Measure Applications Partnership

Comments on the Interim Report to HHS: "Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries"

NQF Response to Comments Received:

The National Quality Forum thanks all who responded with comments on the Interim Report. Multiple commenters highlighted the importance of improving the affordability of care, the need to correctly assign accountability for quality, and promoting alignment with the National Quality Strategy, across Medicare and Medicaid, and between current reporting programs. MAP members also emphasized these points in their deliberations. Input from NQF members and the public will be given careful consideration in the second phase of the MAP Dual Eligible Beneficiaries Workgroup's effort. In particular, MAP will continue to focus on the design of a potential measurement program, candidate measures, measure gaps, and data sources. A final report on the subject of identifying appropriate performance measures for use in the complex and heterogeneous population of dual eligible beneficiaries is due to HHS on June 1, 2012.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments on the Interim Report	America's Health Insurance Plans	Carmella Bocchino	We applaud the effort by the Measures Application Partnership (MAP) to bring together experts from many disciplines in the development of this strategic framework for dual eligible performance measures. Overall, this is an important initiative that has the potential to improve health outcomes while also reducing the rate of healthcare spending among the dual eligibles, a population that includes some of the highest utilizers of healthcare resources and drives much of the current public sector healthcare costs. AHIP supports the interim report of the MAP to Performance Measurement for Dual Eligible Beneficiaries to better facilitate achievement of the three-part aim for this population. For this initiative to be successful effective engagement of providers and patients is critical. This can be achieved through a number of interventions including patient engagement, appropriate provider incentives and value-based benefit design.
General Comments on the Interim Report	National Association of Children's Hospitals and Related Institutions	Ellen Schwalenstocker	Even though the population is described in detail in Appendix D, it might be helpful to include a little more description of dual eligible beneficiaries at a high level on page 4 just to set more context for the report. Of course, I really like the discussion of inclusivity (especially all age groups) on page 6. The Care Coordination measure comments note that the measure is not age-restricted. As far as I know, the measure has only been tested in adult populations although the description on the NQF site suggests it could probably be applied to pediatric settings. Similarly the Tobacco use assessment and intervention measure pair comments say the measures are not limited by age, but I believe they are restricted to >18 year olds.

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General Comments on the Interim Report	Federation of American Hospitals	Jayne Chambers	The Federation of American Hospitals ("FAH") is pleased to have the opportunity to comment on the Measure Applications Partnership report, Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries: Interim Report to HHS. The FAH appreciates the report's clarity identifying the many challenges in a comprehensive measurement and care coordination initiative for the dual eligible population. We suggest that the concepts included in the third paragraph on page 20 also be discussed in the earlier Measurement Design section. The existence of multiple quality reporting programs and the diverse goals of these programs with large numbers of reporting measures exacerbates the challenges of alignment across programs, and increases the challenges in developing a focus on limited number of realistic evidence-based measures that can be leveraged from other programs for use in the dual eligible measurement initiative. The FAH suggests mentioning this overall concept early in the paper and reiterating it in the Program Alignment section would strengthen the paper. We also appreciate the report's recognition that the new comprehensive measure strategy will need to balance immediate, short-term, and long-term steps, and the recognition of the significant challenges of Data Sources. Further, we strongly support the report's statement that providers should not be held accountable for "macro-level elements that are beyond their sphere of influence and for which there is no Medicare or Medicaid benefit."
General Comments on the Interim Report	Georgetown University Law Center	Rachel Nelson	Presumably because it's a draft produced on a tight timeline, there seems to be an edit artifact on Page 5: the NQS aim cited seems less an "example" of what the MAP has espoused than a statement of the aim with which the group's philosophical significant other is consistent.

