MATHEMATICA
Policy Research

FROM: Mathematica Policy Research **DATE:** 9/5/2016

SUBJECT: Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees:
Questions for Public Comment on Measure for Dual Beneficiaries

Project Overview:
The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following groups of Medicaid beneficiaries: (1) those eligible for both Medicare and Medicaid, or "dual enrollees"; (2) those receiving long-term services and supports (LTSS) through managed care organizations or through fee-for-service arrangements; and, (3) people with complex needs and high costs, substance use disorders, and physical and mental health integration needs. The contract number is HHSM-500-2013-13011I, Task Order #HHSM-500-T0004.

Documents and Measures for Comment:
As part of its measure development process, CMS requests interested parties to submit comments on the candidate or concept measures that may be suitable for this project.

This call for public comment concerns the measure specifications and justification for a composite measure for Medicare-Medicaid (dual) beneficiaries. This measure is constructed from three components which are described separately.

- Duals 3, 4, 5 - Access to Care Composite (Medical Equipment, Personal Aide Assistance, Counseling or Treatment - self-reported)

As a composite measure, we have prepared Measure Information Forms (MIFs) and Measure Justification Forms (MJFs) for each component of the composite as well as a MIF for the overall composite. These files are available here: <Duals &HCBS measures MIFs & MJFs.zip>

The project team seeks public comment on the following questions:

1. Does the candidate measure capture an important domain of quality for Medicare-Medicaid (dual) beneficiaries?
2. Are you aware of any new or additional measures (beyond those listed in the MJF) that address access to these services that have already been validated and widely used, are now under development, or will be submitted for consensus-based entity (NQF) endorsement?
3. Are the measure specifications in the MIFs clear, for example, the numerator, denominator, and any potential exclusions? What should be more clearly defined?
4. Are any revisions to the specifications needed either to make measure reporting more feasible, or to include or exclude certain individuals or events?

5. Is the proposed reporting level of managed care plan appropriate?
6. Are you aware of any new or additional studies that should be included in the MJF that support (or weaken) the justification for developing the measure? If so, please describe the findings and provide a full citation.
7. Should the individual rates for self-reported access to medical equipment, personal aide assistance and counseling or treatment be: (a) combined into a single composite score, (b) reported separately, or (c) both?

Public Comment Instructions:

- If you are providing comments on behalf of an organization, include the organization's name and contact information.
- If you are commenting as an individual, submit identifying or contact information.
- Please do not include personal health information in your comments.
- In the subject line of your message, put **Public Comments Duals-HCBS**
- Send your comments **by close of business September 29, 2016** to MedicaidQualMeasures@mathematica-mpr.com

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on August 12, 2016.

Measure Name: Access to Medical Equipment

Descriptive Information
Measure Name (Measure Title De.2.) Access to Medical Equipment

Measure Type De.1. Patient-Reported Outcome (PRO)

Brief Description of Measure De.3. This measure assesses the percentage of individuals reporting a need for medical equipment, who indicated that it was easy to get or replace the medical equipment through their health plan during the last six months. The measure is based on responses to optional supplemental survey items used in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage (MA)

and Prescription Drug Plans (PDP) – currently, these supplemental items are required only when the survey is fielded amongst Medicare-Medicaid (MMP) plans.

If Paired or Grouped De.4. This measure is not currently paired or grouped. However, there is the possibility this measure may be grouped with Access to Personal Aide Assistance and Access to Counseling measures (also under development, and based on CAHPS survey items) in the future. During testing we will also be exploring the possibility of combining these measures into a composite with a single score representing overall access.

Subject/Topic Areas De.5.

- Access
- Prevention: Prevention
- Prevention: Development/Wellness

Crosscutting Areas De 6.

- Health and Functional Status: Health and Functional Status
- Health and Functional Status: Development/Wellness
- Health and Functional Status: Functional Status
- Prevention: Prevention
- Prevention: Social Determinants
- Care Coordination: Care Coordination
- Functional Status
- Safety: Safety

Measure Specifications

Measure-specific Web Page S.1.

Not applicable. This measure is still under development.

If This Is an eMeasure S.2a.

Not applicable. This is not an eMeasure.

Data Dictionary, Code Table, or Value Sets S.2b.

Not applicable. This measure is still under development.

For Endorsement Maintenance S.3.

Not applicable. This measure is still under development.

Numerator Statement S.4.
The numerator consists of the number of individuals in the denominator who indicated it was "always" (or "always/usually[1]") easy to get or replace the medical equipment needed in the past six months.

Note: Numerator statement may change as this measure is still under development.

Time Period for Data S.5.
The survey question asks about the last 6 months, however if the survey may be administered annually, this will only capture perceived access in the previous 6-month period

Numerator Details S.6.
The numerator is based on the individuals responding "always" (or "always/usually[1]") to a survey item (item #CC10) from the CAHPS Health Plan (Adults) Chronic Conditions Supplemental Item Set:

- CC10: "In the last 6 months, how often was it easy to get or replace the medical equipment you needed through your health plan?"
- Response choices are: Never, Sometimes, Usually, Always

Note: Numerator details may change as this measure is still under development.

Denominator Statement S.7. Individuals who responded to the survey and who reported needing special equipment, such as a cane, a wheelchair, or oxygen equipment, in the last six months.

Note: Denominator statement may change as this measure is still under development.

Target Population Category S.8.

- Populations at Risk: Populations at Risk
- Populations at Risk: Dual-Eligible Beneficiaries
- Populations at Risk: Individuals with Multiple Chronic Conditions
- Senior Care

Denominator Details S.9.
The denominator is based on the individual responding "yes" to a survey item (item #CC9) from the CAHPS Health Plan Chronic Conditions Supplemental Item Set:

- CC9: "In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, wheelchair or oxygen equipment?"

[1] The numerator for the measure is still under development. The numerator will be constructed of either 1) individuals selecting "always" or 2) individuals selecting "always" and individuals selecting "usually."

- Response choices are: Yes, No

To be included in the denominator, individual response choices should be as follows:

- CC9 = "Yes"
- CC10 = "Never" or "Sometimes" or "Usually" or "Always"

Continuous enrollment requirements for the denominator may also be considered, e.g., individuals who are continuously enrolled for at least six months, to match the question timeframe.

Note: Denominator details may change as this measure is still under development.

Denominator Exclusions (NQF Includes "Exceptions" in the "Exclusion" Field) S.10. Not applicable.

Note: Denominator exclusions may change as this measure is still under development.

Denominator Exclusion Details (NQF Includes "Exceptions" in the "Exclusion" Field) S.11. Not applicable.

Note: Denominator exclusion details may change as this measure is still under development.

Stratification Details/Variables S.12. Consideration of stratification by the following variables:

- Ages 18-64
- Ages 65+

We will explore the need for stratification based on other variables available in the CAHPS survey as part of measure testing.

Note: Stratification details/variables may change as this measure is still under development.

Risk Adjustment Type S.13.
The need and methods for risk adjustment will be evaluated during the measure testing phase. CAHPS measures are sometimes adjusted for enrollee characteristics.

Statistical Risk Model and Variables S.14.
The need and methods for risk adjustment will be evaluated during the measure testing phase.

Detailed Risk Model Specifications S.15.
The need and methods for risk adjustment will be evaluated during the measure testing phase. Presently, Medicare CAHPS survey results are risk adjusted for age, education, overall self-rated health, self-rated mental health, use of proxy respondent, dual eligibility, Low Income Subsidy receipt, and use of the Chinese language survey. By definition, MMP enrollees are dual eligible and receive the Low Income Subsidy (beneficiaries who are dual eligible are automatically awarded this subsidy). Further, the data available for measure testing is not expected to include Chinese language survey results. As such, this analysis will focus on the CAHPS adjustment

variables of age, education, self-reported overall health, self-reported mental health, and use of proxy respondent.

Because the National Quality Forum is currently conducting a trial period of consideration of risk adjustment for sociodemographic risk factors, the testing phase will also evaluate potential risk factors that may theoretically and empirically be related to access to care and available in CAHPS data (e.g., race, ethnicity, household size).

Type of Score S.16. Rate/Proportion.

Interpretation of Score S.17. A higher score denotes better performance.

Calculation Algorithm/Measure Logic S.18.
The number of individuals who indicated that it was "always" (or "always/usually[2]") easy to get or replace the medical equipment they needed during the last six months, divided by the number of individuals who needed special medical equipment in the last six months.

Note: Calculation algorithm/measure logic may change as this measure is still under development.

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19. Not applicable.

Sampling S.20. The sampling approach will match the sampling methods used for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage (MA) and Prescription Drug Plans (PDP).

Survey/Patient-Reported Data S.21.
The approach for conducting the survey and minimum response rate will match the methods used for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage (MA) and Prescription Drug Plans (PDP).

Missing Data S.22. The approach for addressing missing data will be determined during the measure testing phase.

Data Source S.23. Patient Reported Data/Survey

Data Source or Collection Instrument S.24. Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage (MA) and Prescription Drug Plans (PDP).

Data Source or Collection Instrument (Reference) S.25.

[2] The numerator for the measure is still under development. The numerator will be constructed of either 1) individuals selecting "always" or 2) individuals selecting "always" and individuals selecting "usually."

Health Plan CAHPS Survey. (2016). Available at https://cahps.ahrq.gov/Surveys-Guidance/HP/index.html

Level of Analysis S.26. Health Plan

Care Setting S.27.

- Home Health
- Hospital/Acute Care Facility
- Post-Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility
- Post-Acute/Long Term Care Facility: Inpatient Rehabilitation Facility
- Post-Acute/Long Term Care Facility: Long Term Acute Care Hospital

Composite Performance Measure S.28. If this measure is combined with other access measures into a single composite, aggregation and weighting rules will be determined during the measure testing phase.

Measure Information Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date: Information included is current on August 12, 2016.

Measure Name: Access to Personal Aide Assistance

Descriptive Information

Measure Name (Measure Title De.2.) Access to Personal Aide Assistance

Measure Type De.1. Patient-reported outcome (PRO)

Brief Description of Measure De.3. The measure assesses the percentage of individuals reporting a need for home health care or assistance, who indicated that it was easy to get personal care or aide assistance through their care plan during the last six months. The measure is based on responses to optional supplemental survey items used in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage

(MA) and Prescription Drug Plans (PDP) – currently, these supplemental items are required only when the survey is fielded amongst Medicare-Medicaid (MMP) plans.

If Paired or Grouped De.4. This measure is not paired or grouped. However, there is the possibility this measure may be grouped with Access to Medical Equipment and Access to Counseling or Treatment measures (also under development, and based on CAHPS survey items) in the future. During testing we will also be exploring the possibility of combining these measures into a composite with a single score representing overall access.

Subject/Topic Areas De.5.

- Access
- Prevention: Prevention
- Prevention: Development/Wellness

Crosscutting Areas De 6.

- Health and Functional Status: Health and Functional Status
- Health and Functional Status: Development/Wellness
- Health and Functional Status: Functional Status
- Prevention: Prevention
- Prevention: Social Determinants
- Care Coordination: Care Coordination
- Care Coordination: Readmissions
- Functional Status
- Safety: Safety

Measure Specifications

Measure-specific Web Page S.1.
Not applicable. This measure is still under development.

If This Is an eMeasure S.2a.
Not applicable. This is not an eMeasure.

