX A: MAP Background

The Patient Protection and Affordable Care Act (ACA) of 2010 required that the U.S. Department of Health and Human Services (HHS) implement an annual, federal pre-rulemaking process to provide private-sector input and consensus on the quality and efficiency measures being considered for federal public-reporting and performance-based payment programs. The National Quality Forum (NQF) first convened MAP in 2011 as a multistakeholder entity to provide recommendations on the measures under consideration for use by HHS.

As detailed in the *Process and Approach for MAP Pre-Rulemaking Deliberations, 2016-2017*, MAP used a four-step process to analyze and select measures.

1. **Provide program overview.** Using CMS critical program objectives and the MAP Measure Selection Criteria, NQF staff developed a framework for each program in order to organize each program's current measure set.
2. **Review current measures.** MAP used the program measure set frameworks to better understand the current measures in the program, identify important gaps in measurement, and surface other areas of need. MAP reviewed the current measures to help determine how well the measures under consideration might fit into the program.
3. **Evaluate measures under consideration.** MAP used the Measure Selection Criteria and a MAP-approved preliminary analysis algorithm to determine whether the measures under

consideration would enhance the program measure sets. Staff performed a preliminary analysis on each measure under consideration using the preliminary analysis algorithm. The MAP workgroups made their recommendations for each measure under consideration during December in-person meetings. The MAP Coordinating Committee finalized the recommendations for all measures under consideration at its January in-person meeting.

4. **Provide feedback on current program measure sets.** MAP reviewed the current measure sets to offer input on how to strengthen them, address gaps, and make recommendations for future removal of measures.

As previously noted in its 2016 guidance, MAP aims to provide guidance on the selection, use, and reduction of performance measures on multiple levels. MAP considers the value that an individual measure under consideration may add to a program by carefully balancing the opportunity for improvement with the potential for negative consequences and the burden on providers to report on the measure. Secondly, MAP evaluates a program's measure set as a whole. MAP also provides guidance on prioritizing gaps for measure endorsement and development. For the current pre-rulemaking cycle, MAP added a new focus: It now identifies measures that potentially could be removed from a program measure set in the future. Finally, MAP looks across the various quality initiative programs to identify ways measurement can drive improvement and maximize value across the healthcare system.

APPENDIX B: Rosters for the MAP Dual Eligible Beneficiaries Workgroup, MAP Coordinating Committee, and NQF Staff

MAP Dual Eligible Beneficiaries Workgroup

WORKGROUP CO-CHAIRS (VOTING)

Jennie Chin Hansen, RN, MS, FAAN

Michael Monson, MPP

Nancy Hanrahan, PhD, PN, FAAN
(Inactive March-May, 2017)

ORGANIZATIONAL MEMBERS (VOTING)

AARP Public Policy Institute

Susan Reinhard, RN, PhD, FAAN

American Medical Directors Association

Gwendolen Buhr, MD, MHS, Med, CMD

American Occupational Therapy Association

Joy Hammel, PhD, OTR/L, FAOTA

Association for Community Affiliated Health Plans

Christine Aguiar Lynch, MPH

Centene Corporation

Michael Monson, MPP

Consortium for Citizens with Disabilities

E. Clarke Ross, DPA

Homewatch CareGivers

Jennifer Ramona

iCare

Thomas H. Lutzow, PhD, MBA

Medicare Rights Center

Joe Baker, JD

National Association of Medicaid Directors

Alice Lind, BSN, MPH

National Association of Social Workers

Joan Levy Zlotnik, PhD, ACSW

New Jersey Hospital Association

Aline Holmes, DNP, MSN, RN

SNP Alliance

Richard Bringewatt

INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)

Alison Cuellar, PhD

K. Charlie Lakin, PhD

Pamela Parker, MPA

Kimberly Rask, MD, PhD

FEDERAL GOVERNMENT LIASONS (NON-VOTING)

Administration for Community Living (ACL)

Eliza Bangit, JD, MA

CMS Medicare-Medicaid Coordination Office

Stacey Lytle, MPH

**Office of the Assistant Secretary for Planning and
Evaluation**

D.E.B. Potter, MS

MAP Coordinating Committee

CO-CHAIRS (VOTING)

Chip N. Kahn, III, MPH

Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)

Academy of Managed Care Pharmacy

Marissa Schlaifer, RPh, MS

AdvaMed

Steven Brotman, MD, JD

AFL-CIO

Shaun O'Brien

America's Health Insurance Plans

Aparna Higgins, MA

American Board of Medical Specialties

R. Barrett Noone, MD, FAcS

American Academy of Family Physicians

Amy Mullins, MD, FAAFP

American College of Physicians

Amir Qaseem, MD, PhD, MHA

American College of Surgeons

Bruce Hall, MD, PhD, MBA, FACS

American HealthCare Association

David Gifford, MD, MPH

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

Mary Beth Bresch White

Blue Cross and Blue Shield Association

Carole Flamm, MD, MPH

Consumers Union

John Bott, MSSW, MBA

Healthcare Financial Management Association

Richard Gundling, FHFMA, CMA

The Joint Commission

David Baker, MD, MPH, FACP

The Leapfrog Group

Leah Binder, MA, MGA

Maine Health Management Coalition

Brandon Hotham, MPH

National Alliance for Caregiving

Gail Hunt

National Association of Medicaid Directors

Foster Gesten, MD, FACP

National Business Group on Health

Steve Wojcik, MA

National Committee for Quality Assurance

Mary Barton, MD, MPP

National Partnership for Women and Families

Carol Sakala, PhD, MSPH

Network for Regional Healthcare Improvement

Chris Queram, MS

Pacific Business Group on Health

William E. Kramer, MBA

Pharmaceutical Research and Manufacturers of America (PhRMA)

Jennifer Bryant, MBA

Providence Health and Services

Ari Robicsek, MD

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)

Richard Antonelli, MD, MS

Dori Lotz, MD, MPH

FEDERAL GOVERNMENT MEMBERS (NON-VOTING)

Agency for Healthcare Research and Quality (AHRQ)

Nancy J. Wilson, MD, MPH

Centers for Disease Control and Prevention (CDC)

Chesley Richards, MD, MH, FACP

Centers for Medicare & Medicaid Services (CMS)

Patrick Conway, MD, MSc

Office of the National Coordinator for HIT (ONC)

David Hunt, MD, FACS

NQF Project Staff

Elisa Munthali

Acting Senior Vice President, Quality Measurement

Debjani Mukherjee

Senior Director

Rachel Roiland

Senior Project Manager

Kathryn Buchanan

Project Manager

Madison Jung

Project Analyst

APPENDIX C: MAP Measure Selection Criteria

The Measure Selection Criteria (MSC) are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they provide general guidance on measure selection decisions and complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Although Workgroup members often must weigh competing priorities against one another, the MSC serve as a reference when evaluating the relative strengths and weaknesses of a program measure set and how the addition of an individual measure would contribute to the set.