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General Comments on the Interim Report	SNP Alliance (NHPG)	Richard Bringewatt	The SNP Alliance applauds NQF's dual effort. 1. We support accountability within context of parsimony. 2. We applaud system orientation. Current measures too focused on pieces. 3. Aligning program regulations and performance measurements is critical. 4. Judge all measures within context of the endgame. For consumers: a. Simplify access , b. Improve their experience, c. Improve health and wellbeing; For governments: a. Bend cost curve, b. Reduce administrative costs, c. Achieve better results; For specialized MC: a. Eliminate duplication and conflicts, b. Eliminate impediments to specialization, c. Empower plans to transform care 5. Align all M/M for HEDIS, HOS, CHAPS, QIPs, PIPs, CCIPs, etc. Require validation of the proxy for HOS and CAHPS. 6. Resolve self-report problems for mentally ill, cognitively impaired, and frail elders. 7. Modify STARS to support what's MOST important for duals, particularly for high-risk. 8. Stratify or risk-adjust findings to target populations. 9. Move to outcome methods ASAP. Consider hospitalization, emergency room visits, long-stay NH days, adverse drug events and consumer satisfaction as starting point. 10. Make distinction between care integration, e.g. care management, care transitions, etc. and program integration, e.g. eligibility determination, member communication, grievance and appeals, etc. but focus on both. 11. Make stronger distinction between Over 65 and Under 65. 12. Assure measures will be population focused. 13. Consider three-step process: 1) Eliminate duplication and conflicts, 2) identify core set of existing measures, 3) only add new measures after completing steps 1 and 2. 14. Empower practitioners to make quality care decisions rather than become skilled documentation and compliance specialists. 15. Be wary of unintended consequences.

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General Comments on the Interim Report	State of Minnesota	Pam Parker	I read the section on alignment (pages 19-21) and thought it was doing a nice job of making the points I expressed concern to you about. However I would like to see something added in the fourth paragraph where you list all of the measures that need to be rationalized. You do mention “setting specific” measures, which I assume would mean nursing homes for example, but I think it would be worth mentioning CMS requirements for home and community based waiver services specifically. I would call that out because CMS expectations of States have been growing around measures for this portion of the population and service set (and thus are being passed on to their managed long term care programs and integrated SNP programs as well. So as the SNP expectations have grown as well, we as a State are having a harder time finding “room” for addressing increasing CMS expectations on HCBS. In addition, one of the confusions about those measures that has come up over the years, is the scope creep of expectations. In a desire to look at the comprehensive person centered needs of members, patients, clients or whatever group is being focused on, we are forgetting about who controls what. For example, at one point CMS was considering using a measure that related to how well medications were managed for people getting home and community based services in their homes. However, this is not something Medicaid controls for dual eligibles. Medicare pays for most drugs and primary care for duals, so States lack the normal tools (including data!) for managing accountability for how people are accessing and using prescription drugs. It would be fine, if in our integrated programs we are held responsible for all of this, but if we are unable to have integrated options for some groups, we cannot take responsibility for Medicare requirements. So in the absence of perfect integration, at the same time that we need to rationalize the total measures that are being applied from many different regulatory structures and funding sources to achieve an overarching and efficient framework for a comprehensive set of measures, we also need to consider the scope of accountability of the various entities providing or responsible for care and/or financing to make sure we are holding the right part of the system accountable. This may mean parsing out some of the new comprehensive total package of measures in a new way, thereby avoiding duplication, but not necessarily having each entity collect or be evaluated by the total set unless they are an entity that holds responsibility for all of the care provided. So for example, where there is a fully integrated program, it should be held accountable for all measures including medication management and behavioral health and home and community based services, but where for some reason some of this is in a different payer or provider group or carved out entity , that subset of measures needs to go with the entity responsible. Has there been much discussion around this and does this make sense to you or is there another way to think about this.

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General Comments on the Interim Report	WellPoint	Lisa Latts	This is an honest and practical attempt to measure the process and results of a badly broken and dysfunctional relationship. The challenge is to document present state and ongoing improvement towards goals and vision. Disparate data sources and fragmented care structure make this very difficult. Integrated care systems will likely demonstrate much better scores while unlinked fragments will demonstrate uncoordinated, expensive, worse outcomes. It might be useful to organize the measurements around systems of care so that if we aren't comparing apples and oranges, we can at least compare round fruit... We are concerned that we will monitor reporting capability rather than actual competence of care (recognizing that if it isn't documented, it wasn't done) – but members in fragmented care settings (as the report documents) have significant complexity in measurement. The other issue is, do we report (and reward) systems that already function well or do we focus reporting (and reward) on systems that show improvement. Do we create a scenario where health plans "perform to the test" or do we create measurements that document improvement year over year. We would favor the latter. If we don't measure, we won't manage. But we need to be certain that measurements reflect the complexity of the system(s) and the differences in the system. The logical conclusion of all of this effort will be that a coordinated, integrated care system works far better than the alternative and it will compel the management of all dual eligible persons beyond the current SNP initiatives.
Strategic Approach (Vision and Guiding Principles)	America's Health Insurance Plans	Carmella Bocchino	We support the set of guiding principles described in the report and offer the following additional principles for consideration by the MAP: 1) Align strategy with the three-part aim articulated in the National Quality Strategy 2) Align performance measurement efforts across all HHS programs and also specifically among CMS, state Medicaid, and accreditation programs to ensure consistency across programs, minimize burden on stakeholders, and promote achievement of the three-part aim. 3) Graduate performance measurement to focus on evidence-based health outcomes versus the current predominance of process and program measures including ensuring a focus on measures that have been NQF-endorsed, field tested and validated. 4) Recognize that measurement for the purposes of accountability need to be balanced with the need for promoting innovation in program design and implementation that can improve quality for this population 5) Minimize administrative burden for providers, health plans, and other relevant stakeholders in the performance measurement enterprise through maximizing the use of existing data sources and its conversion to actionable information. 6) Prioritize measures that have high-impact and support improvement. 7) Acknowledge challenge of accounting for risk in the high-risk, high-disease burden dual eligible population and find approaches to address this issue.