Data Dictionary, Code Table, or Value Sets S.2b.
Not applicable. This measure is still under development.

For Endorsement Maintenance S.3.
Not applicable. This measure is still under development.

Numerator Statement S.4.
The numerator consists of the number of individuals in the denominator who indicated it was "always" (or "always/usually[1]") easy to get personal care or aide assistance in the past six months.

Note: Numerator statement may change as this measure is still under development.

Time Period for Data S.5.
The survey question asks about the last 6 months, however if the survey is administered annually, this will only capture perceived access in the previous 6-month period.

Numerator Details S.6.
The numerator is based on the individual responding "always" (or "always/usually[1]") to a survey item (item #CC14) from the CAHPS Health Plan (Adults) Chronic Conditions Supplemental Item Set:

- CC14: "In the last 6 months, how often was it easy to get personal care or aide assistance through your care plan?"
- Response choices are: Never, Sometimes, Usually, Always

Note: Numerator details may change as this measure is still under development.

Denominator Statement S.7. Individuals who responded to the survey and who reported needing home health care or assistance in the last six months.

Note: Denominator statement may change as this measure is still under development.

Target Population Category S.8.

- Populations at Risk: Populations at Risk
- Populations at Risk: Dual-Eligible Beneficiaries
- Populations at Risk: Individuals with Multiple Chronic Conditions
- Senior Care

Denominator Details S.9.
The denominator is based on the individual responding "yes" to a survey item (item #CC13) in the CAHPS Health Plan Chronic Conditions Supplemental Item Set:

- CC13: **"**Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks. In the last 6 months, did you need someone to come into your home to give you home health care or assistance?"
- Response choices are: Yes, No.

[1] The numerator for the measure is still under development. The numerator will be constructed of either 1) individuals selecting "always" or 2) individuals selecting "always" and individuals selecting "usually."

To be included in the denominator, individual response choices should be as follows:

- CC13 = “Yes”
- CC14 = “Never” or “Sometimes” or “Usually” or “Always”

Continuous enrollment requirements for the denominator may also be considered, e.g., individuals who are continuously enrolled for at least six months, to match the question timeframe.

Note: Denominator details may change as this measure is still under development.

Denominator Exclusions (NQF Includes “Exceptions” in the “Exclusion” Field) S.10. Not applicable.

Note: Denominator exclusions may change as this measure is still under development.

Denominator Exclusion Details (NQF Includes “Exceptions” in the “Exclusion” Field) S.11. Not applicable.

Note: Denominator exclusion details may change as this measure is still under development.

Stratification Details/Variables S.12. Consideration of stratification by the following variables:

- Ages 18-64
- Ages 65+

We will explore the need for stratification based on other variables available in the CAHPS survey as part of measure testing.

Risk Adjustment Type S.13.
The need and methods for risk adjustment will be evaluated during the measure testing phase. CAHPS measures are sometimes adjusted for enrollee characteristics.

Statistical Risk Model and Variables S.14.
The need and methods for risk adjustment will be evaluated during the measure testing phase.

Detailed Risk Model Specifications S.15.
The need and methods for risk adjustment will be evaluated during the measure testing phase. Presently, Medicare CAHPS survey results are risk adjusted for age, education, overall self-rated health, self-rated mental health, use of proxy respondent, dual eligibility, Low Income Subsidy receipt, and use of the Chinese language survey. By definition, MMP enrollees are dual eligible and receive the Low Income Subsidy (beneficiaries who are dual eligible are automatically awarded this subsidy). Further, the data available for measure testing is not expected to include Chinese language survey results. As such, this analysis will focus on the CAHPS adjustment

variables of age, education, self-reported overall health, self-reported mental health, and use of proxy respondent.

Because the National Quality Forum is currently conducting a trial period of consideration of risk adjustment for sociodemographic risk factors, the testing phase will also evaluate potential risk factors that may theoretically and empirically be related to access to care and available in CAHPS data (e.g., race, ethnicity, household size).

Type of Score S.16. Rate/Proportion.

Interpretation of Score S.17. A higher score denotes better performance.

Calculation Algorithm/Measure Logic S.18.
The number of individuals who indicated that it was "always" (or "always/usually[2]) easy to get personal care or aide assistance through their care plan during the last six months, divided by the number of individuals who received home health care or assistance in the last six months.

Note: Calculation algorithm/measure logic may change as this measure is still under development.

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19. Not Applicable.

Sampling S.20. The sampling approach will match the sampling methods used for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage (MA) and Prescription Drug Plans (PDP).

Survey/Patient-Reported Data S.21. The approach for conducting the survey and minimum response rate will match the methods used for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage (MA) and Prescription Drug Plans (PDP).

Missing Data S.22. The approach for addressing missing data will be determined during the measure testing phase.

Data Source S.23. Patient Reported Data/Survey

Data Source or Collection Instrument S.24. Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage (MA) and Prescription Drug Plans (PDP).

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[2] The numerator for the measure is still under development. The numerator will be constructed of either 1) individuals selecting "always" or 2) individuals selecting "always" and individuals selecting "usually."

Data Source or Collection Instrument (Reference) S.25.

Health Plan CAHPS Survey. (2016). Available at https://cahps.ahrq.gov/Surveys-Guidance/HP/index.html

Level of Analysis S.26. Health Plan

Care Setting S.27.

- Home Health

Composite Performance Measure S.28. If this measure is combined with other access measures into a single composite, aggregation and weighting rules will be determined during the measure testing phase.

Measure Information Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on August 12, 2016.

Measure Name Access to Counseling or Treatment

Descriptive Information

Measure Name (Measure Title De.2.) Access to Counseling or Treatment

Measure Type De.1. Patient-reported outcome (PRO)

Brief Description of Measure De.3. The measure assesses the percentage of individuals reporting a need for treatment or counseling for personal or family problems, who indicated that it was easy to get treatment or counseling through their health plan during the last six months. The measure is based on responses to optional supplemental survey items used in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage (MA) and Prescription Drug Plans (PDP). Currently, these supplemental items are required only when the survey is fielded amongst Medicare-Medicaid (MMP) plans.

Although psychosocial interventions, psychotherapies, and pharmacotherapies are not explicitly mentioned in the CAHPS supplemental survey items, we are including them in our interpretation of 'treatment.'

If Paired or Grouped De.4. This measure is not currently paired or grouped. However, there is the possibility this measure may be grouped with Access to Medical Equipment and Access to Personal Aide Assistance measures (also under development, and based on CAHPS survey items) in the future. During testing we will also be exploring the possibility of combining these three measures into a single composite with one score representing overall access.

Subject/Topic Areas De.5.

- Access
- Behavioral Health: Behavioral Health
- Behavioral Health: Serious Mental Illness
- Mental Health: Mental Health

Crosscutting Areas De 6.

- Health and Functional Status: Health and Functional Status
- Health and Functional Status: Development/Wellness
- Health and Functional Status: Functional Status
- Prevention: Prevention
- Prevention: Social Determinants
- Care Coordination: Care Coordination
- Functional Status
- Safety: Safety

Measure Specifications

Measure-specific Web Page S.1.

Not applicable. This measure is still under development.

If This Is an eMeasure S.2a.

Not applicable. This is not an eMeasure.

Data Dictionary, Code Table, or Value Sets S.2b.

Not applicable. This measure is still under development.

For Endorsement Maintenance S.3.

Not applicable. This measure is still under development.

Numerator Statement S.4.
The numerator consists of the number of individuals in the denominator who indicated it was "always" (or "always/usually[1]") easy for them to get treatment or counseling in the last six months.

Note: Numerator statement may change as this measure is still under development.

Time Period for Data S.5.
The survey question asks about the last 6 months, however if the survey is administered annually, this will only capture perceived access in the previous 6-month period.

Numerator Details S.6.
The numerator is based on the individual responding "always" (or "always/usually[1]") to a survey item (item #MH3) from the CAHPS Health Plan (Adults) Supplemental Item Set:

- MH3: "In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan?"
- Response choices are: Never, Sometimes, Usually, Always.

Note: Numerator details may change as this measure is still under development.

Denominator Statement S.7. Individuals who responded to the survey and who reported needing treatment or counseling in the last six months.

Note: Denominator statement may change as this measure is still under development.

Target Population Category S.8.

- Populations at Risk: Populations at Risk
- Populations at Risk: Dual-Eligible Beneficiaries
- Populations at Risk: Individuals with Multiple Chronic Conditions
- Senior Care

Denominator Details S.9.
The denominator is based on the individual responding "yes" to a survey item (item #MH2) in the CAHPS Health Plan Behavioral Health Supplemental Item Set:

- MH2: "In the last 6 months, did you need any treatment or counseling for a personal or family problem?"
- Response choices are: Yes, No.

To be included in the denominator, individual response choices should be as follows:

[1] The numerator for the measure is still under development. The numerator will be constructed of either 1) individuals selecting "always" or 2) individuals selecting "always" and individuals selecting "usually."

- MH2 = “Yes”
- MH3 = “Never” or “Sometimes” or “Usually” or “Always”

Continuous enrollment requirements for the denominator may also be considered, e.g., individuals who are continuously enrolled in the health plan for at least six months, to match the question timeframe.

Note: Denominator details may change as this measure is still under development.

Denominator Exclusions (NQF Includes “Exceptions” in the “Exclusion” Field) S.10.

Not applicable.

Note: Denominator exclusions may change as this measure is still under development.

Denominator Exclusion Details (NQF Includes “Exceptions” in the “Exclusion” Field) S.11.

Not applicable.

Note: Denominator exclusion details may change as this measure is still under development.

Stratification Details/Variables S.12.

- Ages 18-64
- Ages 65+

We will explore the need for stratification based on other variables available in the CAHPS survey as part of measure testing.

Risk Adjustment Type S.13.

The need and methods for risk adjustment will be evaluated during the measure testing phase. CAHPS measures are sometimes adjusted for enrollee characteristics.

Statistical Risk Model and Variables S.14.

The need and methods for risk adjustment will be evaluated during the measure testing phase.

Detailed Risk Model Specifications S.15.

The need and methods for risk adjustment will be evaluated during the measure testing phase. Presently, Medicare CAHPS survey results are risk adjusted for age, education, overall self-rated health, self-rated mental health, use of proxy respondent, dual eligibility, Low Income Subsidy receipt, and use of the Chinese language survey. By definition, MMP enrollees are dual eligible and receive the Low Income Subsidy (beneficiaries who are dual eligible are automatically awarded this subsidy). Further, the data available for measure testing is not expected to include Chinese language survey results. As such, this analysis will focus on the CAHPS adjustment variables of age, education, self-reported overall health, self-reported mental health, and use of proxy respondent.

Because the National Quality Forum is currently conducting a trial period of consideration of risk adjustment for sociodemographic risk factors, the testing phase will also evaluate potential risk factors that may theoretically and empirically be related to access to care and available in CAHPS data (e.g., race, ethnicity, household size).

Type of Score S.16. Rate/proportion

Interpretation of Score S.17. A higher score denotes better performance.

Calculation Algorithm/Measure Logic S.18.
The number of individuals who indicated that it was "always" (or "always/usually"[2]) easy to get treatment or counseling through their health plan during the last six months, divided by the number of individuals who report needing treatment or counseling in the last six months.

Note: Calculation algorithm/measure logic may change as this measure is still under development and may be combined into a composite with similar measures of access to care.