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.

- Subcriterion 1.1** Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need
- Subcriterion 1.2** Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs
- Subcriterion 1.3** Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

2. Program measure set adequately addresses each of the National Quality Strategy's three aims

Demonstrated by a program measure set that addresses each of the National Quality Strategy (NQS) aims and corresponding priorities. The NQS provides a common framework for focusing efforts of diverse stakeholders on:

- Subcriterion 2.1** Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment
- Subcriterion 2.2** Healthy people/healthy communities, demonstrated by prevention and well-being
- Subcriterion 2.3** Affordable care

3. Program measure set is responsive to specific program goals and requirements

Demonstrated by a program measure set that is “fit for purpose” for the particular program.

- Subcriterion 3.1** Program measure set includes measures that are applicable to and appropriately tested for the program’s intended care setting(s), level(s) of analysis, and population(s)
- Subcriterion 3.2** Measure sets for public reporting programs should be meaningful for consumers and purchasers
- Subcriterion 3.3** Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)
- Subcriterion 3.4** Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program
- Subcriterion 3.5** Emphasize inclusion of endorsed measures that have eMeasure specifications available

4. 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, composite, and structural measures necessary for the specific program

- Subcriterion 4.1** In general, preference should be given to measure types that address specific program needs
- Subcriterion 4.2** Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes
- Subcriterion 4.3** Payment program measure sets should include outcome measures linked to cost measures to capture value

5. Program measure set enables measurement of person- and family-centered care and services

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

- Subcriterion 5.1** Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination
- Subcriterion 5.2** Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives
- Subcriterion 5.3** Measure set enables assessment of the person’s care and services across providers, settings, and time

6. Program measure set includes considerations for healthcare disparities and cultural competency

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, sexual orientation, age, 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).

- Subcriterion 6.1** Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)
- Subcriterion 6.2** Program measure set includes measures that are sensitive to disparities measurement (e.g., beta-blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

7. Program measure set promotes parsimony and alignment

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting, and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

- Subcriterion 7.1** Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)
- Subcriterion 7.2** Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System, Meaningful Use for Eligible Professionals)

APPENDIX D: MAP Dual Eligible Beneficiaries Family of Measures (2017 Update)

The MAP Dual Eligible Beneficiaries Family of Measures is a group of the best available measures to address the unique needs of the dual eligible beneficiary population. The MAP Dual Eligible Beneficiaries Family of Measures functions like a menu that stakeholders can consult to select subsets of measures that best suit the needs of particular programs. The Workgroup selected the current MAP Dual Eligible Beneficiaries Family of Measures based on the MAP Measure Selection Criteria

(Appendix C) and update it over time. Additional details about each measure are available on the [NQF Quality Positioning System \(QPS\)](#). The MAP Dual Eligible Beneficiaries Family of Measures is also available in the spreadsheet accompanying this report on the [project webpage](#).

An asterisk (*) indicates a measure in the Starter Set for dual eligible beneficiaries. For information on the Starter Set see [Appendix E](#) of the report.

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0004* Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) <i>National Committee for Quality Assurance (NCQA)</i>	Process	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. <ul style="list-style-type: none"> Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. 	Administrative claims, Electronic Clinical Data	Health Plan, Integrated Delivery System
0005 Endorsed CAHPS® Clinician & Group Surveys (CG-CAHPS®)-Adult, Child <i>Agency for Healthcare Research and Quality (AHRQ)</i>	Patient-Reported Outcome Measure	The Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS®) is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months.	Patient Reported Data/Survey	Clinician: Group/ Practice, Clinician: Individual
0006 Endorsed Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, Version 5.0 (Medicaid and Commercial) <i>AHRQ</i>	Patient-Reported Outcome Measure	The CAHPS® Health Plan Survey is a standardized survey instrument which asks enrollees to report on their experiences accessing care and health plan information, and the quality of care received by physicians. HP-CAHPS® Version 4.0 was endorsed by NQF in July 2007 (NQF #0006). The survey is part of the CAHPS® family of patient experience surveys and is available in the public domain at https://CAHPS.ahrq.gov/surveys-guidance/hp/index.html .	Patient Reported Data/ Survey	Health Plan

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0008* Endorsement Deferred Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions) <i>AHRQ</i>	Composite	52- questions including patient demographic information. The survey measures patient experiences with behavioral health care (mental health and substance abuse treatment) and the organization that provides or manages the treatment and health outcomes. Level of analysis: health plan—HMO, PPO, Medicare, Medicaid, commercial	Survey: Patient Reported Data/ Survey	Health Plan
0018* Endorsed Controlling High Blood Pressure <i>NCQA</i>	Outcome	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System
0022 Endorsed Use of High-Risk Medications in the Elderly (DAE) <i>NCQA</i>	Process	There are two rates for this measure: <ul style="list-style-type: none"> • The percentage of patients 65 years of age and older who received at least one high-risk medication. • The percentage of patients 65 years of age and older who received at least two different high-risk medications. For both rates, a lower rate represents better performance.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System
0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation (MSC) <i>NCQA</i>	Process	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: <p>Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.</p> <p>Discussing Cessation Medications: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.</p> <p>Discussing Cessation Strategies: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users who discussed or were provided smoking cessation methods or strategies during the measurement year.</p>	Patient Reported Data/ Survey	Health Plan, Integrated Delivery System
0032 Endorsed Cervical Cancer Screening (CCS) <i>NCQA</i>	Process	Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> • Women age 21-64 who had cervical cytology performed every 3 years. • Women age 30-64 who had cervical cytology/ human papillomavirus (HPV) co-testing performed every 5 years. 	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0034 Endorsement Deferred Colorectal Cancer Screening (COL) NCQA	Process	The percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer.	Administrative claims, Electronic Clinical Data: Imaging/ Diagnostic Study, Electronic Clinical Data: Laboratory, Paper Medical Records	Health Plan, Integrated Delivery System
0097* Endorsed Medication Reconciliation Post-Discharge NCQA	Process	The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual, Health Plan, Integrated Delivery System
0101* Endorsed Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls NCQA	Process	This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates: A) Screening for Future Fall Risk: Percentage of patients aged 65 years and older who were screened for future fall risk at least once within 12 months B) Falls Risk Assessment: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months C) Plan of Care for Falls: Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months	Administrative claims, Electronic Clinical Data, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual
0104 Endorsed Adult Major Depressive Disorder (MDD): Suicide Risk Assessment <i>AMA-convened Physician Consortium for Performance Improvement</i>	Process	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry	Clinician: Group/ Practice, Clinician: Individual, Clinician: Team
0105 Endorsed Antidepressant Medication Management (AMM) NCQA	Process	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0166 Endorsed HCAHPS® <i>Centers for Medicare & Medicaid Services (CMS)</i>	Outcome	HCAHPS® (NQF #0166) is a 32-item survey instrument that produces 11 publicly reported measures: 7 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information and care transition); and 4 single-item measures (cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of hospital)	Patient Reported Data/ Survey	Facility
0176 Endorsed Improvement in management of oral medications <i>CMS</i>	Outcome	Percentage of home health episodes of care during which the patient improved in ability to take their medicines correctly, by mouth.	Electronic Clinical Data	Facility
0202 Endorsed Falls with injury <i>American Nurses Association</i>	Outcome	All documented patient falls with an injury level of minor or greater on eligible unit types in a calendar quarter. Reported as Injury falls per 1000 Patient Days. (Total number of injury falls / Patient days) X 1000 Measure focus is safety. Target population is adult acute care inpatient and adult rehabilitation patients.	Electronic Clinical Data, Other, Paper Medical Records	Clinician: Team, Facility
0228* Endorsed 3-Item Care Transition Measure (CTM-3) <i>University of Colorado Denver Anschutz Medical Campus</i>	Patient-Reported Outcome Measure	The CTM-3 is a hospital level measure of performance that reports the average patient reported quality of preparation for self-care response among adult patients discharged from general acute care hospitals within the past 30 days.	Patient Reported Data/ Survey	Facility
0326* Endorsed Advance Care Plan <i>NCQA</i>	Process	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Administrative claims, Electronic Clinical Data	Clinician: Group/ Practice, Clinician: Individual
0419* Endorsed Documentation of Current Medications in the Medical Record <i>CMS</i>	Process	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/ mineral/ dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration	Administrative claims, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry	Clinician: Group/ Practice, Clinician: Individual
0420 Endorsed Pain Assessment and Follow-Up <i>CMS</i>	Process	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record	Clinician: Individual