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Strategic Approach (Vision and Guiding Principles)	Consumer-Purchaser Disclosure Project	Christine Chen	Vision Statement: We recommend that MAP modify the title of the vision statement to read: “Vision for High-Quality AND High-Value Care” (page 4). Currently, the title only reflects quality (page 4). Better value is critical to achieving sustainability, a key pillar of the vision statement. This recommendation is also in line with the statement that “the vision aspires to high-value care . . .” (page 5). Guiding Principles: **Desired effects**: The MAP identified “promoting integrated care,” “ensuring cultural competence,” and “health equity” as desired effects. We encourage MAP to add “improving outcomes and affordability of care” to the list. At the end of the day, changes in how providers and others care for dual eligible beneficiaries should result in better health. Given the fiscal challenges that Medicare and Medicaid facing, advancing affordability is critical. **Measurement design**: This section highlights, “the measurement approach should evaluate person-level outcomes relative to the goals that are defined in the process of developing a person- and family-centered plan of care. Such goals might include maintaining or improving function, longevity, palliative care, or a combination of factors. It also is vital to include outcome measure related to the individual’s or family’s assessment of the care and supports received.” We applaud the MAP’s recognition that care should meet patients’ (and their families’) expectations, with a focus on outcomes. Measure design is impacted by the level at which measures are captured (e.g., individual physician, practice, hospital, ACO). Shared accountability should therefore be a part of this discussion (although shared accountability is briefly mentioned in a few places in the document, it is never defined). Whenever feasible, there should be a focus on individual clinicians, particularly where variation in performance is most evident, and not just higher levels of aggregation. Promoting individual accountability, together with shared accountability, will generate the greatest improvements in care. Shared accountability means holding all components of a system (or all members of a team) accountable, not just the system or team itself. Focusing on individual accountability reinforces professional motivation for quality improvement, provides information for patients to use in choosing physicians, and identifies improvement opportunities that are masked by higher levels of aggregation.

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Strategic Approach (Vision and Guiding Principles)	Georgetown University Law Center	Rachel Nelson	In one individual's opinion: measurement design should use stratification and risk adjustment to avoid exacerbating access problems while still assuring providers are appropriately accountable for furnishing quality care to even the most clinically complex, vulnerable and socioeconomically disadvantaged patients. (Use of strategic process measures may be needed to be sure strategy doesn't weigh so heavily toward access that it sets the accountability bar too low for services providers furnish to duals.) Using Data Dynamically; in this context, draft phrasing does not convey to those who don't follow MAP closely just what MAP means by "data exchange platform." Suggest rephrasing to something that is a more immediate and unambiguous reference to the QDM and associated formats/standards for specific purposes of exchange (e.g. eMeasures Format, whatever emerges as the exchange standard for transition of care). The shortest way to avoid the unintended implications would be to use "strategy" in place of "platform." (A more pedantic solution it might be to spell out right here, up front, what you mean by "platform" -- or at least what I understand you to mean by platform, based on the Quality Measurement Enterprise slide with its explanatory boxes and Dr. Valuck's accompanying explanations to the various workgroups.) Use of, not mere alignment with, nationally adopted vocabulary standards for interoperability and exchange of data is essential. Such use of standards adopted by the Secretary could, in the multi-setting exchange model, accommodate various data stewards continuing to store and use data in local vocabulary so long as it was translated into the common national vocabulary standards at some point along its way to the next data steward. (There may be more than one happy medium between [all standard, all the time, everywhere] and [translated by central hub], depending what "central hub" is used to convey.) Is "portable EHR" a creative way to reference methods of accessing EHRs from places other than the physician office or hospital that maintains the EHR? Web and mobile interfaces to EHRs and PHRs that can exchange data with certified EHRs in standard vocabularies and using standard protocols seem to be what is described here.