Calculation Algorithm/Measure Logic Diagram URL or Attachment S.19. Not applicable.

Sampling S.20. The sampling approach will match the sampling methods used for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage (MA) and Prescription Drug Plans (PDP).

Survey/Patient-Reported Data S.21. The approach for conducting the survey and minimum response rate will match the methods used for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage (MA) and Prescription Drug Plans (PDP).

Missing Data S.22. The approach for addressing missing data will be determined during the measure testing phase.

Data Source S.23. Patient Reported Data/Survey

Data Source or Collection Instrument S.24. Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults), Medicare Advantage (MA) and Prescription Drug Plans (PDP).

Data Source or Collection Instrument (Reference) S.25.
Health Plan CAHPS Survey. (2016). Available at https://www.cahps.ahrq.gov/surveys-guidance/item-sets/index.html

[2] The numerator for the measure is still under development. The numerator will be constructed of either 1) individuals selecting "always" or 2) individuals selecting "always" and individuals selecting "usually."

Level of Analysis S.26. Health Plan

Care Setting S.27.

- Behavioral Health/Psychiatric: Inpatient
- Behavioral Health/Psychiatric: Outpatient

Composite Performance Measure S.28. If we combine this measure with other access measures into a single composite, aggregation and weighting rules will be determined during the measure testing phase.

Measure Justification Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations
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The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on July 6, 2016.

Measure Name

Access to Medical Equipment

Type of Measure

Patient-Reported Outcome (PRO)

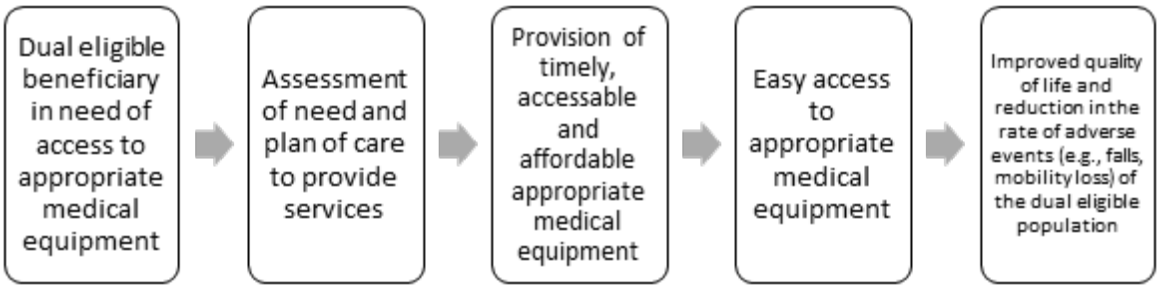
Importance

1a—Opportunity for Improvement

1a.1. This is a measure of outcome.

- Health outcome: This measure assesses the ease of access to medical equipment for the dual eligible population. Easy access to appropriate medical equipment for prevention and maintenance of acute and chronic conditions in this population can enhance the ability of individuals to live in the community, improve population health and quality of life, and lower the risk of adverse events (e.g., falls risk, mobility loss) for a vulnerable population.

1a.2.—Linkage



1a.2.1 Rationale

Importance of Access to Care for Dual Eligible Beneficiaries

National Health Expenditure data indicate that 15.5 million Medicare beneficiaries use home medical equipment and that durable medical equipment (DME) represented approximately 1.25 percent of Medicare spending in 2014 (CMS 2015). In 2008, dual enrollees with five or more chronic conditions had higher per capita Medicare spending on "Other Select Part B Services" (which include DME) than Medicare-only beneficiaries with 5 or more chronic conditions (The Scan Foundation 2010).

Appropriate access to all types of care can reduce the probability that individuals with chronic and acute conditions will develop complications or exacerbations that result in complications or other adverse events (e.g., falls, loss of mobility or functional status, hospitalization). Easy access to appropriate medical equipment enables individuals to live in the community, improve population health and quality of life, and lower the risk of adverse events (e.g., falls risk, mobility loss) for a vulnerable population. Health plans and providers serving dual eligible beneficiaries can improve access to medical equipment by assessing individual needs for medical equipment, implementing care plans that meet patient goals for medical equipment, and providing timely authorization of services. Measurement of

appropriate access to medical equipment could provide important information to states, health plans, providers, consumers and other stakeholders about problems with access to medical equipment.

Importance of Access to Medical Equipment to Dual Eligible Beneficiaries:
Access to medical equipment, particularly in combination with the provision of community-based long term-services and supports (LTSS), has been shown to be effective in reducing institutional care use. Research shows that using assistive technology, or "devices and techniques that can eliminate, ameliorate or compensate for functional limitations for the care of older, disabled persons" (Pope et al 1991) in home-based long-term care can contribute to important quality of life and economic implications. Specifically, assistive technology can promote independence of the elderly and disabled, relieve excess burden on family members, reduce unmet need and reduce expenditures (Agree et al 2000).

Some specific equipment examples follow:

- An AHRQ 2004 assessment of clinical literature on long-term oxygen therapy found that in home oxygen therapy reduced mortality and hospital frequency and length of stay for patients with severe COPD. The study found that the average number of hospital admissions decreased from 2.1 to 1.6 per patient year and the average number of days hospitalized decreased from 23.7 to 13.4 after long-term oxygen therapy (Lau et al 2004).
- A 2000 study looking at the integration of assistive devices in community-based long term care found that simple, typically inexpensive devices may promote independence for the elderly and disabled and that these devices could lessen demands on caregivers and delay the introduction of formal care services (Agree et al 2000).

Access to medical equipment in the home allows enrollees to manage their own health and reduce time spent at the doctor's office or nursing home (Fausset et al 2014).

Barriers to Dual Beneficiary Access to Medical Equipment:
Although medical equipment is covered for dual enrollees, many beneficiaries often have difficulty accessing these benefits due to lack of coordination between Medicare and Medicaid. While state Medicaid programs cover medical equipment used outside of the home (if it avoids institutional care use), Medicare coverage requires that beneficiaries must use medical equipment primarily in the home. Furthermore, payment for both programs varies by item and geography. While both programs use fee schedules, Medicare is now also using competitive bidding in some areas of the country (ICRC 2014). These differences may make it more difficult to coordinate a "blended" payment approach (ICRC 2014).

The dual enrollee population may also have significant physical disabilities requiring more specialized complex rehabilitation technology (CRT) – including custom power wheelchairs

or other individually configured medical technology – involving a broader range of services and specialized personnel than those required for standard durable medical equipment (DME). However, Medicare does not always recognize the distinction between standard DME and the range of services offered by CRT providers – resulting in beneficiaries experiencing additional barriers accessing this type of medical equipment (Christopher & Dana Reeve Foundation 2012).

Because Medicaid coverage standards for DME are generally less restrictive than Medicare coverage standards, Medicaid beneficiaries may experience additional conflicts once they become eligible for Medicare. Dual enrollees who were covered by Medicaid initially must have DME requirements processed through Medicare first and often endure delays and rejections in receiving DME (Prindiville et al 2011).

Research on Access to Medical Equipment in Dual Eligible Population:
A 2003 study examined rates of access to assistive equipment among individuals with disabilities in the U.S. Results suggested that more than half of the sample population (n=500) expressed a need for assistive equipment in the last 12 months and almost a third of those that expressed a need for assistive equipment did not receive it each time it was needed. The study found that access rates did not noticeably differ between individuals covered by managed care and FFS health plans (Bingham et al 2003).

An assessment of access to ambulatory medical and long-term care services among elderly dual enrollees found that special equipment accounted for at least 15 percent of the most commonly needed services among elderly dual enrollees, and that 76 percent of dual enrollees expressed the need for special equipment (defined as a physician referral for a special equipment or special equipment the elderly dual enrollee believed was needed despite no physician referral being made). However, 33 percent of elderly dual enrollees who needed a service (including special equipment) experienced an organizational, geographic, or financial access-to-care barrier (Niefeld et al 2005).

Some more recent data comes from a national, population-based survey of over 70,000 U.S. households found that – of those reporting trouble obtaining durable medical equipment – the majority (37 percent) were dual enrollees, compared to 17 percent covered by private insurance, 24 percent covered by Medicare, 9 percent covered by Medicaid and 13 percent who were uninsured (Christopher & Dana Reeve Foundation 2012).

1a.3.—Linkage

1a.3.1. Source of Systematic Review. Not applicable.

1a.4.—Clinical Practice Guideline Recommendation

1a.4.1. Guideline Citation. Not applicable.

1a.4.2. Specific Guideline. Not applicable.

1a.4.3. Grade. Not applicable.

1a.4.4. Grades and Associated Definitions. Not applicable.

1a.4.5. Methodology Citation. Not applicable.

1a.4.6. Quantity, Quality, and Consistency. Not applicable.

1a.5.—United States Preventative Services Task Force Recommendation

1a.5.1. Recommendation Citation. Not applicable.

1a.5.2. Specific Recommendation. Not applicable.

1a.5.3. Grade. Not applicable.

1a.5.4. Grades and Associated Definitions. Not applicable.

1a.5.5. Methodology Citation. Not applicable.

1a.6.—Other Systematic Review of the Body of Evidence

1a.6.1. Review Citation. Not applicable.

1a.6.2. Methodology Citation. Not applicable.

1a.7.—Findings from Systematic Review of Body of the Evidence Supporting the Measure

1a.7.1. Specifics Addressed in Evidence Review. Not applicable.

1a.7.2. Grade. Not applicable.

1a.7.3. Grades and Associated Definitions. Not applicable.

1a.7.4. Time Period. Not applicable.

1a.7.5. Number and Type of Study Designs. Not applicable.

1a.7.6. Overall Quality of Evidence. Not applicable.

1a.7.7. Estimates of Benefit. Not applicable.

1a.7.8. Benefits Over Harms. Not applicable.

1a.7.9. Provide for Each New Study. Not applicable.

1a.8.—Other Source of Evidence

1a.8.1. Process Used. Not applicable.

1a.8.2. Citation

Agree, E. M., & Freedman, V. A. (2000). Incorporating Assistive Devices into Community-Based Long-Term Care: An Analysis of the Potential for Substitution and Supplementation. Journal of Aging and Health, 12(3), 426-450.

Bingham, S., & Beatty, P. (2003). Rates of access to assistive equipment and medical rehabilitation services among people with disabilities. Disability and Rehabilitation, 25(9), 487-490.

Centers for Medicare and Medicaid Services (CMS). (2015). Special Needs Plan (SNP) Data. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

Fausset, C., & Harley, L. (2014). Designing home health technologies for older adults: The human systems integration approach. Biomedical Instrumentation & Technology, 48(5), 361-5. Retrieved from https://www.researchgate.net/publication/265971039_Designing_Home_Health_Technologies_For_Older_Adults_The_Human_Systems_Integration_Approach

Integrated Care Resource Center (ICRC) (2014). ICRC Study Hall Call: Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment Initiative [PowerPoint slides]. Retrieved from https://www.mathematica-mpr.com/~/media/publications/pdfs/health/icrc_shc_home_health_and_dme_09_08_14.pdf

Lau, J., Chew, P. W., Wang, C., & White, A. C. (2004, June 11). Long-Term Oxygen Therapy for Severe COPD. Retrieved June 2, 2016, from http://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/id36TA.pdf

Policy Data Brief: Access to Durable Medical Equipment. (2012). Retrieved from http://www.nationaldisabilitynavigator.org/wp-content/uploads/news-items/2015ReeveFoundation_AccessDMEBrief.PDF .