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0553 Endorsed Care for Older Adults (COA) – Medication Review <i>NCQA</i>	Process	Percentage of adults 66 years and older who had a medication review during the measurement year; a review of all a patient's medications, including prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan, Integrated Delivery System
0576* Endorsed Follow-Up After Hospitalization for Mental Illness (FUH) <i>NCQA</i>	Process	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: <ul style="list-style-type: none"> • The percentage of discharges for which the patient received follow-up within 30 days of discharge • The percentage of discharges for which the patient received follow-up within 7 days of discharge. 	Administrative claims, Electronic Clinical Data	Health Plan, Integrated Delivery System
0640 Endorsed HBIPS-2 Hours of Physical Restraint Use <i>The Joint Commission</i>	Process	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.	Electronic Clinical Data, Paper Medical Records	Facility, Population: National
0641 Endorsed HBIPS-3 Hours of Seclusion Use <i>The Joint Commission</i>	Process	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan Created and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.	Electronic Clinical Data, Paper Medical Records	Facility, Population: National
0674 Endorsed Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) <i>CMS</i>	Outcome	This measure reports the percentage of residents who have experienced one or more falls with major injury during their episode of nursing home care ending in the target quarter (3-month period). Major injury is defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma. The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury. Long-stay residents are identified as residents who have had at least 101 cumulative days of nursing facility care.	Electronic Clinical Data	Facility

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
<p>0678 Endorsed</p> <p>Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short-Stay)</p> <p><i>CMS</i></p>	Outcome	<p>This quality measure reports the percent of patients or short-stay residents with Stage 2-4 pressure ulcers that are new or worsened since admission. The measure is based on data from the Minimum Data Set (MDS) 3.0 assessments for Skilled Nursing Facility (SNF) / Nursing Home (NH) residents, the Long-Term Care Hospital (LTCH) Continuity Assessment Record & Evaluation (CARE) Data Set for LTCH patients, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for Inpatient Rehabilitation Facility (IRF) patients. Data are collected separately in each of the three settings using standardized items that have been harmonized across the MDS, LTCH CARE Data Set, and IRF-PAI. For residents in a SNF/NH, the measure is calculated by examining all assessments during an episode of care for reports of Stage 2-4 pressure ulcers that were not present or were at a lesser stage since admission. For patients in LTCHs and IRFs, this measure reports the percent of patients with reports of Stage 2-4 pressure ulcers that were not present or were at a lesser stage on admission.</p> <p>Of note, data collection and calculation for this measure are conducted and reported separately for each of the three provider settings and will not be combined across settings.</p> <p>For SNF/NH residents, this measure is restricted to the short-stay population defined as those who have accumulated 100 or fewer days in the SNF/NH as of the end of the measure time window. In IRFs, this measure is restricted to IRF Medicare (Part A and Part C) patients. In LTCHs, this measure includes all patients.</p>	Electronic Clinical Data, Electronic Clinical Data: Laboratory	Facility, Population: National
<p>0679 Endorsed</p> <p>Percent of High Risk Residents with Pressure Ulcers (Long Stay)</p> <p><i>CMS</i></p>	Outcome	<p>This measure reports the percentage of long-stay residents identified as at high risk for pressure ulcers in a nursing facility who have one or more Stage 2-4 or unstageable pressure ulcer(s) reported on a target Minimum Data Set (MDS) assessment (OBRA, PPS, and/or discharge) during their episode during the selected target quarter. High risk populations are defined as those who are comatose, or impaired in bed mobility or transfer, or suffering from malnutrition.</p> <p>Long-stay residents are identified as residents who have had at least 101 cumulative days of nursing facility care. A separate measure (NQF#0678, Percent of Residents With Pressure Ulcers That are New or Worsened (Short-Stay)) is to be used for residents whose length of stay is less than or equal to 100 days.</p>	Electronic Clinical Data	Facility
<p>0709 Endorsed</p> <p>Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year.</p> <p><i>Bridges To Excellence</i></p>	Outcome	<p>Percent of adult population aged 18 – 65 years who were identified as having at least one of the following six chronic conditions: Diabetes Mellitus (DM), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD) or Asthma, were followed for one-year, and had one or more potentially avoidable complications (PACs). A Potentially Avoidable Complication is any event that negatively impacts the patient and is potentially controllable by the physicians and hospitals that manage and co-manage the patient. Generally, any hospitalization related to the patient’s core chronic condition or any co-morbidity is considered a potentially avoidable complication, unless that hospitalization is considered to be a typical service for a patient with that condition. Additional PACs that can occur during the calendar year include those related to emergency room visits, as well as other professional or ancillary services tied to a potentially avoidable complication. (Please reference attached document labeled NQF_Chronic_Care_PACs_Risk_Adjustment_2.9.10.xls).</p>	Administrative claims, Electronic Clinical Data: Pharmacy	Clinician: Group/ Practice, Health Plan, Population: County or City, Population: National, Population: Regional, Population: State