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Strategic Approach (Vision and Guiding Principles)	SNP Alliance (NHPG)	Richard Bringewatt	1. There should be more clarity about the endgame. If you don't know where you're going, any pathway can get you there. If you look at measurement, a number of the existing measures may not be the most important for advancing care for duals, particularly for high-risk/high-need persons. We made some suggestions above. 2. We strongly support principles focused on: a. Promoting integrated care, the ability to drive integrated, collaborative, and coordinated care. b. Health equity, important to measure dual eligible beneficiaries in contrast to Medicare-only and Medicaid-only beneficiaries in order to assess any differences in program access. Important to also address differences in beneficiary needs. c. Assessing outcomes related to goals. We support the intent of this goal but we believe the goals of "person level" outcomes and parsimonious approach that uses the fewest number of measures may be in conflict. May be best to focus on structure for this to occur. Implementation of a person-specific measurement approach is probably too detailed for federal oversight. d. Parsimony design. To minimize the resources required to conduct performance measurement and reporting, a core measure set should be parsimonious. e. Avoiding Undesirable Consequences (MD): We think risk stratification and case mix adjustment will be critical for proper review of findings for plans specializing in care of certain populations. f. Use Data Dynamically (Data): Dynamic data exchanges is critical to effective care management, care transition, etc.
High-Need Subgroups	Consumer-Purchaser Disclosure Project	Christine Chen	Link to Affordability of Care: The report provides important information about the cost of care for dual eligible beneficiaries. CPDP strongly agrees that "any discussion of the quality of duals' care is inextricable from discussion of its affordability." We are therefore surprised that the earlier sections on measurement strategy do not reinforce that need to capture cost and resource use. While measuring total cost may be challenging because of fragmented data sources (as the report details), it doesn't mean that we shouldn't begin measuring this important facet of care immediately.

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High-Need Subgroups	Molina Healthcare, Inc.	Berenice Nunez	Molina Healthcare has over 30 years of experience serving patients who have traditionally faced barriers to obtaining quality healthcare; primarily individuals covered by government sponsored health insurance programs. We serve over 23,000 dual eligible members, making Molina Healthcare the eighth largest Special Needs Plans (SNP) in the nation. Molina Healthcare believes that measurement of the quality of care provided for dual eligible populations should focus on outcomes not process measures. The majority of the “illustrative measures” reviewed in the MAP report were structure and process measures and several only applied to limited segments of the population. Molina does not believe that structure and process measures such as those reviewed in the report are necessarily linked to quality outcomes. Subjective, self-reported quality measures are particularly problematic in the dual population due to the high prevalence of cognitive, behavioral health and substance abuse disorders. HOS and CAHPS measures currently in place already use such measures. Several of the “illustrative measures” in the MAP report contained self-reported data. Molina would like to see less emphasis on the current HOS and CAHPS measures for dual eligible populations as well as avoiding adding any future quality measures utilizing self-reported data.
High-Need Subgroups	Renal Physicians Association	Amy Beckrich (on behalf of Robert Blaser)	The Renal Physicians Association (RPA) strongly supports the explicit inclusion of ESRD dual eligible beneficiaries as a high-need subgroup.