Pope, A. M., & Tarlov, A. (1991). Disability in America: Toward a national agenda for prevention. Washington, DC: National Academy Press.

Prindiville, K., & Burke, G. (2011, August). Medicare and Medicaid Alignment: Challenges and Opportunities for Serving Dual Eligibles. Retrieved from http://www.thescanfoundation.org/sites/default/files/nsclc_issue_brief_2_3.pdf

The Scan Foundation (2010). Dual Eligibles and Medicare Spending. 2010. Available at http://www.thescanfoundation.org/sites/default/files/attachments/databrief_no3.ppt

1b.—Evidence to Support Measure Focus

1b.1. Rationale

Easy access to appropriate medical equipment for prevention and maintenance of acute and chronic conditions for the dual eligible population could significantly improve population health and quality of life and lower the risk ad adverse events for a vulnerable population.

1b.2. Performance Scores

1b.3. Summary of Data Indicating Opportunity

Reference section 1a.2.1 (Rationale) above.

1b.4. and 1b.5. Disparities

Studies have found that medical equipment expenditures can vary by socioeconomic status and by race. A 2003 study looking at racial and ethnic differences in total public and private medical care expenditures among aged Medicare beneficiaries found that black and Hispanic seniors had higher expenditures than did white seniors for home health care and medical equipment (Escarce et al 2003). A 2004 study evaluating socioeconomic disparities in the use of home health services in the Medicare Managed Care population found enrollees who did not complete high school had a 30 percent lower odds of using DME compared to enrollees who had completed high school (Freedman et al 2004).

Niefeld's analyses of organizational, geographic and financial access-to-care barriers found disparities by race and ethnicity and disability status. African American dual enrollees were 1.95 times as likely to experience an access-to-care barrier as opposed to white dual enrollees. African American dual enrollees were reported as being more likely to have an organizational and geographic barrier to care due to financial burden, fair or poor health status and an unfavorable assessment of their usual physician's information-giving skills (reflecting language or communication difficulties) in comparison to white dual enrollees. Dual enrollees needing support in activities of daily living or instrumental activities of daily living (ADL/IADL) were also likely to experience access-to-care barriers (Niefeld et al 2005).

A study using 2001-2007 Medical Expenditure Panel Survey data found evidence of disparities in access and use of care among adults with disabilities, with substantially poorer access to care among those uninsured than the insured (Miller et al 2014).

Citations

Escarce, J. J., & Kapur, K. (2003). Racial and Ethnic Differences in Public and Private Medical Care Expenditures among Aged Medicare Beneficiaries. The Milbank Quarterly, 81(2), 249–275. http://doi.org/10.1111/1468-0009.t01-1-00053

Freedman, V. A., Rogowski, J., Wickstrom, S. L., Adams, J., Marainen, J., & Escarce, J. J. (2004). Socioeconomic Disparities in the Use of Home Health Services in a Medicare Managed Care Population. Health Services Research, 39(5), 1277–1298. http://doi.org/10.1111/j.1475-6773.2004.00290.x

Miller, N. A., Kirk, A., Kaiser, M. J., & Glos, L. (2014). The Relation Between Health Insurance and Health Care Disparities Among Adults With Disabilities. American Journal of Public Health, 104(3), e85–e93. http://doi.org/10.2105/AJPH.2013.301478

Niefeld, M. R. (2005). Access to Ambulatory Medical and Long-Term Care Services Among Elderly Medicare and Medicaid Beneficiaries: Organizational, Financial, and Geographic Barriers. Medical Care Research and Review, 62(3), 300-319.

1c.—High Priority

1c.1. Demonstrated High-Priority Aspect of Health Care

- Affects large numbers
- High resource use
- Patient/social consequences of poor quality

1c.3. Epidemiologic or Resource Use Data

Medicare Spending on DME in Dual Eligible Populations:
Research shows that Medicare spending on medical equipment is higher for dual eligible beneficiaries compared to Medicare-only beneficiaries. In 2008, dual enrollees accounted for $1,248 per user Medicare FFS spending on DME, compared to non-dual enrollee Medicare beneficiaries who accounted for $746 per user Medicare FFS spending on DME (MedPAC 2008). Furthermore, National Health Expenditure data indicate that 15.5 million Medicare beneficiaries use home medical equipment and that durable medical equipment (DME) represented approximately 1.25 percent of Medicare spending in 2014 (CMS 2015).

1c.4. Citations

Centers for Medicare and Medicaid Services (CMS). (2015). Special Needs Plan (SNP) Data. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

MedPAC. (2013). Chapter 6: Care needs for dual-eligible beneficiaries. 2013. Available at http://www.medpac.gov/docs/default-source/reports/chapter-6-online-only-appendixes-care-needs-for-dual-eligible-beneficiaries-june-2013-report-.pdf?sfvrsn=0 . Patient-Reported Outcome Performance Measure (PRO-PM)

Measure data is collected through supplemental questions to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults). The measure is currently only collected through the CAHPS survey for Medicare-Medicaid plans. Additional information can be found at http://www.ma-pdpcahps.org/. The measure is part of a CAHPS Health Plan supplemental item set and may be used in other CAHPS Health Plan surveys – its use is not limited to the CAHPS MA PDP survey.

Although CAHPS health plan surveys may be required in various reporting programs, questions relating to need for and access to medical equipment are part of a supplemental item set (rather than in the core survey), so they are currently optional (at the discretion of the health plan). If this measure becomes part of a core set for programs or plans that enroll all dual beneficiaries, these questions would be added to all CAHPS surveys for this population.

Scientific Acceptability

1.—Data Sample Description

1.1. What Type of Data was Used for Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.2. Identify the Specific Dataset

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.3. What are the Dates of the Data Used in Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.4. What Levels of Analysis Were Tested?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.5. How Many and Which Measured Entities Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.6. How Many and Which Patients Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.7. Sample Differences, if Applicable

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a.2—Reliability Testing

2a2.1. Level of Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.2. Method of Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.3. Statistical Results from Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.4. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2—Validity Testing

2b2.1. Level of Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.2. Method of Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.3. Statistical Results from Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.4. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3—Exclusions Analysis

2b3.1. Method of Testing Exclusions

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3.2. Statistical Results From Testing Exclusions

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4—Risk Adjustment or Stratification

2b4.1. Method of controlling for differences

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.2. Rationale why Risk Adjustment is not Needed

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.3. Conceptual, Clinical, and Statistical Methods

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.4. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.5. Method Used to Develop the Statistical Model or Stratification Approach

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.6. Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R2)

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.7. Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic)

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.8. Statistical Risk Model Calibration—Risk decile plots or calibration curves

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.9. Results of Risk stratification Analysis

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.10. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.11. Optional Additional Testing for Risk Adjustment

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5—Identification of statistically significant and clinically meaningful differences

2b5.1. Method for determining

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5.2. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6—Comparability of performance scores

2b6.1. Method of testing conducted to demonstrate comparability

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6.2. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

Feasibility

3a.1. How are the data elements needed to compute measure scores generated

Not applicable. Feasibility will be determined during the measure testing phase.

3b.1. Are the data elements needed for the measure as specified available electronically

Not applicable. Feasibility will be determined during the measure testing phase.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment

Not applicable. Feasibility will be determined during the measure testing phase.

3c.1. Describe what you have learned or modified as a result of testing

Not applicable. Feasibility will be determined during the measure testing phase.

3c.2. Describe any fees, licensing, or other requirements

Not applicable. Feasibility will be determined during the measure testing phase.

Usability and Use

4.1—Current and Planned Use

The measure is a part of the CAHPS Health Plan Supplemental Item Set. Thus, it may potentially be used in quality reporting programs that use the CAHPS Health Plan Survey.

Use	Planned	Current	For current use, provide Program Name and URL
a. Public Reporting	X		**HEDIS HPCAHPS.** CAHPS Health Plan Survey 5.0H, Adult and Child Versions. More information available at http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISSurveyVendorCertification.aspx **CAHPS for Prescription Drug Plans.** CAHPS survey administered for Medicare Advantage and Prescription Drug Plan contracts under the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. More information available at http://www.ma-pdpcahps.org/ **Medicaid Adult Core Set.** CAHPS Health Plan Survey 5.0H. More information available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html
b. Public Health/Disease Surveillance			
c. Payment Program			

Use	Planned	Current	For current use, provide Program Name and URL
d. Regulatory and Accreditation Programs			
e. Professional Certification or Recognition Program			
f. Quality Improvement with Benchmarking (external benchmarking to multiple organizations)			
g. Quality Improvement (Internal to the specific			
h. Not in use			
i. Use Unknown			

4a.1. Program, sponsor, purpose, geographic area, accountable entities, patients

HEDIS: The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of performance measures used in managed care (Medicare, Medicaid and commercial payers) and is developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks. An incentive for many health plans to collect HEDIS data is a Centers for Medicare and Medicaid Services (CMS) requirement that health maintenance organizations (HMOs) submit Medicare HEDIS data in order to provide HMO services for Medicare enrollees under a program called Medicare Advantage.

CAHPS for Prescription Drug Plans. Medicare CAHPS surveys are a set of surveys sponsored by CMS as required under the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. The CAHPS survey for prescription drug plans provides data to Medicare beneficiaries on the quality of care and services delivered through Medicare Advantage and Medicare Part D prescription drug plans. By contract, data collected through the CAHPS survey for prescription drug plans are reported and published in the Medicare and You handbook available on Medicare.gov. These measures and data are used by beneficiaries when choosing Medicare Advantage and Part D prescription drug plans.

Medicaid Adult Core Set: This is a core set of health quality measures for Medicaid-enrolled adults. The Medicaid Adult Core Set was identified by the Centers for Medicare & Medicaid (CMS) in partnership with the Agency for HealthCare Research and Quality (AHRQ). The data collected from these measures will help CMS to better understand the quality of health care that adults enrolled in Medicaid receive nationally. Beginning in January 2014 and every three years thereafter, the Secretary is required to report to Congress on the quality of care received by adults enrolled in Medicaid. Additionally, beginning in September 2014, state data on the adult quality measures will become part of the Secretary's annual report on the quality of care for adults enrolled in Medicaid.

4a.2. If not publicly reported or used for accountability, reasons

Not applicable.

4a.3. If not, provide a credible plan for implementation

Not applicable.

4b.1. Progress on improvement

Not applicable. This is a new measure.

4b.2. If no improvement was demonstrated, what are the reasons

Not applicable. This is a new measure.

Related and Competing Measures

5—Relation to Other NQF-Endorsed Measures

5.1a. No related or competing measures identified.

5.1b. If the measures are not NQF-endorsed, indicate the measure title

5a—Harmonization

5a.1. Are the measure specifications completely harmonized

5a.2. If not completely harmonized, identify the differences rationale, and impact

5b—Competing measures

5b.1 Describe why this measure is superior to competing measures

Not applicable.