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
0710 Endorsed Depression Remission at Twelve Months <i>MN Community Measurement</i>	Patient-Reported Outcome Measure	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Facility
0712 Endorsed Depression Utilization of the PHQ-9 Tool <i>MN Community Measurement</i>	Process	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during the four month measurement period. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Facility
0729 Endorsed Optimal Diabetes Care <i>MN Community Measurement</i>	Composite	The percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, blood pressure, statin use, tobacco non-use and daily aspirin or anti-platelet use 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 less than 8.0, Blood Pressure less than 140 systolic and less than 90 diastolic, Statin use unless contraindications or exceptions, Tobacco-free (non-user) and for patients with diagnosis of ischemic vascular disease daily aspirin or antiplatelet 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.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice
1626 Endorsed Patients Admitted to ICU who Have Care Preferences Documented <i>RAND Corporation</i>	Process	Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.	Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Facility, Health Plan, Integrated Delivery System
1659 Endorsed Influenza Immunization <i>CMS</i>	Process	Inpatients age 6 months and older discharged during October, November, December, January, February, or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.	Administrative claims, Paper Medical Records	Facility, Population: National, Population: Regional, Population: State

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
1662 Endorsed Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy <i>Renal Physicians Association</i>	Process	Percentage of patients aged 18 years and older with a diagnosis of CKD (not receiving RRT) and proteinuria who were prescribed ACE inhibitor or ARB therapy within a 12-month period	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Medical Records	Clinician: Group/Practice, Clinician: Individual, Clinician: Team
1768* Endorsed Plan All-Cause Readmissions (PCR) <i>NCQA</i>	Process	For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned 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* (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission *An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).	Patient Reported Data/ Survey	Health Plan, Integrated Delivery System
1789 Endorsed Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) <i>CMS</i>	Outcome	The measure estimates a hospital-level risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge. The measure reports a single summary risk-standardized readmission rate (RSRR), derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on 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-level standardized risk ratios (SRR) for each of these five specialty cohorts. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Admissions for planned procedures that are not accompanied by an acute diagnosis do not count as readmissions in the measure outcome. The target population is patients 18 and over. CMS annually reports the measure for patients who are 65 years or older and are enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals.	Administrative claims	Facility
1927 Endorsed Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications <i>NCQA</i>	Process	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System, Population: State

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
1932 Endorsed Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) <i>NCQA</i>	Process	The percentage of patients 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy	Health Plan, Integrated Delivery System, Population: State
2079 Endorsed HIV Medical Visit Frequency <i>Health Resources and Services Administration - HIV/AIDS Bureau</i>	Process	Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits A medical visit is any visit in an outpatient/ ambulatory care setting with a nurse practitioner, physician, and/ or a physician assistant who provides comprehensive HIV care.	Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Facility
2091 Endorsed Persistent Indicators of Dementia without a Diagnosis—Long Stay <i>American Medical Directors Association</i>	Process	Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.	Electronic Clinical Data	Facility
2092 Endorsed Persistent Indicators of Dementia without a Diagnosis—Short Stay <i>American Medical Directors Association</i>	Process	Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.	Electronic Clinical Data	Facility
2111* Endorsed Antipsychotic Use in Persons with Dementia <i>Pharmacy Quality Alliance</i>	Process	The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.	Administrative claims	Health Plan
2152 Endorsed Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling <i>AMA-convened Physician Consortium for Performance Improvement</i>	Process	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user	Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry	Clinician: Group/ Practice, Clinician: Individual, Clinician: Team
2158 Endorsed Payment-Standardized Medicare Spending Per Beneficiary (MSPB) <i>CMS</i>	Cost/ Resource Use	The MSPB Measure assesses the cost of services performed by hospitals and other healthcare providers during an MSPB hospitalization episode, which comprises the period immediately prior to, during, and following a patient's hospital stay. Beneficiary populations eligible for the MSPB calculation include Medicare beneficiaries enrolled in Medicare Parts A and B who were discharged from short-term acute hospitals during the period of performance.	Administrative Claims	Hospital/ facility/ agency

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
2380 Endorsed Rehospitalization During the First 30 Days of Home Health <i>CMS</i>	Outcome	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay were admitted to an acute care hospital during the 30 days following the start of the home health stay.	Administrative claims	Facility
2456 Endorsed Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient <i>Brigham and Women's Hospital</i>	Outcome	This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult patient. The time frame is the hospitalization period. At the time of admission, the admission orders are compared to the preadmission medication list (PAML) compiled by trained pharmacist (i.e., the gold standard) to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This process is repeated at the time of discharge where the discharge medication list is compared to the PAML and medications ordered during the hospitalization.	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Pharmacy, Healthcare Provider Survey, Other, Paper Medical Records, Patient Reported Data/ Survey	Facility
2502 Endorsed All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs) <i>CMS</i>	Outcome	This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) discharged from an Inpatient Rehabilitation Facility (IRF) who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital (LTCH), within 30 days of an IRF discharge. The measure is based on data for 24 months of IRF discharges to non-hospital post-acute levels of care or to the community.	Administrative claims, Other	Facility
2505 Endorsed Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health <i>CMS</i>	Outcome	Percentage of home health stays in which patients who had an acute inpatient hospitalization in the 5 days before the start of their home health stay used an emergency department but were not admitted to an acute care hospital during the 30 days following the start of the home health stay.	Administrative claims	Facility
2510* Endorsed Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) <i>CMS</i>	Outcome	This measure estimates the risk-standardized rate of all-cause, unplanned, hospital readmissions for patients who have been admitted to a Skilled Nursing Facility (SNF) (Medicare fee-for-service [FFS] beneficiaries) within 30 days of discharge from their prior proximal hospitalization. The prior proximal hospitalization is defined as an admission to an IPPS, CAH, or a psychiatric hospital. The measure is based on data for 12 months of SNF admissions.	Administrative claims, Other	Facility
2512 Endorsed All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs) <i>CMS</i>	Outcome	This measure estimates the risk-standardized rate of unplanned, all-cause readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) discharged from a Long-Term Care Hospital (LTCH) who were readmitted to a short-stay acute-care hospital or a Long-Term Care Hospital (LTCH), within 30 days of an LTCH discharge. The measure is based on data for 24 months of LTCH discharges to non-hospital post-acute levels of care or to the community.	Administrative claims, Other	Facility