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High-Need Subgroups	SNP Alliance (NHPG)	Richard Bringewatt	1. We like the schemata for identifying risk levels but implementation may be too complicated. Consider using a limited set of high-need subgroups, e.g., frail elderly, adults with physical, mental or developmental disabilities, and persons with complex chronic conditions, such as AIDS, or a set of co-morbid conditions such as diabetes, CHF, and COPD. This could also encourage targeting key subgroups. 2. We need to get a better handle on the total cost of care, even though it's difficult. However, we have many questions about the unintended consequences of using encounter data for payment and performance evaluation before full analysis. 3. Things like access to primary care and team-based care, are important, but just having access and care teams doesn't always equal quality. The "evidence-base" for some measures are also still pretty thin to be mandated or applied to broadly. 4. Give more emphasis to using rapid-transformation/multi-variant analysis and continuous quality improvement. Consider collecting information on a set of utilization measures, such as hospitalization rates, ER visits, long-stay nursing home admits (over 90 days), and medication management; stratify or risk adjustment to account for population differences; and rigorously study specific interventions associated with positive outcomes. Also, consider costs of inadequate end of life care and how individual preferences for "person centered" care impact costs. 5. A major deterrent to specialized managed care is broad application of generic measures that are either inappropriate for a given population or they are not the best indicators for the subgroups being targeted.
High-Need Subgroups	[not supplied]	Richard Smith	Is all Mental Health now addressed within Dual Eligibility? More attention is needed for this underdeveloped vulnerable and costly care?

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High-Leverage Opportunities, Illustrative Measures, Gaps	America's Health Insurance Plans	Carmella Bocchino	We concur with the high leverage areas and offer additional comments: 1) Quality of Life— Functional status assessments are important indicators and there is need for alignment and consistency among assessments, across different settings including long-term care. 2) Care Coordination and Mental Health and Substance Abuse — These are important focus areas, but confidentiality rules regarding mental health and substance abuse may limit the ability to achieve full benefits from coordination and other programs. 3) Screening and Assessment—Prevention and usual screening should be age appropriate, condition specific, and tailored to patient, with special focus on frailty, cognitive impairment, and mental health and substance abuse. Measures such as reductions in emergency room (ER) visits or preventive screenings (e.g. mammography screening) can be used to ensure that patients are receiving appropriate care in an ambulatory setting and can serve as proxies for monitoring behavior modification in an SNP that frequently is sicker and uses ERs rather than seeking preventative care. Benchmarks should be utilized with the recommendation of developing quality measure benchmarks specific to the unique characteristics and healthcare challenges of the dual eligible population. Current benchmarks for existing quality measures (HEDIS, HOS, CAHPS, and other Star Ratings components) are generated from the entire Medicare population and do not reflect the dual eligible population. This makes it difficult to identify the impact of the challenged of dual eligible beneficiaries on quality measures as well as measure quality of care progress within the dual eligible population. The lack of population specific benchmarks also penalizes health plans and providers that focus on providing care for this important and vulnerable group of beneficiaries. Developing and scoring against dual eligible specific benchmarks would make existing and future quality measures more meaningful to beneficiaries and providers.

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			Comments on illustrative measures: 1) Some of the “illustrative measures” appear to require additional chart review beyond those already required for HEDIS, which is an expensive and burdensome requirement. 2) For the care coordination measure, MAP should consider using Plan of Care goals. 3) While we support the metrics related to ADLs and function, we recommend coordination of care between medical and behavioral health services is a key area in the success of goal achievement. Therefore, we recommend expanding mental health metrics to include members with Dementia and Alzheimer’s Disease. 4) We recommend developing specific metrics to measure impact of The Medical Home (Health Home). 5) The provider’s role is one that is critical to achieving desired outcomes. Specifically, for the Falls Assessment metric, we do not agree with the statement that, “the Measure does not push the provider to change the care plan based on results of the assessment, only to document that one was performed”. Therefore, we recommend using language aimed at engaging the provider to react to a positive screen with follow up (PT/OT evaluation, assistive device, med review, etc.). 6) On page 14, last box in grid ‘Mental Health and Substance Use Measure’, we ask for clarification on whether the mental health issue is strictly a primary diagnosis or if it also includes secondary diagnosis, or dual diagnosis.
High-Leverage Opportunities, Illustrative Measures, Gaps	Consumer-Purchaser Disclosure Project	Christine Chen	**Quality of life**: We strongly support the MAP’s emphasis on quality of life and that “measures in this care domain should focus on outcomes.” We also appreciate the MAP underscoring the importance of capturing functional status over time and from the patient’s perspective. **Care coordination**: We suggest adding readmissions and outcomes into the mix of proposed measure areas (i.e., medication management, access to an inter-professional care team, advance care planning, and palliative care). They can be helpful indicators of whether care was effectively coordinated. **Screening and Assessment**: We agree that appropriate screening and assessment are important. The document notes that “after screening and assessment is complete, the results should be incorporated into an individual’s plan of care.” While this is helpful, the results should also be reported. This is line with the MAP’s commitment to “tracking ‘delta measures’ of change in outcomes of interest” (page 6). For example, Minnesota Community Measurement’s measure of depression remission actually reports whether remission occurred. **Mental Health and Substance Use**: We are pleased to see that this section underscores the importance of having measures of outcomes and patient experience.