Additional Information

Co.1.—Measure Steward Point of Contact

Co.1.1. Centers for Medicaid and Medicare Services

Co.1.2. Roxanne

Co.1.3. Dupert-Frank

Co.1.4. Roxanne.Dupert-Frank@cms.hhs.gov

Co.1.5. (410) 786-9667

Co.2.—Developer Point of Contact (indicate if same as Measure Steward Point of Contact

Co.2.1. Mathematica Policy Research

Co.2.2. Debra

Co.2.3. Lipson

Co.2.4. DLipson@Mathematica-Mpr.com

Co.2.5. (202) 238-3325

Ad.1. Workgroup/Expert Panel Involved in Measure Development. Not applicable.

Ad.2. Year the Measure Was First Released. Not applicable.

Ad.3. Month and Year of Most Recent Revision. Not applicable.

Ad.4. What is your frequency for review/update of this measure? Not applicable.

Ad.5. When is your next scheduled review/update for this measure? Not applicable.

Ad.6. Copyright Statement. Not applicable.

Ad.7. Disclaimers. Not applicable.

Ad.8. Additional Information/Comments. Not applicable.

Measure Justification Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on July 6, 2016.

Measure Name.

Access to Personal Aide Assistance

Type of Measure.

Patient-reported outcome (PRO)

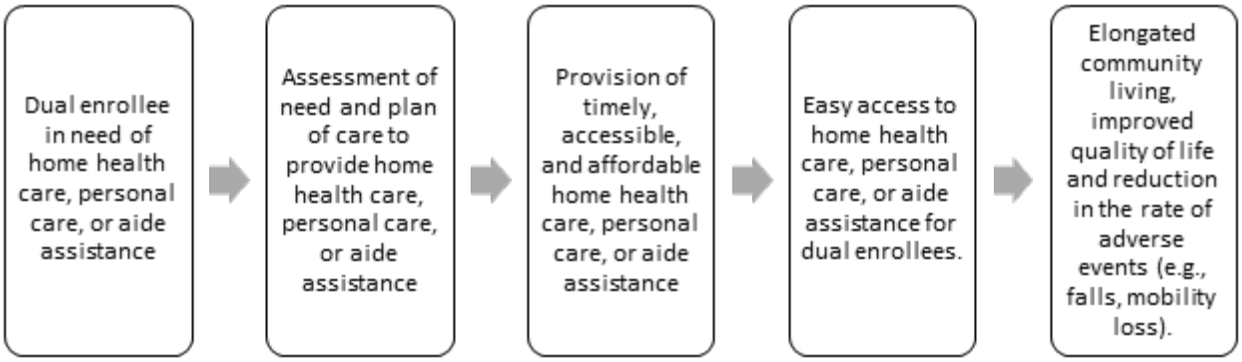
Importance

1a—Opportunity for Improvement

1a.1. This is a measure of patient-reported outcome (PRO).

- Health outcome: This measure assesses the ease of access to home health care, personal care and aide assistance for the dual enrollee population. Easy access to home health and assistance services could help individuals remain in the community longer, improve population health and quality of life, and lower the risk of adverse events (e.g., falls risk, mobility loss) for a vulnerable population.

1a.2.—Linkage



1a.2.1 Rationale

Importance of Access to Care for Dual Enrollees

Appropriate access to all types of care can reduce the probability that individuals with chronic and acute conditions will develop complications or exacerbations that result in complications or other adverse events (e.g., falls, loss of mobility or functional status, hospitalization). Health plans and providers serving dual enrollees can improve access by assessing individual needs, developing care plans that match patient goals, providing timely authorization of services, and ensuring a wide network of providers and facilities. Easy access to home health care, personal care, and aide assistance for the dual enrollee population could prolong the ability of individuals to remain living in the community, improve population health and quality of life, and lower the risk of hospitalization and complications for a vulnerable population. Measurement of appropriate access to home health care, personal care, and aide assistance could provide important information to states, health plans, providers, consumers and other stakeholders as to how well health care systems provides easy access to home health and assistive services in the home.

Importance of Home Health Services to Dual Enrollees

Because dual enrollees are more likely than Medicare-only and Medicaid-only beneficiaries to be frail, sick, cognitively impaired, and have multiple chronic conditions, home health and other assistive services are especially critical to maintain independent living in the community, improve beneficiary quality of life and avert avoidable hospitalizations and complications (MedPAC, 2014; Han et al., 2013).

Compared to Medicare-only beneficiaries, dual enrollees are more likely to self-report their health as fair or poor. Additionally, more than half of dual enrollees (50.6%) suffer from chronic conditions such as asthma, cancer, arthritis, diabetes mellitus, hypertension, and cardiac conditions compared to 47.7% in Medicare-only beneficiaries. On average, dual enrollees have 6.47 co-morbidities, compared to an average of 5.44 co-morbid conditions in Medicare-only beneficiaries. Dual enrollees are also more likely than Medicare-only beneficiaries to have limitations to activities of daily living (ADL) (20.3% v. 8.6%, respectively) and instrumental activities of daily living (IADL) (32.7% v. 15.4%, respectively) (Shin & Moon, 2005). Dual enrollee access to home health care, personal care, and aide assistance may help mitigate some of these limitations, as research has demonstrated that higher state expenditures on Medicaid home health benefits is correlated with reduced rates of unmet needs (Dey et al., 2011).

Benefits of Home Health Services

Studies have shown that home health services are cost-effective and can prevent negative health outcomes. Limited access to Medicare home health care services can increase the probability of health deterioration, preventable hospital readmission, emergency room visits, and prolonged recovery periods. Such adverse events often necessitate admission to costlier institutional care (Davitt & Marcus, 2008; McCall et al., 2002; Schlenker et al., 2005). In their 2011 Report to Congress, MedPAC noted that home health services are, on average, less expensive than care provided in alternative institutional settings. MedPAC found that while the average cost per day for care provided in institutional settings was $1,805 for hospitals and $373 for skilled nursing facilities, Medicare home health care services cost an average of only $145 per visit (MedPAC, 2011).

Easy access to personal care and aide assistance for ADLs and IADLs for dual enrollees can help elongate community living, improve quality of life, and reduce the rate of adverse events. CMS' Home Health Compare tool reports data on several quality measures related to an agency's capacity to improve beneficiaries' rate of hospitalization, limitations to ADLs, and functioning. In 2013, 58.5% of Medicare beneficiaries accessing care through a home health agency experienced improvement in walking and 53.8% of beneficiaries experienced improvement in transferring. In 2012, 27.5% of Medicare beneficiaries accessing care through a home health agency experienced improvement in hospitalization (MedPAC, 2014).

Dual Enrollee Access to Home Health Services

In recent years, the number of home health agencies in the United States has continued to rise. A 2014 report indicated that over 99 percent of Medicare-only beneficiaries live within a ZIP code with at least one operating Medicare-certified home health agency and 97 percent live within a ZIP code with two or more operating agencies (MedPAC, 2014). Despite this growth, dual enrollees' use of home health agency services remains low. While in 2011, 58% of dual enrollees reported one or more limitations to ADL, only 14% are currently accessing Medicare home health benefits (MedPAC, 2015; MedPAC/MACPAC, 2015). Additionally, although home health care, personal care, and aide assistance are reimbursable and covered under both Medicare and Medicaid, discrepancies in the programs' payment and eligibility rules can restrict access in dual enrollees. For example, Medicare requires that beneficiaries receiving home health services must be homebound, while state Medicaid programs are barred from implementing this restriction. Additionally, while Medicare pays for home health services through a prospective payment system for 60-day episodes, Medicaid reimburses on a per-visit or per-service basis (Verdier, 2014).

1a.3.—Linkage

1a.3.1. Source of Systematic Review. Not applicable.

1a.4.—Clinical Practice Guideline Recommendation

1a.4.1. Guideline Citation. Not applicable.

1a.4.2. Specific Guideline. Not applicable.

1a.4.3. Grade. Not applicable.

1a.4.4. Grades and Associated Definitions. Not applicable.

1a.4.5. Methodology Citation. Not applicable.

1a.4.6. Quantity, Quality, and Consistency. Not applicable.

1a.5.—United States Preventative Services Task Force Recommendation

1a.5.1. Recommendation Citation. Not applicable.

1a.5.2. Specific Recommendation. Not applicable.

1a.5.3. Grade. Not applicable.

1a.5.4. Grades and Associated Definitions. Not applicable.

1a.5.5. Methodology Citation. Not applicable.

1a.6.—Other Systematic Review of the Body of Evidence

1a.6.1. Review Citation. Not applicable.

1a.6.2. Methodology Citation. Not applicable.

1a.7.—Findings from Systematic Review of Body of the Evidence Supporting the Measure

1a.7.1. Specifics Addressed in Evidence Review. Not applicable.

1a.7.2. Grade. Not applicable.

1a.7.3. Grades and Associated Definitions. Not applicable.

1a.7.4. Time Period. Not applicable.

1a.7.5. Number and Type of Study Designs. Not applicable.

1a.7.6. Overall Quality of Evidence. Not applicable.

1a.7.7. Estimates of Benefit. Not applicable.

1a.7.8. Benefits Over Harms. Not applicable.

1a.7.9. Provide for Each New Study. Not applicable.

1a.8.—Other Source of Evidence

1a.8.1. Process Used. Not applicable.

1a.8.2. Citation

Davitt, J., & Marcus, S. (2008). The Differential Impact of Medicare Home Health Care Policy on Impaired Beneficiaries. Journal of Policy Practice, 7(1), 3–22. Available at http://www.tandfonline.com/doi/abs/10.1080/15588740801909911?journalCode=wjpp20

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Verdier, J. (2014). Issues in Overlapping Coverage for Home Health and Durable Medical Equipment. *Integrated Care Resource Center and Mathematica Policy Research.* Available at https://www.mathematica-mpr.com/~/media/publications/pdfs/health/icrc_shc_home_health_and_dme_09_08_14.pdf

1b.—Evidence to Support Measure Focus

1b.1. Rationale

Easy access to home health care, personal care, and aide assistance for the prevention and maintenance care of acute and chronic conditions in the dual enrollee population could significantly improve population health and quality of life and lower the risk of hospitalization and complications for a vulnerable population.

1b.2. Performance Scores

1b.3. Summary of Data Indicating Opportunity.

Reference Section 1a.2.1 (Rationale) above.

1b.4. and 1b.5. Disparities

Disparate Use of and Access to Home Health Services Utilization

A number of studies have documented marked disparities among demographic and diagnosis groups in both access to home health/personal care and health outcomes with home health care (Davitt, 2012). Several studies have identified increases in disparities in access to Medicare home health care following the passage of specific health policy legislation. For example, researchers have noted that following the passage of the Balanced Budget Act of 1997 which made cuts in reimbursement for Medicare home health patients, African American and other minority beneficiaries experienced a greater decrease in utilization of home health care than did White beneficiaries (Davitt & Kaye, 2010). Female Medicare beneficiaries, beneficiaries over the age of eighty-five, and beneficiaries with chronic obstructive pulmonary disease, stroke and heart failure also experienced a similar greater-than-expected decrease in utilization of Medicare home health services following the passage of the Balanced Budget Act (McCall et al., 2001; McCall et al., 2003).

Researchers have also observed differences in health outcomes among populations of home care users with similar service utilization. Elderly Hispanic and Asian home health and personal care users were less likely to experience improved physical functioning than their White and Black counterparts. Additionally, elderly White patients were more likely to self-report depressive and anxiety symptoms while receiving home health and personal care than any other ethnic or racial group (Peng et al., 2003).