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
2597 Endorsed eMeasure Approved for Trial Use Substance Use Screening and Intervention Composite <i>American Society of Addiction Medicine</i>	Composite	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record	Clinician: Group/ Practice, Clinician: Individual
2599 Endorsed Alcohol Screening and Follow-Up for People with Serious Mental Illness <i>NCQA</i>	Process	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI).	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan
2600 Endorsed Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence <i>NCQA</i>	Process	The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported. Rate 1: The percentage of patients 18 years and older with a diagnosis of serious mental illness who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Rate 2: The percentage of adults 18 years and older with a diagnosis of alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention NQF #0028). This measure is currently stewarded by the AMA-PCPI and used in the Physician Quality Reporting System.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan
2601 Endorsed Body Mass Index Screening and Follow-Up for People with Serious Mental Illness <i>NCQA</i>	Process	The percentage of patients 18 years and older with a serious mental illness who received a screening for body mass index and follow-up for those people who were identified as obese (a body mass index greater than or equal to 30 kg/ m ²). Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care & Screening: Body Mass Index: Screening and Follow-Up NQF #0421). It is currently stewarded by CMS and used in the Physician Quality Reporting System.	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
<p>2602 Endorsed Controlling High Blood Pressure for People with Serious Mental Illness NCQA</p>	Outcome	<p>The percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.</p> <p>Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0018: Controlling High Blood Pressure). It was originally endorsed in 2009 and is owned and stewarded by NCQA. The specifications for the existing measure (Controlling High Blood Pressure NQF #0018) have been updated based on 2013 JNC-8 guideline. NCQA will submit the revised specification for Controlling High Blood Pressure NQF #0018 in the 4th quarter 2014 during NQF's scheduled measure update period. This measure uses the new specification to be consistent with the current guideline.</p>	Administrative claims, Electronic Clinical Data, Paper Medical Records	Health Plan
<p>2603 Endorsed Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing NCQA</p>	Process	<p>The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing during the measurement year.</p> <p>Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0057: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing). This measure is endorsed by NQF and is stewarded by NCQA.</p>	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan
<p>2604 Endorsed Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy NCQA</p>	Process	<p>The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.</p> <p>Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0062: Comprehensive Diabetes Care: Medical Attention for Nephropathy). It is endorsed by NQF and is stewarded by NCQA.</p>	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
2605 Endorsed Follow-Up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence NCQA	Process	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported: <ul style="list-style-type: none"> • The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge. • The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge. • The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge. • The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge. 	Administrative claims	Health Plan, Population: State
2606 Endorsed Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/ 90 mm Hg) NCQA	Outcome	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading during the measurement year is <140/ 90 mm Hg. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0061: Comprehensive Diabetes Care: Blood Pressure Control <140/ 90 mm Hg) which is endorsed by NQF and is stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan
2607 Endorsed Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) NCQA	Outcome	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control >9.0%). This measure is endorsed by NQF and is stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan
2608 Endorsed Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%) NCQA	Outcome	The percentage of patients 18-75 years of age with a serious mental and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is <8.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0575: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0). This measure is endorsed by NQF and is currently stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Laboratory, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
2609 Endorsed Diabetes Care for People with Serious Mental Illness: Eye Exam <i>NCQA</i>	Process	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had an eye exam during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0055: Comprehensive Diabetes Care: Eye Exam). This measure is endorsed by NQF and is stewarded by NCQA.	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy, Paper Medical Records	Health Plan
2624 Endorsed Functional Outcome Assessment <i>CMS</i>	Process	NOTE: Specification information in this section is from the 2014 Physician Quality Reporting System Manual. Note that Testing Information is based on the specification in the 2012 Physician Quality Reporting System Manual. Both 2012 and 2014 Specifications are included in the attached "NQF Endorsement Measurement Submission Summary Materials" Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	Administrative claims, Paper Medical Records	Clinician: Group/Practice, Clinician: Individual
2775 Endorsed Functional Change: Change in Motor Score for Skilled Nursing Facilities <i>Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.</i>	Outcome	Change in rasch derived values of motor function from admission to discharge among adult short term rehabilitation skilled nursing facility patients aged 18 years and older who were discharged alive. The time frame for the measure is 12 months. The measure includes the following 12 items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.	Electronic Health Record (Only), Other, Paper Records	Facility
2776 Endorsed Functional Change: Change in Motor Score for Long Term Acute Care Facilities <i>Uniform Data System for Medical Rehabilitation, a division of UB Foundation Activities, Inc. and its successor in interest, UDSMR, LLC.</i>	Outcome	Change in rasch derived values of motor function from admission to discharge among adult long term acute care facility patients aged 18 years and older who were discharged alive. The timeframe for the measure is 12 months. The measure includes the following 12 items: Feeding, Grooming, Dressing Upper Body, Dressing Lower Body, Toileting, Bowel, Expression, Memory, Transfer Bed/Chair/Wheelchair, Transfer Toilet, Locomotion and Stairs.	Electronic Health Record (Only), Other, Paper Records	Facility
2858 Endorsed Discharge to Community <i>American Health Care Association</i>	Outcome	The Discharge to Community measure determines the percentage of all new admissions from a hospital who are discharged back to the community alive and remain out of any skilled nursing center for the next 30 days. The measure, referring to a rolling year of MDS entries, is calculated each quarter. The measure includes all new admissions to a SNF regardless of payer source.	Electronic Health Record (Only)	Facility

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
<p>2967* Endorsed CAHPS® Home-and Community -Based Services Measures <i>CMS</i></p>	<p>Outcome: PRO</p>	<p>CAHPS® Home- and Community-Based Services measures derive from a cross disability survey to elicit feedback from adult Medicaid beneficiaries receiving home and community based services (HCBS) about the quality of the long-term services and supports they receive in the community and delivered to them under the auspices of a state Medicaid HCBS program. The unit of analysis is the Medicaid HCBS program, and the accountable entity is the operating entity responsible for managing and overseeing a specific HCBS program within a given state. (For additional information on the accountable entity, see Measures Testing form item #1.5 below.)</p> <p>The measures consist of seven scale measures, 6 global rating and recommendation measures, and 6 individual measures:</p> <p>Scale Measures: (1) Staff are reliable and helpful -top-box score composed of 6 survey items. (2) Staff listen and communicate well -top-box score composed of 11 survey items. (3) Case manager is helpful - top-box score composed of 3 survey items. (4) Choosing the services that matter to you - top-box score composed of 2 survey items. (5) Transportation to medical appointments - top-box score composed of 3 survey items. (6) Personal safety and respect - top-box score composed of 3 survey items. (7) Planning your time and activities top-box score composed of 6 survey items. Global Ratings Measures. (8) Global rating of personal assistance and behavioral health staff- top-box score on a 0-10 scale. (9) Global rating of homemaker- top-box score on a 0-10 scale. (10) Global rating of case manager- top-box score on a 0-10 scale.</p> <p>Recommendations Measures: (11) Would recommend personal assistance/behavioral health staff to family and friends - top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes). (12) Would recommend homemaker to family and friends -- top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes). (13) Would recommend case manager to family and friends- top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes). Unmet Needs Measures. (14) Unmet need in dressing/bathing due to lack of help-top-box score on a Yes, No scale. (15) Unmet need in meal preparation/eating due to lack of help- top-box score on a Yes, No scale. (16) Unmet need in medication administration due to lack of help- top-box score on a Yes, No scale. (17) Unmet need in toileting due to lack of help- top-box score on a Yes, No scale. (18) Unmet need with household tasks due to lack of help- top-box score on a Yes, No scale. Physical Safety Measure. (19) Hit or hurt by staff - top-box score on a Yes, No scale</p>	<p>Patient Reported Data</p>	<p>Other</p>
<p>3039* Endorsed Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan <i>CMS</i></p>	<p>Process</p>	<p>Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.</p> <p>Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 - 64 years BMI > or = 18.5 and < 25</p>	<p>Administrative claims, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Medical Records</p>	<p>Clinician: Group/ Practice, Clinician: Individual, Population: County or City, Population: National, Population: Regional, Population: State</p>