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			Structural measures: There are some structural measures such as those related to care coordination which may help advance organization of care in doctors' offices, medical care groups and hospitals to better support patient-centered care. However, they are often thought of as minimum standards—necessary qualifications, but not sufficient to ensure or foster improvements in the quality of care. A recent Hearth Affairs article found that "measuring structural characteristics and care processes in primary care practices and patient-centered medical homes is not necessarily associated with higher quality of care."1 Structural measures also provide little information on how well the capacities and resources are being used for their intended purposes. We ask the MAP recognize these challenges and to exercise caution in selecting structural measures. **Measure development gaps**: We agree with many of the identified measure development gaps and encourage the MAP to add measures of health status.
High-Leverage Opportunities, Illustrative Measures, Gaps	Molina Healthcare, Inc.	Berenice Nunez	Molina Healthcare recommends that actual health outcomes measures reflect the quality of care being provided to this population. Hospital admission rates-avoiding unnecessary hospitalizations reflects good access to primary care as well as the effectiveness of outpatient care plans and care coordination activities Emergency department visit rates-lowering ER visits shows good access to primary care, effectiveness of outpatient care plans and care coordination activities Hospital readmission rates-avoiding hospital readmissions shows the effectiveness of care transitions, outpatient care plans and care coordination activities Hospital admissions from LTC facilities- avoiding preventable hospital admissions from Long Term Care facilities demonstrates the effectiveness of care transitions and care coordination activities HEDIS preventive service screening and outcomes measures-well established measures of preventive care being provided to dual eligible beneficiaries and care outcomes achieved, reflects access to care and that care providers are following evidence based care guidelines Molina Healthcare strongly recommends developing quality measure benchmarks specific to the unique characteristics and healthcare challenges of the dual eligible population. Wherever possible, Molina Healthcare recommends using measures that are already reported as data analysis measures.

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High-Leverage Opportunities, Illustrative Measures, Gaps	SNP Alliance (NHPG)	Richard Bringewatt	1. We like the five domains listed for driving positive change. 2. Quality of Life: We encourage research on measuring illness and/or disability trajectories. Analyze cost trajectories associated with certain conditions. Provide incentives to prevent, delay or minimize disease and disability progression…for bending the cumulative cost curve…delaying nursing home admissions, or other indicators re: disease and disabling prevention. 3. Care Coordination: Give more emphasis to: high-risk screening, addressing co-morbid illnesses, managing illnesses within the context of disability, family caregiver support, use of principal care managers; safe and effective care transitions; integrating mental, behavioral and physical health; self-care empowerment; care management linkage with provider care planning; standardized assessments and care plans across settings; use of extended care pathways; and ensuring care continuity among related providers. 4. Assessment and Screening: Consider screening and triage for persons at-risk of death, hospitalization, nursing home admissions, functional decline, and cumulative costs with ongoing assessment and care planning for targeted high-risk groups. Consider inappropriate preventive screening. (VA study). 5. Mental Health and Substance Abuse: Mental health carve outs can make difficult accurate assessment, tracking service use and interventions, etc. Confidentiality issues also important. Strengthen relationship to health management. Be clear about primary and secondary diagnoses, as well as co-morbid relationships. 6. Structural Measures: Measuring structural issues re: disconnects between Medicare and Medicaid, among related care providers, and use of system management methods are key. Consider SNP Alliance Gold Standards Framework.
Data Sources	America's Health Insurance Plans	Carmella Bocchino	There are specific challenges with the data available for performance measurement of the dual eligible population. These challenges include: 1) Lack of integrated data sources across Medicare and Medicaid. The approach presented in the report to integrate disparate data sources can help with calculation of measures but may lead to lack of measure validity and reliability as the data are not captured in a standardized manner across these sources. 2) Attention should be given to the use of reliable data sources for measurement. While patient surveys can serve as additional sources of data, results from these surveys may not always be reliable given the mental health, cognitive and behavioral problems associated with this population. 3) The frequency of the data collection can also impact the ability to measure quality in a valid and reliable manner as individuals' frequently cycle on and off Medicaid. While dual eligibles cycle less quickly that TANF recipients, they are often dually eligible at the end of life and the length of their stay on a given program can be limited. The frequency with which the data are collected will impact the credibility of the data and needs to be factored into the quality measurement program.