1c.—High Priority

1c.1. Demonstrated High-Priority Aspect of Health Care

- Affects large numbers
- High resource use
- Patient/social consequences of poor quality

1c.3. Epidemiologic or Resource Use Data

Prevalence of Home Health Services Utilization in Dual Enrollee Populations

In 2013, Medicare provided home health care provided to 3.5 million beneficiaries (approximately 9% of all fee-for-service beneficiaries) over 114.1 million home health visits (MedPAC, 2014). Of the home health delivered to Medicare beneficiaries, 13% was provided by a home health aide, 53% was classified as skilled nursing, 33% was classified as therapy, and 1% was classified as medical social services (MedPAC, 2014). Medicare beneficiaries receiving services from a home health aide had an average of 2.4 visits per episode of care in 2013, down from 5.5 visits per episode in 2001 and 13.4 visits per episode of care in 1998 (MedPAC, 2014).

Data from MedPAC's Medicare Current Beneficiary Survey suggests that although a majority of dual enrollees report limitations to activities of daily living (ADL), relatively few enrollees utilize home health services or personal care/aide assistance. In 2011, 58% of dual enrollees reported one or more limitations to ADL, but only 14% were currently accessing Medicare home health benefits (MedPAC, 2015; MedPAC/MACPAC, 2015).

Expenditures for Home Health Services

Current Medicare spending on home health services is $17.9 billion (approximately 4% of all fee-for-service spending) (MedPAC, 2014). In 2010, 14% of dual enrollees utilized Medicare home health services and had an average spending of $6,305 per enrollee (compared to 9% and $4,970 for non-dual enrollees) (MedPAC/MACPAC, 2015). In 2008, 9.8% of dual enrollees had at least one claim for Medicare-based home health services while 5.1% of Medicare-only beneficiaries had filed a similar claim (The SCAN Foundation, 2011).

Studies have shown that home health services can serve as a cost-effective alternative to care delivered in institutional settings. In their 2011 Report to Congress, MedPAC noted that home health services are, on average, less expensive than care provided in alternative institutional settings. MedPAC found that while the average cost per day for care provided in institutional settings was $1,805 for hospitals and $373 for skilled nursing facilities, Medicare home health care services cost an average of only $145 per visit (MedPAC, 2011).

1c.4. Citations

Davitt, J. (2012). Racial/Ethnic Disparities in Home Health Care: Charting a Course for Future Research. *Home Health Care Services Quarterly.* 31: 1-40. Available at http://www.tandfonline.com/doi/abs/10.1080/01621424.2011.641919

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MedPAC/MACPAC. (2015). Databook: Beneficiaries Dually Eligible for Medicare and Medicaid. Available at http://www.medpac.gov/docs/default-source/data-book/january-2015-medpac-and-macpac-data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid.pdf?sfvrsn=0

Peng, T.R., Navaie-Waliser, M., Feldman, P.H. (2003). Social Support, Home Health Service Use, and Outcomes Among Four Racial-Ethnic Groups. *Gerontologist.* 43(4): 503-13. Available at http://www.ncbi.nlm.nih.gov/pubmed/12937329

The Scan Foundation. (2011). DataBrief: Dual Eligibles – Health Services Utilization. 10. Available at http://www.thescanfoundation.org/sites/default/files/1pg_databrief_no10.pdf

1c.5. Patient-Reported Outcome Performance Measure (PRO-PM)

Measure data is collected through supplemental questions to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults). The measure is currently only collected through the CAHPS survey for Medicare-Medicaid plans. Additional information can be found at http://www.ma-pdpcahps.org/. The measure is part of a CAHPS Health Plan supplemental item set and may be used in other CAHPS Health Plan surveys – its use is not limited to the CAHPS MA PDP survey.

Although CAHPS health plan surveys may be required in various reporting programs, questions relating to need for and access to home health care are part of a supplemental item set (rather than in the core survey), so they are currently optional (at the discretion of the health plan). If this measure becomes part of a core set for programs or plans that enroll all dual enrollees, these questions would be added to all CAHPS surveys for this population. The measure may not be a required component of reporting, as it is part of a supplemental item set (rather than a core survey).

Scientific Acceptability

1.—Data Sample Description

1.1. What Type of Data was Used for Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.2. Identify the Specific Dataset

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.3. What are the Dates of the Data Used in Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.4. What Levels of Analysis Were Tested?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.5. How Many and Which Measured Entities Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.6. How Many and Which Patients Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.7. Sample Differences, if Applicable

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a.2—Reliability Testing

2a2.1. Level of Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.2. Method of Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.3. Statistical Results from Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.4. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2—Validity Testing

2b2.1. Level of Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.2. Method of Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.3. Statistical Results from Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.4. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3—Exclusions Analysis

2b3.1. Method of Testing Exclusions

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3.2. Statistical Results From Testing Exclusions

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4—Risk Adjustment or Stratification

2b4.1. Method of controlling for differences

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.2. Rationale why Risk Adjustment is not Needed

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.3. Conceptual, Clinical, and Statistical Methods

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.4. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.5. Method Used to Develop the Statistical Model or Stratification Approach

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.6. Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R^2)

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.7. Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic)

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.8. Statistical Risk Model Calibration—Risk decile plots or calibration curves

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.9. Results of Risk stratification Analysis

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.10. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.11. Optional Additional Testing for Risk Adjustment

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5—Identification of statistically significant and clinically meaningful differences

2b5.1. Method for determining

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5.2. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6—Comparability of performance scores

2b6.1. Method of testing conducted to demonstrate comparability

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6.2. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

Feasibility

3a.1. How are the data elements needed to compute measure scores generated

Not applicable. Feasibility will be determined during the measure testing phase.

3b.1. Are the data elements needed for the measure as specified available electronically

Not applicable. Feasibility will be determined during the measure testing phase.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment

Not applicable. Feasibility will be determined during the measure testing phase.

3c.1. Describe what you have learned or modified as a result of testing

Not applicable. Feasibility will be determined during the measure testing phase.

3c.2. Describe any fees, licensing, or other requirements

Not applicable. Feasibility will be determined during the measure testing phase.

Usability and Use

The measure is a part of the CAHPS Health Plan Supplemental Item Set. Thus, it may potentially be used in quality reporting programs that use the CAHPS Health Plan Survey.

4.1—Current and Planned Use

Use	Planned	Current	For current use, provide Program Name and URL
a. Public Reporting	X		**HEDIS HPCAHPS.** CAHPS Health Plan Survey 5.0H, Adult and Child Versions. More information available at http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISSurveyVendorCertification.aspx **CAHPS for Prescription Drug Plans.** CAHPS survey administered for Medicare Advantage and Prescription Drug Plan contracts under the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. More information available at http://www.ma-pdpcahps.org/ **Medicaid Adult Core Sets.** CAHPS Health Plan Survey 5.0H. Available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html
b. Public Health/Disease Surveillance			
c. Payment Program			

Use	Planned	Current	For current use, provide Program Name and URL
d. Regulatory and Accreditation Programs			
e. Professional Certification or Recognition Program			
f. Quality Improvement with Benchmarking (external benchmarking to multiple organizations)			
g. Quality Improvement (Internal to the specific organization)			
h. Not in use			
i. Use Unknown			

4a.1. Program, sponsor, purpose, geographic area, accountable entities, patients. Usability will be determined during the measure testing phase.

The measure is a part of the CAHPS Health Plan Supplemental Item Set. Thus, it may potentially be used in quality reporting programs that use the CAHPS Health Plan Survey.

HEDIS: The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of performance measures used in managed care (Medicare, Medicaid and commercial payers) and is developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks. An incentive for many health plans to collect HEDIS data is a Centers for Medicare and Medicaid Services (CMS) requirement that health maintenance organizations (HMOs) submit Medicare HEDIS data in order to provide HMO services for Medicare enrollees under a program called Medicare Advantage.

CAHPS for Prescription Drug Plans. Medicare CAHPS surveys are a set of surveys sponsored by CMS as required under the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. The CAHPS survey for prescription drug plans provides data to Medicare beneficiaries on the quality of care and services delivered through Medicare Advantage and Medicare Part D prescription drug plans. By contract, data collected through the CAHPS survey for prescription drug plans are reported and published in the Medicare and You handbook available on Medicare.gov. These measures and data are used by beneficiaries when choosing Medicare Advantage and Part D prescription drug plans.

Medicaid Adult and Child Core Sets: These are a core set of health quality measures for Medicaid-enrolled adults and children. The Medicaid Adult and Child Core Sets were identified by the Centers for Medicare & Medicaid (CMS) in partnership with the Agency for HealthCare Research and Quality (AHRQ). The data collected from these measures will help CMS to better understand the quality of health care that adults and children enrolled in Medicaid receive nationally. Beginning in January 2014 and every three years thereafter, the Secretary is required to report to Congress on the quality of care received by adults enrolled in Medicaid. Additionally, beginning in September 2014, state data on the adult quality measures will become part of the Secretary's annual report on the quality of care for adults enrolled in Medicaid. 4a.2. If not publicly reported or used for accountability, reasons. Usability will be determined during the measure testing phase.

Not applicable.

4a.3. If not, provide a credible plan for implementation. Usability will be determined during the measure testing phase.

Not applicable.

4b.1. Progress on improvement. Usability will be determined during the measure testing phase.

Not applicable. This is a new measure.

4b.2. If no improvement was demonstrated, what are the reasons. Usability will be determined during the measure testing phase.

Not applicable. This is a new measure.

Related and Competing Measures

5—Relation to Other NQF-Endorsed Measures

5.1a. The measure titles and NQF numbers are listed here

No related or competing measures identified.

5.1b. If the measures are not NQF-endorsed, indicate the measure title

5a—Harmonization

5a.1. Are the measure specifications completely harmonized?

5a.2. If not completely harmonized, identify the differences rationale, and impact

5b—Competing measures

5b.1 Describe why this measure is superior to competing measures.

Not applicable.

Additional Information

Co.1.—Measure Steward Point of Contact

Co.1.1. Centers for Medicare and Medicaid Services

Co.1.2. Roxanne

Co.1.3. Dupert-Frank

Co.1.4. Roxanne.Dupert-Frank@cms.hhs.gov

Co.1.5. (410) 786-9667

Co.2.—Developer Point of Contact (indicate if same as Measure Steward Point of Contact)

Co.2.1. Mathematica Policy Research

Co.2.2. Debra

Co.2.3. Lipson

Co.2.4. DLipson@Mathematica-Mpr.com

Co.2.5. (202) 238-3325

Ad.1. Workgroup/Expert Panel Involved in Measure Development. Not applicable.

Ad.2. Year the Measure Was First Released. Not applicable.

Ad.3. Month and Year of Most Recent Revision. Not applicable.

Ad.4. What is your frequency for review/update of this measure? Not applicable.

Ad.5. When is your next scheduled review/update for this measure? Not applicable.

Ad.6. Copyright Statement. Not applicable.

Ad.7. Disclaimers. Not applicable.

Ad.8. Additional Information/Comments. Not applicable.

Measure Justification Form

Project Title:

Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with Mathematica Policy Research and its partners, the American Medical Association, Brandeis University, the National Committee for Quality Assurance, and Truven Health Analytics, to develop measures for the following populations of Medicaid beneficiaries:

- People eligible for both Medicare and Medicaid, or "Dual enrollees"
- People receiving long-term services and supports (LTSS) through managed care organizations
- People with substance use disorders, beneficiaries with complex needs, physical and mental health conditions, or who receive LTSS in the community, corresponding to the priority areas of the Medicaid Innovation Accelerator Program

The contract name is Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees. The contract number is HHSM-500-2013-13011I, Task Order # HHSM-500-T0004.