Measure Status, Title, and Steward	Measure Type	Measure Description	Data Source	Level of Analysis
3086 Endorsed Population Level HIV Viral Load Suppression <i>Centers for Disease Control and Prevention</i>	Intermediate Clinical Outcome	Percentage of persons >13 years of age with diagnosed HIV infection who are virally suppressed in the measurement year.	Other	Population: Regional and State
3148* Endorsed Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan <i>CMS</i>	Process	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented Note: This measure is adapted from an existing measure used in a variety of reporting programs (NQF #0418: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan). This measure is endorsed by NQF and is stewarded by CMS.	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual, Clinician: Team, Population: Community, Population: County or City, Population: National, Population: Regional, Population: State
3225* Endorsed Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention <i>AMA-convened Physician Consortium for Performance Improvement</i>	Process	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Medical Records	Clinician: Group/ Practice, Clinician: Individual, Clinician: Team

APPENDIX E: MAP Dual Eligible Beneficiaries Starter Set

An asterisk (*) indicates additions to the Starter Set.

NQF #	Measure Title	Measure Type	Measure Steward
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Process	National Committee for Quality Assurance (NCQA)
0008	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)	Composite	Agency for Healthcare Research and Quality
0018	Controlling High Blood Pressure	Outcome	NCQA
0097	Medication Reconciliation Post-Discharge	Process	NCQA
0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	Process	NCQA
0228	3-Item Care Transition Measure (CTM-3)	PRO	University of Colorado Denver Anschutz Medical Campus
0326	Advance Care Plan	Process	NCQA
0419	Documentation of Current Medications in the Medical Record	Process	CMS
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Process	NCQA
1768	Plan All-Cause Readmissions (PCR)	Process	NCQA
2111	Antipsychotic Use in Persons with Dementia	Process	Pharmacy Quality Alliance
2510	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)	Outcome	CMS
2967*	CAHPS® Home- and Community-Based Services Measures	Outcome	CMS
3039	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Process	CMS
3148	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Process	CMS
3225	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	AMA-convened Physician Consortium for Performance Improvement

APPENDIX F: Public Comments

General Comments

Community Catalyst

Ann Hwang

Community Catalyst appreciates the opportunity to comment on the 2017 draft report of the Measure Application Partnership Dual Eligible Beneficiaries Workgroup (MAP Workgroup).

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the U.S. health system. The Center for Consumer Engagement in Health Innovation is a hub devoted to teaching, learning, and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer advocates to enhance their skills and power to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals, and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers. We have been working to improve Medicaid and Medicare for consumers for more than a decade, producing tools for consumer advocates to use in state-based advocacy as well as tools for use by other stakeholders.

We appreciate the continued focus on improving the ability to measure quality of care for the Medicare-Medicaid enrollee population. We note that measurement in this area lags greatly behind what is needed, with critical gaps remaining in our tools for quality measurement. We are therefore concerned that the workgroup is being discontinued, and we hope that CMS and the NQF will continue to support this important work.

We are aware that the need for improved quality measurement tools is immediate and pressing, and the development of measures requires time and resources. We urge NQF and CMS to accelerate

measure development in the high priority areas we have comment on. Throughout this process, we believe that the strong participation of patients, families, caregivers, and communities will be critical to ensuring that we create measures that are meaningful to consumers. We hope that CMS and NQF will reconsider discontinuation of the MAP Workgroup.

Consortium for Citizens with Disabilities

E. Clarke Ross

CAHPS HCBS Experience Survey (pages 8-9 & 16-17): The American Association on Health and Disability and the Lakeshore Foundation enthusiastically endorse and support the workgroup's recommended endorsement and inclusion in the "starter set" of the CAHPS Home-and-Community-Based Services (HCBS) Experience Survey.

Other Issues of Particular Interest: The American Association on Health and Disability and the Lakeshore Foundation are very pleased to see the following items included in the report: (1) Page 8 - discharge to the community; (2) Pages 9-10 - high priority gaps - repeated from previous years; (3) Page 10 - NQF behavioral health project summary; (4) Pages 10-11 - NQF disparities project summary; (5) Pages 11-14 & 19-20 - HHS ASPE socio-demographic factor analysis; (6) Page 13 - National Core Indicators mentioned; (7) Pages 14-16 - NIDILRR & ACL funded University of MN project summary; and (8) Page 17 - coordination and integration as a strategic issue. Where the National Core Indicators are mentioned (page 13), it would be nice to also see the Personal Outcome Measures mentioned (as presented at the May meeting of the MAP workgroup on Medicaid adult measures and as considered and mentioned by other previous NQF reports).

Engagement with the NQF: The American Association on Health and Disability and the Lakeshore Foundation join Community Catalyst emphasizing the active engagement in all NQF forums and entities - of participants, beneficiaries, consumers, and patients; their families; their advocates; and non-medical community-based organizations. We are concerned that with the

termination of the MAP workgroup on persons dually eligible for Medicare and Medicaid, such engagement has been significantly diminished within NQF.

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross.

Justice in Aging

Jennifer Goldberg

Justice in Aging is a national non-profit legal advocacy organization that fights senior poverty through law. Since our founding in 1972, we have worked for access to affordable health care and economic security for older adults with limited resources, focusing especially on populations that have traditionally lacked legal protection.

As an organization that focuses much of our advocacy on the needs of dual eligibles, Justice in Aging has been pleased that CMS and NQF chose to establish the Workgroup on this high need, high cost, and highly diverse population. We also have appreciated the many opportunities for stakeholder input and the focus the workgroup has had on the needs and experiences of beneficiaries. We urge CMS and NQF to continue their efforts to improve measurement development for duals in a way that maximizes opportunity for stakeholder input and keeps a focus on the needs of beneficiaries.

SNP Alliance

Deborah Paone

The SNP Alliance thanks the MAP and joins others in the hope that the focus on duals as a specific area for quality measurement will continue. We believe in the following principles:

Measures reflect the dual population needs and characteristics.

Every beneficiary should be able to participate equally in the quality measurement process.

Social determinants of health risk factors are fully considered--minimum standards are set for measure developers and stewards for testing and adjustment.

Quality metrics are adjusted for high dual plan types so that plans focusing on like populations are compared with each other consistently.

Fairness and attention to administrative burden is demonstrated.

There is a balance of process and outcome measures, with greater focus on outcomes that plans can impact.

There is value of aligning metrics across states, where possible, recognizing state's authority.

Reporting comparisons ensure match of like to like in terms of plans and populations enrolled.

Duals - We agree that CMS focus specific quality measurement development on dual eligible beneficiaries and guide measure developers to oversample, test, and validate measures with these beneficiaries. We particularly endorse the MAP recommendation to identify and separate the subgroups within the dually-eligible population. It is crucial to ensure that measures, measure definitions exclusions/exceptions, and data collection methods take into account differences across subpopulations in order to have meaningful and accurate measurement.