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Data Sources	Consumer-Purchaser Disclosure Project	Christine Chen	**Data Sharing**: This section should include a reference on the need to share data with patients and their families, not just with providers. Patients need timely data to better manage their health. **Using Data Dynamically**: This section only identifies the usefulness of data for quality improvement. It should also address the importance of having data for supporting consumer-decision making and accountability. The document importantly highlights the importance of tracking longitudinal data, in particular outcomes. **Making the Best Use of Available Data**: We appreciate that the report includes administrative claims data and registries. We suggest that the report add patient-reported data. Patients are often in the best position to evaluate the effectiveness of the health services they receive.
Data Sources	SNP Alliance (NHPG)	Richard Bringewatt	1. Aligning data elements and overall management structures for Medicare and Medicaid and among providers across the continuum is central…if not a prerequisite…to advancing a truly integrated program. This is particularly important for high-risk/high-need populations that represent the majority of dual expenditures and who experience the majority of complications from the current system. 2. EHRs are important, but many do not fully encompass all provider elements or include an aligned set of Medicare and Medicaid requirements. It is important for federal and state governments to invest in transformation of EHR systems, working with states and the federal government, as well as the spectrum of primary, acute and long-term care providers and related professional and consumer organizations so that at some point record systems are not simply computerized but truly integrated, with the spectrum of data elements responsive to doing what is necessary for all parties involved to manage care around person-centered, system-oriented care plans. We propose developing standard EHR elements. 3. The starting point is obviously getting Medicare and Medicaid to align…sharing data between states and the fed…and retooling the composition of BOTH to embrace more of a person-centered, system-oriented approach to program management, with primary regard for the multi-dimensional, interdependent, disabling, personal and ongoing care needs of high-risk/high-need subgroups. 4. We are concerned about combining measures with different definition, e.g., ADLs. ADLs measures are important but standardization is critical for meaningful alignment. 5. We caution NQF in introducing new measures that are not broadly used in the industry. Claims data is a reliable source.

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Comment Category	Commenter Organization	Commenter Name	Comment
Program Alignment	Consumer-Purchaser Disclosure Project	Christine Chen	We agree with the need for greater alignment in performance measurement across Medicare and Medicaid programs, but the desire for alignment should be balanced with the need for impactful measures of care. The MAP recommends that: “The core measurement approach should leverage other programs’ required measures whenever possible and expand to specialized measures for key segment s of the dual eligible population. Adding the complexity of many new measures will likely not drive as much improvement as focusing on the specific identified opportunities to improve quality and affordability.” But to facilitate rapid improvements in care and judicious use of public funds, it is extremely important that the Medicare and Medicaid measures that MAP selects are high value and not low value for the sake of alignment.
Program Alignment	SNP Alliance (NHPG)	Richard Bringewatt	1. We cannot over emphasize the importance of “alignment across programs and a concerted focus on a limited number of realistic evidence-based measures as vital to reducing the burden of reporting”. While some elements of our current system should be retained, the level of confusion, complexity, and financial commitment involved actually detracts from a plan’s ability to provide the right care, at the right time, in the right place. Alignment and parsimony can actually increase, not decrease, quality and accountability. We are committed to both. 2. We support use of evidence-based measures, but we caution doing what is measurable rather than what is meaningful. In most cases, there is not sufficient evidence to mandate a certain care approach. Therefore, while we support moving toward “uniform performance measurement’ we caution simple adoption of measures that may be common without reassessing their value proposition. 3. We suggest starting with a comprehensive review of ALL reporting requirements for Medicare and Medicaid. Then, identify ALL places where existing measures are either defined differently or have different or parallel reporting processes. Once the confusion and disconnects are resolved, identify a core set of measures that are MOST important for advancing the OVERALL GOALS of INTEGRATION, with special regard for serving HIGH-RISK/HIGH-NEED beneficiaries. Then, hone in on those measures that are most important for defined subsets, e.g., frail elders, adults with serious and persistent mental illness, AIDS, etc. and establish a limited set of reporting requirements, with a single process, that is responsive to all duals as well as defined subgroups. 4. We believe coordination of alignment through the CMS Dual Office is critical.