Date:

Information included is current on July 6, 2016.

Measure Name

Access to Counseling or Treatment

Type of Measure

Patient-reported outcome (PRO)

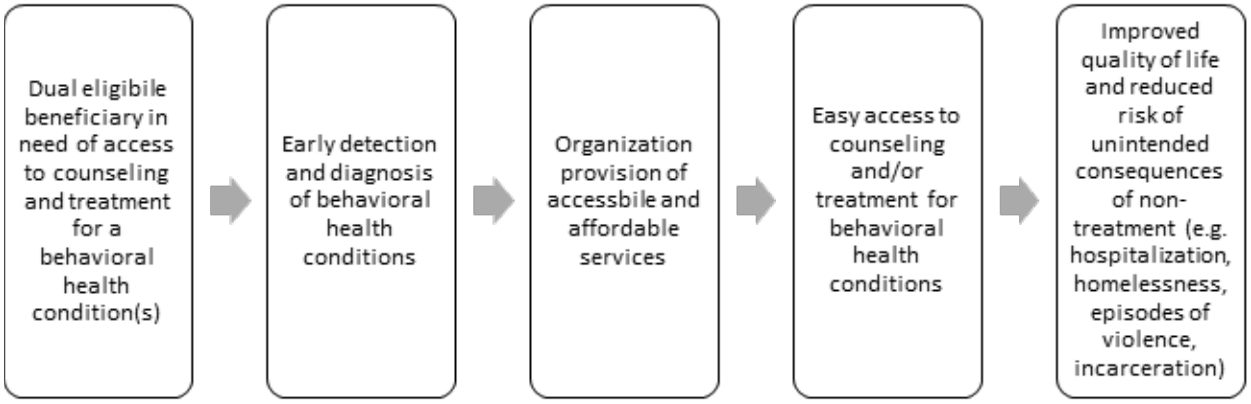
Importance

1a—Opportunity for Improvement

1a.1. This is a measure of outcome.

Health outcome: Ensuring easy access to counseling and/or treatment for behavioral health conditions in the dual eligible population may prevent prolonged distress and could reduce the risk of damaging effects caused by long term suffering. Early detection and treatment may reduce hospitalizations, improve overall functioning, and lessen the impact of serious mental illness on quality of life.

1a.2.—Linkage



1a.2.1 Rationale

Importance of Access to Care for Dual Eligible Beneficiaries

In comparison to nondual Medicare beneficiaries, full duals were three times as likely to have been diagnosed with a mental illness (CBO, 2013). From 2006-2009, in any given year, 25 percent of dual eligible beneficiaries with a behavioral health condition were hospitalized, and approximately 12 percent were hospitalized twice or more (Frank et al, 2014), higher than Medicare-only beneficiaries with the same conditions." (The SCAN Foundation, 2013).

Appropriate access to care can reduce the probability that individuals diagnosed with behavioral health conditions suffer prolonged distress and may help to prevent unintended consequences caused by untreated mental illness. Ensuring appropriate access to vital services and prescription drugs for individuals with mental illnesses could significantly improve population health and quality of life. Measurement of appropriate access to counseling and treatment for dual eligible beneficiaries with behavioral health needs could provide important information to health plans, providers, consumers and other stakeholders as to how well a system of care helps those suffering from behavioral health conditions

acquire and maintain the resources necessary to treat their illnesses. In order to improve ease of access to care, health plans and providers can proactively assess behavioral health needs in the population, ensure the development of care plans that match patient goals for treatment and counseling, offer wide provider networks, connect individuals with services in the network and community, and provide timely authorization of services.

Importance of Access to Counseling to Dual Eligible Beneficiaries

Depression, anxiety disorders, schizophrenia/other psychotic disorders, and other bipolar disorders are among the most common behavioral health conditions among dual-eligible beneficiaries (MedPac/MACPAC, 2015). According to a report released in 2013, among the 7.1 million full dual-eligible[1] beneficiaries in 2009, approximately 30% had been diagnosed with a mental illness (CBO, 2013). The report went on to state that among full duals, approximately 37% of beneficiaries under age 65 were diagnosed with a mental illness, compared to 25% of beneficiaries age 65 or older (CBO 2013).

Research on Psychosocial Interventions for Behavioral Health Conditions

Evidence-based psychosocial interventions such as psychotherapies, (for example, psychodynamic therapy, cognitive-behavioral therapy, interpersonal psychotherapy, or problem solving therapy), community-based treatment (for example, assertive community treatment or first episode psychosis interventions), vocational rehabilitation, peer support services, and integrated care interventions are effective in improving outcomes for vulnerable patients with complex conditions (England et al. 2015). Furthermore, psychosocial interventions are often preferred over psychotropic treatments by patients when outcomes have similar efficacy (England et al. 2015).

Direct access to psychosocial interventions has proved effective for patients. For example, a qualitative assessment of the Blueprint pilots in Vermont in 2010 (including Medicaid and commercial payers) found that having a behavioral specialist on site made it more likely that patients with chronic conditions referred for mental health services would obtain those services. Providers reported that behavioral health providers in the community health teams expanded their ability to respond to patients' clinical and nonclinical needs, due to the teamwork at play. The pilot found significant decreases between two years in hospital admissions and ED visits per 1,000 patients (inpatient use and per-person per-month costs decreased 21 percent and 22 percent, respectively; ED use and per-person per-month costs decreased 31 percent and 36 percent, respectively; and overall use and costs per person per

[1] Dual-eligible beneficiaries are people who are enrolled in Medicare and Medicaid at the same time and who are eligible to receive benefits from both programs. "Full duals" qualify for full benefits from both programs "partial duals" qualify for full benefits from Medicare but only partial benefits from Medicaid (meaning that Medicaid pays some of the expenses they incur under Medicare, such as premiums, but does not cover additional health care services, such as long-term services and supports).

month decreased 8.9 percent and 11.6 percent, respectively) (Bielaszka-DuVernay 2011). Another study evaluating the impact of evidence-based social interventions on depressed nursing home residents in western Pennsylvania found that self-determined social interventions such as recreational programs can effectively treat depression in nursing home residents as long as the resident is capable of participating in the design of his or her recreational program (Rosen 2014).

Effective, evidence-based psychosocial interventions are not often available as a treatment option due to gaps in training of mental health and substance use providers in primary and specialty care, making it even less likely that dual eligible beneficiaries would have access to behavioral health treatments (England et al. 2015). Although implementation of psychosocial treatments could be cost-effective, many Medicare managed care organizations may not be prepared to incur the costs if the treatments are not factored into their capitation rates, as they therefore may not be cost-saving for them (Loftis and Salinsky 2006).

Research on Access to Pharmacologic Treatment for Behavioral Health Conditions in Dual Eligible Population

Since enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003, dual-eligible beneficiaries have received their prescription drug benefit through Medicare. As a result, approximately 6 million dual eligible beneficiaries saw their prescription drug benefit transition from Medicaid to Medicare Part D plans. Among other obstacles created by this transition, "a key challenge to integrating mental health services and general medical care in insurance markets is the risk of adverse selection and the incentives this risk creates for insurers to stint on mental health treatment" (Donohue, 2006). Because all dual-eligibles were randomly assigned to a Part D plan, CMS addressed this challenge by issuing guidance which directed plans to cover "all or substantially all" medications that fell within six drug classes: anticonvulsants, antidepressants, antineoplastic, antipsychotics, antiretrovirals, and immunosuppressants. Despite these provisions, however, dual-eligible beneficiaries were especially vulnerable to major shifts in their prescription drug coverage due to their "low educational attainment, very low incomes, poor health status, and greater likelihood of cognitive and physical impairments" and may "have difficulty navigating a complex market" (Donohue et al, 2009).

In a 2009 study, observational, clinician-reported surveys tracked patient experiences in the 12 months following implementation of Medicare Part D; researchers examined the changes in access to treatment for dual-eligible patients with psychiatric conditions and any subsequent effects in the first year after their drug coverage was changed. This study found that "patients who experienced a medication access problem were more likely to use psychiatric care provided in the emergency room but were not more likely to use inpatient

psychiatric care" (Huskamp et al, 2009). Another study of 1,193 dual eligible patients from January to April of 2006, shortly after dual eligible beneficiaries transitioned to Medicare Part D, found that "although one in 10 patients was reported to have enhanced medication access as a result of the Part D benefit, approximately half of all patients were reported to have experienced at least one medication access or continuity problem (West et al, 2007).

Recently, CMS has revisited the criteria that previously informed the decision to establish six protected drug classes for which Medicare Part D plans were required to provide "all or substantially all" medications. In a press release issued in January of 2014, CMS proposed "to change the categories or classes of Part D drugs of clinical concern using criteria established through this notice and comment rule making. Under the proposed criteria, CMS would…no longer require all drugs from the antidepressant and immunosuppressant drug classes to be on all Part D formularies. Although antipsychotics do not meet the criteria, they will remain protected at least through 2015 while CMS evaluates additional considerations and the need for any other formulary exceptions" (CMS, 2014). Later in February of 2015, CMS released a follow-up announcing finalization of program changes to Medicare Part D; while they were being considered with the other program changes under rule 4159P, the rule did not finalize the provisions "lifting the protected class designation on three drug classes – antidepressants, antipsychotics, and immunosuppressants for transplant rejection," suggesting they may still be under review (CMS, 2015).

1a.3.—Linkage

1a.3.1. Source of Systematic Review. Not applicable.

1a.4.—Clinical Practice Guideline Recommendation

1a.4.1. Guideline Citation. Not applicable.

1a.4.2. Specific Guideline. Not applicable.

1a.4.3. Grade. Not applicable.

1a.4.4. Grades and Associated Definitions. Not applicable.

1a.4.5. Methodology Citation. Not applicable.

1a.4.6. Quantity, Quality, and Consistency. Not applicable.

1a.5.—United States Preventative Services Task Force Recommendation

1a.5.1. Recommendation Citation. Not applicable.

1a.5.2. Specific Recommendation. Not applicable.

1a.5.3. Grade. Not applicable.

1a.5.4. Grades and Associated Definitions. Not applicable.

1a.5.5. Methodology Citation. Not applicable.

1a.6.—Other Systematic Review of the Body of Evidence

1a.6.1. Review Citation. Not applicable.

1a.6.2. Methodology Citation. Not applicable.

1a.7.—Findings from Systematic Review of Body of the Evidence Supporting the Measure

1a.7.1. Specifics Addressed in Evidence Review. Not applicable.

1a.7.2. Grade. Not applicable.

1a.7.3. Grades and Associated Definitions. Not applicable.

1a.7.4. Time Period. Not applicable.

1a.7.5. Number and Type of Study Designs. Not applicable.

1a.7.6. Overall Quality of Evidence. Not applicable.

1a.7.7. Estimates of Benefit. Not applicable.

1a.7.8. Benefits Over Harms. Not applicable.

1a.7.9. Provide for Each New Study. Not applicable.

1a.8.—Other Source of Evidence

1a.8.1. Process Used. Not applicable.

1a.8.2. Citation.