Social Risk Factors - We agree more guidance is needed on adjusting for dual eligible status and for social risk factors. Stratification and risk adjustment is crucial for accurate measurement and reporting. Additional measure testing and adjustment, using the smallest geographic area as a unit of analysis, should be done.

Core Set - We strongly support the recommendation that there be a core set of key issues/measures relevant across the population at large—and that these core issues guide the selection of measures that can be used across settings and over time. This will help to integrate quality improvement, connecting settings and services, plans and providers. We recommend at least a few special needs health plans be included in any implementation examination and analysis.

CAHPS HCBS - We support the use of experience of care measures, with proper attribution, also ensuring they are understood by persons with language diversity or low health literacy. We note limitations with the HOS instrument currently used to evaluate quality performance of plans serving dual-eligible beneficiaries under Medicare. Additionally, HCBS providers may need technical assistance--there are vast differences among providers in: organizational capacity, information systems and data handling/transmittal capability.

The National Consumer Voice for Quality Long-Term Care

Robyn Grant

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) is a national non-profit organization that advocates on behalf of long-term care consumers across care settings. Our membership consists primarily of consumers of long-term care and services, their families, long-term care ombudsmen, individual advocates, and citizen advocacy groups. Consumer Voice works to empower long-term care consumers to engage in shaping the policy decisions that impact their care, services and lives.

We thank the National Quality Forum for the opportunity to comment on the 2017 draft report of the Measure Application Partnership Dual Eligible Beneficiaries Workgroup (MAP).

Our comments are outlined comments below.

We commend the MAP workgroup for including the CAHPS Home-and Community-Based Services (HCBS) Measures. The consumer experience is an essential part of measuring quality. Consumer choice, participant-directed services, individual experience and satisfaction with services and supports, shared decision-making, and beneficiary sense of control/ autonomy/self-determination within a community integration and inclusion approach are among the most important quality indicators and are prioritized by many disability and aging advocates.

We urge the MAP Workgroup to consider the high-priority measurement gap areas identified in the draft report and work to advance measures in these areas.

Patient reported outcome measures that provide insight into care experiences are essential.

We support the MAP Workgroup's focus on healthcare disparities in the dual eligible population and its approach outlined in the ASPE report. We have noted significant disparities in both access to and quality of long-term care and much remains to be done to address these issues.

We recommend that NQF and CMS accelerate measurement development in these critical priority areas. There is an urgent need for improved quality measurement tools.

We join the American Association on Health and Disability and the Lakeshore Foundation, as well as Community Catalyst, in emphasizing the active engagement in all NQF forums and entities – of participants, beneficiaries, consumers, and patients; their families; their advocates; and non-medical community-based organizations. We echo their concerns that such engagement will be lost with the termination of the MAP workgroup on persons dually eligible for Medicare and Medicaid, and call on both CMS and NQF to reconsider the decision to discontinue the MAP Workgroup.

Thank you for your consideration of these comments.

The SCAN Foundation

Megan Burke

Research shows functional impairment is a critical risk indicator. The SCAN Foundation is encouraged by the workgroup's discussion about function as a risk indicator and the need for a standard set of observational questions to properly risk adjust for function. A new analysis of Medicare spending (http://media.mcknights.com/documents/270/ati_fact_sheet_fi_and_medical__67496.pdf) shows that older adults with chronic conditions and functional impairment have much greater health care spending than those with chronic conditions alone. Research from Avalere (<http://www.thescanfoundation.org/defining-business-case-targeted-care-coordination-0>) reveals that assessing medical conditions alone will not improve risk identification. In order to develop a more complete understanding of predictors of risk, functional impairments along with other non-medical characteristics (e.g., cognitive impairments, behavior health conditions, and living situation) should be considered. Additionally, a report from Bipartisan Policy Center (<https://bipartisanpolicy.org/library/improving-care-for-high-need-high-cost-medicare-patients/>) makes the argument for including functional impairment in Medicare's risk adjustment model. These studies may be appropriate for the University of Minnesota Institute on Community Integration's efforts to identify variables for risk adjustment as part of their effort to develop HCBS outcome measures.

Recommended/Removed Measures

Community Catalyst

Ann Hwang

Below are comments to specific measures noted in the draft report:

We applaud inclusion of CAHPS Home-and Community-Based Services (HCBS) Measures. As we have noted in our past comments, these are important measures to assess HCBS quality. Consumer choice, participant-directed services, individual experience and satisfaction with services and supports, shared decision-making, and beneficiary sense of control/autonomy/self-determination within a community integration and inclusion approach are among the most important quality indicators and are prioritized by many disability and aging advocates.

We recommend the MAP Workgroup focus on patient reported outcome measures that will provide insight into care experiences. Towards that end, we urge the MAP Workgroup to consider the high-priority measurement gap areas identified in the draft report, and work to advance measures in these areas (See pages 9-10 of the 2017 draft report).

We appreciate the MAP Workgroup's interest in addressing healthcare disparities in the dual eligible population. We are supportive of the three-pronged approach outlined in the ASPE report and we encourage continued efforts to improve data collection and reduce disparities.

Justice in Aging

Jennifer Goldberg

Justice in Aging fully supports inclusion of NQF #2967 CAHPS Home and Community-Based Services Measures to the Duals Family of Measures and the inclusion of that measure to the Starter Set. (Page 16-17 of the report). It is hard to overstate the importance of HCBS in maintaining the health and safety of dual eligibles living in the community and the need for good measures in this area is urgent.

SNP Alliance

Deborah Paone

The MAP endorsed many measures in their family of measures for dually-eligible beneficiaries. Twenty-eight of them would be applied to health plans. Many focus on elements of care and follow-up around diabetes, and screening and control (e.g., blood pressure, cervical cancer, colorectal cancer, cardiovascular, diabetes, alcohol, tobacco use, body mass index) with a particular focus on persons with serious mental illness and care for older adults. The additional focus on experience with home and community based and behavioral health is noted. Both of these require a survey of patients/members.

We believe in the importance and value of consumer experience of care measures to guide quality improvement and highlight strengths and weaknesses in care approaches. We have already remarked on several significant challenges: connecting experience of care measure results with a particular provider or provider organization, data accessibility and accuracy, and survey design and administration. These current challenges with self-report do not accommodate the dual eligible beneficiary population well (e.g., 2-year look-back, lack of robust language accommodation, requirement for communication device, stable residence, health literacy), and sampling inadequacies (lack of oversampling of ethnic/language diverse populations which results in very small numbers in the final sample). All of these issues potentially bias results. These issues need to be addressed prior to finalizing the measurement set and using it in the field.

We encourage additional testing and piloting in the field prior to implementation, particularly focusing on high dual health plans serving a high proportion of specific subgroups as outlined by the MAP--with the concomitant provider networks. Testing and seeing how the measures fit the characteristics of the population and are handled by providers serving the dual subgroup is extremely valuable. We strongly urge this kind of field testing on implementation of a dual measure set across settings and services and with the health plan that has both the Medicare and Medicaid contracts for that group of beneficiaries.

There are 18 measures in the “Starter Set” are described as “most ready for implementation as currently specified.”

We appreciate the work of the MAP to offer these measures as a starter set. Again, we would strongly encourage pilot testing that would include subgroups of duals (e.g., defined by age, medical/behavioral health, LTSS needs, social risk factors, language diversity, and other characteristics) and different types of provider networks and special needs health plans.

This real-world testing would offer valuable insight into the utility, accuracy, and effect of these measures toward performance evaluation and quality improvement.

Strategic Plan and Direction

Community Catalyst

Ann Hwang

We support the MAP workgroup members’ call for a fundamental paradigm shift in how measures are conceptualized and developed for this population. The MAP workgroup members correctly state that future measures should “consider the population’s needs and gap areas”. In addition to the changes suggested in the report, we urge NQF to actively engage consumers, consumer advocates and the community when developing measures (http://www.rand.org/pubs/research_reports/RR1760.html).

Justice in Aging

Jennifer Goldberg

Justice in Aging recognizes that there are many areas that affect dual eligible beneficiaries that are not included in current measures. We encourage the MAP Workgroup to consider the high-priority measurement gap areas identified in the draft report, and work to advance measures in these areas (See Page 9-10 of the report). We particularly appreciate the ongoing efforts of the Dual Eligible Beneficiary Workgroup to consider the implications of social risk factors and how to address them effectively. While, as the report notes, finding measurement approaches that work well to address these factors creates challenges, the challenges should not deter efforts to develop effective tools. We also applaud

the Workgroup’s interest in addressing health care disparities.

We strongly endorse the recommendation of the Workgroup that all measure development begin from the perspective of the beneficiary. CMS has rightly made person-centered care a centerpiece of its efforts to improve the health of beneficiaries. Person-centered measurement must necessarily follow, particularly for the dual eligible population, which disproportionately faces cross-cutting challenges in access to quality care.

SNP Alliance

Deborah Paone

Excessive, Redundant Measures - We support the finding that there are conflicting, duplicative/ redundant, and excessive measures as well as gaps in measure areas. This siphons off resources and does not advance quality improvement.

Integration - We note that integration between the Medicaid (State authority) and Medicare (federal authority) programs is a primary barrier to integration at the plan, provider, and beneficiary level. It is impossible to fully realize the benefits of integration without State and federal support.

We believe that performance evaluation should be based on comparing “like plans to like plans”—those with similar beneficiary enrollment, regional area served, and regulatory requirements at the state level. These clearly affect what plans and providers can offer and how beneficiaries use the health and LTSS systems. This then impacts outcomes observed. Ensuring risk stratification, and segmenting plans into groups that are more homogeneous, are two steps to consider when comparing quality results between plans. This helps avoid incomplete or inaccurate reporting to the public. There wide differences across states and even within regions.

Paradigm Shift - We agree on the need for reframing measures and measure development. The practice of measuring “healthy days living in the community” is an excellent example. As stated in the current specifications the current “healthy days” measure is very broad and thus has limitations. There are examples where the use of services described would be counted as “unhealthy days” would support positive care. For example when a beneficiary is

well enough to tolerate an elective procedure, (e.g., knee or hip surgery) the time in acute, rehab, and home health care is a positive transition to a life with better functional status. This builds toward a goal set by the person—to have the ability to walk better and without pain. We would not want to see efforts to restrict appropriate use of services to these vulnerable populations.

Data Issues - We support and agree with the MAP regarding challenges with data collection and reporting. Medical care, HCBS, and behavioral health providers have varying levels of staff capacity, electronic record systems, privacy/secure data transmittal systems--particularly small and rural providers that are not part of larger systems. There are already data access, data integrity, and interoperability issues health plans experience trying to receive accurate and timely data on beneficiaries. In addition, there are real challenges with self-report survey data—small sample sizes, respondent sample that does not reflect the full enrolled population (skewed), difficulty with administration given communication barriers. These issues must be attended to prior to widespread application.

The SCAN Foundation

Megan Burke

Measurement paradigm shift: The SCAN Foundation agrees with the workgroup's assertion of a need for a measurement paradigm shift. In 2016, a panel of national experts articulated four Essential Attributes (<http://www.thescanfoundation.org/what-matters-most-essential-attributes-high-quality-system-care-adults-complex-care-needs?platform=hootsuite>) of a high-quality system of care, centering on person-centered care concepts. The Essential Attributes closely align with domains outlined in the NQF report, *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*, and specify standards for a high-quality HCBS delivery system that is inclusive of and responsive to what matters most to people with complex care needs. We recommend that NQF develop new quality measures that directly relate to the Essential Attributes framework and specifically address the integration of medical and non-medical services for people with complex care needs.

Include person-driven outcome measures as part of the measurement paradigm shift. The workgroup noted that measure development should start at the individual level and the data collection should speak to quality of care and quality of life. The National Committee for Quality Assurance (NCQA), in partnership with The SCAN Foundation and the John A. Hartford Foundation, is currently working to develop person-driven outcome measures (<http://www.ncqa.org/hedis-quality-measurement/research/measuring-what-matters-most>) that focus on coordination and delivery of LTSS. This body of work tests two promising methods for documenting person-driven outcomes in a standardized format, and could form a basis for building person-driven quality metrics in the future. To inform NQF efforts, we recommend reviewing NCQA's work, with consideration of person-driven outcome measures when available.

Collaboration and integration between government agencies: The workgroup identified the need for collaboration and integration between government agencies and community-based organizations for measure and survey development. A 2016 Bipartisan Policy Center (BPC) report (<https://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/>) recommends that the Centers for Medicare and Medicaid Services (CMS) align oversight functions for programs serving dual eligible individuals. Such consolidation of authority within CMS could help improve coordination and integration of measure development.

Standardize measurement across programs. The workgroup underlined the importance of a standardized comprehensive assessment. Evaluation results from California's financial alignment demonstration, Cal MediConnect (CMC), could inform such efforts. In particular, the Cal MediConnect Health System Response Study (http://www.thescanfoundation.org/sites/default/files/cal_medicconnect_health_system_key_findings.pdf) showed the importance of improving data collection and reporting to better understand service delivery across health plans, as well as to highlight promising practices. The evaluation stressed the importance of clearly defining person-centered care to ensure the health plans elicit individuals' goals in the HRA process. Additionally, findings showed

significant variation in the data collection and reporting processes between CMC plans, creating administrative burdens for community-based organizations that contract with multiple plans. Potential solutions include adoption of systems that enable data sharing and collaboration across stakeholder organizations, and development of a universal screening assessment tool and process.

NATIONAL QUALITY FORUM
1030 15TH STREET, NW, SUITE 800
WASHINGTON, DC 20005

www.qualityforum.org