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progress/article/november-december-2014/a-doctor's-view-depression-in-long-term-care-residents.

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1b.—Evidence to Support Measure Focus

1b.1. Rationale

Easy access to counseling and treatment for behavioral health conditions in the dual eligible population could significantly improve health and quality of life, and reduce the risk of unintended consequences caused by non-treatment.

1b.2. Performance Scores

1b.3. Summary of Data Indicating Opportunity

Refer to section 1a.2.1 above (research on access to counseling in dual eligible population).

1b.4. and 1b.5. Disparities

By nature of the eligibility criteria, the dual eligible population is comprised of individuals who have physical disabilities, intellectual and developmental disabilities, serious behavioral health conditions, and are low-income. As such, studies comparing access to care between dual-eligible beneficiaries and non-dual-eligible beneficiaries highlight and address disparities by those characteristics. In 2011, approximately 49 percent of dual eligible beneficiary adults aged 18 to 64 were identified as having any mental illness or substance use disorder (behavioral health conditions) within the past year, compared with 14 percent among adults who were not dual eligible beneficiaries (SAMHSA, 2014). Difficulties accessing counseling and treatment among dual eligible beneficiaries may lead to greater need for hospitalization.

Research has found evidence of racial disparities in access and utilization of mental health services. In the U.S. Surgeon General's first report and supplement on mental health, it was reported that compared to whites, racial and ethnic minorities were less likely to receive

needed care, more likely to receive poor-quality care, and overall had less access to mental health services (U.S. Department of Health and Human Services, 2001). A 2001 study, which looked at survey data to assess quality of care for alcoholism, drug abuse, and mental health conditions, found that compared to non-Hispanic whites (37.6%), African Americans (25%) and Hispanics (22.4%) were less likely to be receiving active treatment (Wells et al, 2001). Further, they reported that among those with perceived need, compared to whites, African Americans were more likely to have no access to care, and Hispanics were more likely to have delayed or inadequate care. (Wells et al, 2001). Another study looking into factors associated with detection of mental health problems found that physicians were less likely to detect mental health problems in African Americans compared with whites (Borowsky et al, 2000).

1c.—High Priority

1c.1. Demonstrated High-Priority Aspect of Health Care

- Affects large numbers
- High resource use
- Patient/social consequences of poor quality
- Severity of illness

1c.3. Epidemiologic or Resource Use Data

Differences in prevalence of health conditions and disabilities in the dual eligible population significantly impacts the variation in average spending per beneficiary. One in five dual eligible beneficiaries has more than one mental/cognitive condition (Kasper et al. 2010). In comparison to nondual Medicare beneficiaries, full duals were three times as likely to have been diagnosed with a mental illness (CBO, 2013). A 2014 study of data from the Medicare Current Beneficiary Survey for the period 2006-2009 found that in a given year, 25 percent of dual eligible beneficiaries with a behavioral health condition were hospitalized, and approximately 12 percent were hospitalized twice or more (Frank et al, 2014).

In a 2012 study of dual eligible beneficiaries 65 years and older, researchers estimated the incremental effects of mental health disorders[2] on expenditures including medical care, long-term care, and prescription drugs across long term care (LTC) settings. Using 2005 claims data, the authors grouped beneficiaries into three groups: non-LTC, community LTC, and institutional LTC. They found that the average incremental effect of mental health

[2] The authors included anxiety, bipolar, major depression, mild depression, and schizophrenia in their analysis.

disorders on expenditures was 27%, 23%, and 75% for community LTC, institutional LTC, and non-LTC respectively (Lum et al, 2012).

1c.4. Citations

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1c.5. Patient-Reported Outcome Performance Measure (PRO-PM)

Measure data is collected through supplemental questions to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Health Plans (Adults). The measure is currently only collected through the CAHPS survey for Medicare-Medicaid plans. Additional information can be found at http://www.ma-pdpcahps.org/. The measure is part of a CAHPS Health Plan supplemental item set and may be used in other CAHPS Health Plan surveys – its use is not limited to the CAHPS MA PDP survey.

Although CAHPS health plan surveys may be required in various reporting programs, questions relating to need for and access to behavioral health counseling and treatment are part of a supplemental item set (rather than in the core survey), so they are currently optional (at the discretion of the health plan). If this measure becomes part of a core set for programs or plans that enroll all dual beneficiaires, these questions would be added to all CAHPS surveys for this population.

Scientific Acceptability

1.—Data Sample Description

1.1. What Type of Data was Used for Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.`

1.2. Identify the Specific Dataset

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.3. What are the Dates of the Data Used in Testing?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.4. What Levels of Analysis Were Tested?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.5. How Many and Which Measured Entities Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.6. How Many and Which Patients Were Included in the Testing and Analysis?

Not applicable. Scientific acceptability will be determined during the measure testing phase.

1.7. Sample Differences, if Applicable

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a.2—Reliability Testing

2a2.1. Level of Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.2. Method of Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.3. Statistical Results from Reliability Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2a2.4. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2—Validity Testing

2b2.1. Level of Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.2. Method of Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.3. Statistical Results from Validity Testing

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b2.4. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3—Exclusions Analysis

2b3.1. Method of Testing Exclusions

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3.2. Statistical Results From Testing Exclusions

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b3.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4—Risk Adjustment or Stratification

2b4.1. Method of controlling for differences

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.2. Rationale why Risk Adjustment is not Needed

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.3. Conceptual, Clinical, and Statistical Methods

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.4. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.5. Method Used to Develop the Statistical Model or Stratification Approach

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.6. Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R2)

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.7. Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic)

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.8. Statistical Risk Model Calibration—Risk decile plots or calibration curves

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.9. Results of Risk stratification Analysis

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.10. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b4.11. Optional Additional Testing for Risk Adjustment

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5—Identification of statistically significant and clinically meaningful differences

2b5.1. Method for determining

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5.2. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b5.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6—Comparability of performance scores

2b6.1. Method of testing conducted to demonstrate comparability

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6.2. Statistical Results

Not applicable. Scientific acceptability will be determined during the measure testing phase.

2b6.3. Interpretation

Not applicable. Scientific acceptability will be determined during the measure testing phase.

Feasibility

3a.1. How are the data elements needed to compute measure scores generated

Not applicable. Feasibility will be determined during the measure testing phase.

3b.1. Are the data elements needed for the measure as specified available electronically

Not applicable. Feasibility will be determined during the measure testing phase.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment

Not applicable. Feasibility will be determined during the measure testing phase.

3c.1. Describe what you have learned or modified as a result of testing

Not applicable. Feasibility will be determined during the measure testing phase.

3c.2. Describe any fees, licensing, or other requirements

Not applicable. Feasibility will be determined during the measure testing phase.

Usability and Use

4.1—Current and Planned Use

The measure is a part of the CAHPS Health Plan Supplemental Item Set. Thus, it may potentially be used in quality reporting programs that use the CAHPS Health Plan Survey.

Use	Planned	Current	For current use, provide Program Name and
a. Public Reporting	X		**HEDIS HPCAHPS.** CAHPS Health Plan Survey 5.0H, Adult and Child Versions. More information available at http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISSurveyVendorCertification.aspx **CAHPS for Prescription Drug Plans.** CAHPS survey administered for Medicare Advantage and Prescription Drug Plan contracts under the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. More information available at http://www.ma-pdpcahps.org/ **Medicaid Adult Core Set.** CAHPS Health Plan Survey 5.0H. Available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html
b. Public Health/Disease Surveillance			
c. Payment Program			
d. Regulatory and Accreditation Programs			

Use	Planned	Current	For current use, provide Program Name and
e. Professional Certification or Recognition Program			
f. Quality Improvement with Benchmarking (external benchmarking to multiple organizations)			
g. Quality Improvement (Internal to the specific organization)			
h. Not in use			
i. Use Unknown			

4a.1. Program, sponsor, purpose, geographic area, accountable entities, patients

Usability will be determined during the measure testing phase.

HEDIS: The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of performance measures used in managed care (Medicare, Medicaid and commercial payers) and is developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks. An incentive for many health plans to collect HEDIS data is a Centers for Medicare and Medicaid Services (CMS) requirement that health maintenance organizations (HMOs) submit Medicare HEDIS data in order to provide HMO services for Medicare enrollees under a program called Medicare Advantage.

CAHPS for Prescription Drug Plans. Medicare CAHPS surveys are a set of surveys sponsored by CMS as required under the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. The CAHPS survey for prescription drug plans provides data to Medicare beneficiaries on the quality of care and services delivered through Medicare Advantage and Medicare Part D prescription drug plans. By contract, data collected through the CAHPS

survey for prescription drug plans are reported and published in the Medicare and You handbook available on Medicare.gov. These measures and data are used by beneficiaries when choosing Medicare Advantage and Part D prescription drug plans.

Medicaid Adult Core Set: This is a core set of health quality measures for Medicaid-enrolled adults. The Medicaid Adult Core Set was identified by the Centers for Medicare & Medicaid (CMS) in partnership with the Agency for HealthCare Research and Quality (AHRQ). The data collected from these measures will help CMS to better understand the quality of health care that adults enrolled in Medicaid receive nationally. Beginning in January 2014 and every three years thereafter, the Secretary is required to report to Congress on the quality of care received by adults enrolled in Medicaid. Additionally, beginning in September 2014, state data on the adult quality measures will become part of the Secretary's annual report on the quality of care for adults enrolled in Medicaid.

4a.2. If not publicly reported or used for accountability, reasons

Usability will be determined during the measure testing phase.

4a.3. If not, provide a credible plan for implementation

Usability will be determined during the measure testing phase.

4b.1. Progress on improvement

Not applicable.

Usability will be determined during the measure testing phase.

Not applicable.

4b.2. If no improvement was demonstrated, what are the reasons

Not applicable. This is a new measure.

Usability will be determined during the measure testing phase.

Not applicable. This is a new measure.

Related and Competing Measures

5—Relation to Other NQF-Endorsed Measures

5.1a. No related or competing measures identified.

5.1b. If the measures are not NQF-endorsed, indicate the measure title

5a—Harmonization

5a.1. Are the measure specifications completely harmonized

Not applicable.

5a.2. If not completely harmonized, identify the differences rationale, and impact

5b—Competing measures

5b.1 Describe why this measure is superior to competing measures

Not applicable.

Additional Information

Co.1.—Measure Steward Point of Contact

Co.1.1. Center for Medicaid and Medicare Services

Co.1.2. Roxanne

Co.1.3. Dupert-Frank

Co.1.4. Roxanne.Dupert-Frank@cms.hhs.gov

Co.1.5. Phone Number (410) 786-9667

Co.2.—Developer Point of Contact (indicate if same as Measure Steward Point of Contact

Co.2.1. Mathematica Policy Research

Co.2.2. Debra

Co.2.3. Lipson

Co.2.4. DLipson@mathematica-Mpr.com

Co.2.5. (202) 238-3325

Ad.1. Workgroup/Expert Panel Involved in Measure Development Not applicable.

Ad.2. Year the Measure Was First Released Not applicable.

Ad.3. Month and Year of Most Recent Revision Not applicable.

Ad.4. What is your frequency for review/update of this measure? Not applicable.

Ad.5. When is your next scheduled review/update for this measure? Not applicable.

Ad.6. Copyright Statement Not applicable.

Ad.7. Disclaimers Not applicable.

Ad.8. Additional Information/Comments Not applicable.