

MEASURE APPLICATIONS PARTNERSHIP

Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2017

FINAL REPORT

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CONTENTS

EXECUTIVE SUMMARY	2
INTRODUCTION AND PURPOSE	4
BACKGROUND ON MEDICAID AND THE CHILD CORE SET	5
STATE EXPERIENCE COLLECTING AND REPORTING THE CHILD CORE SET	8
MAP REVIEW OF THE CHILD CORE SET	11
STRATEGIC CONSIDERATIONS FOR STATE-LEVEL QUALITY IMPROVEMENT	17
CONCLUSION	20
APPENDIX A: MAP Background	23
APPENDIX B: Rosters for the MAP Medicaid Child Task Force and MAP Coordinating Committee	26
APPENDIX C: MAP Measure Selection Criteria	29
APPENDIX D: MAP Medicaid Preliminary Analysis Algorithm	32
APPENDIX E: Characteristics of the Current Child Core Set	34
APPENDIX F: Current Child Core Set and MAP Recommendations for Addition	35
APPENDIX G: Additional Measures Considered	47
APPENDIX H: Gap Areas in the Child Core Set	48
APPENDIX I: Public Comments	49

EXECUTIVE SUMMARY

As of March 2017, 74 million people are enrolled in Medicaid and the Children’s Health Insurance Program (CHIP).¹ Nearly 36 million, or almost half of the people enrolled in Medicaid and CHIP, are children.² Moreover, Medicaid covers nearly 50 percent of all births as well as 40 percent of all children’s healthcare.

The Children’s Health and Insurance Program Reauthorization Act of 2009 (CHIPRA) required the U.S. Department of Health and Human Services (HHS) to develop standards to measure the quality of children’s healthcare. This legislative mandate led to the identification of a Core Set of healthcare quality measures for children enrolled in Medicaid and CHIP. The Centers for Medicare & Medicaid Services (CMS) released the initial Child Core Set in 2010. Measures in the Child Core Set are relevant to children ages 0-18 as well as pregnant women because these measures address both prenatal and postpartum quality-of-care issues. CHIPRA also required CMS to update the initial Child Core Set annually beginning in January 2013. The 2017 Child Core Set contains 27 healthcare quality measures.

The Measure Applications Partnership (MAP), a multistakeholder partnership convened by the National Quality Forum (NQF), provides guidance to HHS on the selection of performance measures for use in federal health programs. Each year, through its Medicaid Child Task Force, MAP makes recommendations to strengthen the Child Core Set. Guided by MAP’s Measure Selection Criteria and feedback from states regarding implementation issues, MAP is providing its latest round of annual recommendations to HHS for strengthening the measures in the Child Core Set. MAP also identified several high-priority measure gaps for future consideration.

MAP recommends removal of five measures and the addition of another five measures. MAP examined all measures based on each measure’s ability to provide contextual information and to effectively measure an important aspect of child health. In its recommendations to remove certain measures from the Core Set, MAP emphasizes the need for better measures that focus on the quality of care, not just the frequency of care (Exhibit ES1).

EXHIBIT ES1. MEASURES RECOMMENDED BY MAP FOR REMOVAL FROM THE CHILD CORE SET

NQF Number (if applicable) and Measure Title
NQF #1391 Frequency of Ongoing Prenatal Care
NQF #1517 Prenatal and Postpartum Care - Timeliness of Prenatal Care
NQF #1799 Medication Management for People with Asthma
NQF #1365 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
Behavioral Health Risk Assessment (for Pregnant Women)

MAP recommends the addition of the five measures listed below (Exhibit ES2). MAP recommends measures that would strengthen the measure set by promoting measurement of a variety of high-priority quality issues, including access to care, behavioral health, and asthma.

EXHIBIT ES2. MEASURES RECOMMENDED BY MAP FOR PHASED ADDITION TO THE CHILD CORE SET

Rank	NQF Number and Measure Title
1	NQF #2903 Contraceptive Care: Most & Moderately Effective Methods
	NQF #1800 Asthma Medication Ratio
2	NQF #3154 Informed Participation
3	NQF #3148 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan*
4	NQF #2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics

* Formerly NQF #0418. The measure number is updated to reflect measures with multiple formats.

MAP recognizes that many priority areas for quality measurement and improvement lack fully developed metrics. MAP documents these gaps in current measures as future measurement needs for the developer community. The list of 13 gap areas is a suggested starting point for subsequent discussions and revisions to the Child Core Set.

MAP also discussed ways of improving quality and Child Core Set reporting at the state level. These discussions focused on the evolution in quality

measurement and included the following topical areas:

- optimizing data connections between data systems and among organizations;
- improving integration across local, state, and federal health entities as well as coordination of programs and data systems;
- aligning measurement and data requirements; and
- incorporating methodological paradigm shifts through stratification of data and acknowledgment of the impact of social complexities on care delivery and outcomes.

As the Medicaid Child Core Set evolves, success in improving quality depends on voluntary reporting, which encompasses issues of data availability, collection, and reporting burden. Success also depends on methodological issues such as risk adjustment for social risk factors and measure stratification. Therefore, education, communication, and collaboration across care systems that treat children covered by Medicaid and CHIP will be necessary to advance the evolution of Medicaid care quality.

INTRODUCTION AND PURPOSE

The Measure Applications Partnership (MAP) ([Appendix A](#)) is a multistakeholder partnership that guides the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs. As part of this process, MAP convenes stakeholders for an intensive annual review of the quality measures HHS is considering for 20-plus federal health programs, including Medicaid and the Children's Health Insurance Program (CHIP). The National Quality Forum (NQF) convenes MAP and brings together a multistakeholder group of consumers, providers, healthcare organizations, communities and states, among others, to recommend core measures for assessing and improving the quality of care for children in Medicaid and CHIP. This ensures the appropriate evolution of the measure set over time.

The MAP Medicaid Child Task Force advises the MAP Coordinating Committee on recommendations to HHS for strengthening the Core Set of Health Care Quality Measures for Children Enrolled in Medicaid and CHIP (the Child Core Set), and identifies high-priority measure gaps in the Child Core Set. The Task Force is charged with reviewing states' experiences reporting measures to date, refining previously identified measure gap areas, and recommending potential measures for addition or removal from the Child Core Set, with a focus on addressing high-priority measure gap areas. The Task

Force consists of MAP members from the MAP Coordinating Committee and MAP workgroups with relevant interests and expertise ([Appendix B](#)).

MAP's annual recommendations are guided by feedback from states with regards to the Child Core Set measure implementation, Medicaid population-specific gap areas, the most recent available measure implementation data from the Centers for Medicare & Medicaid Services (CMS), the NQF Measure Selection Criteria (MSC) ([Appendix C](#)), and a defined decision algorithm based on the MSC ([Appendix D](#)). The MSC are not absolute rules; rather, they provide general guidance for selecting measures that would contribute to a balanced measure set by addressing the National Quality Strategy's three aims, being responsive to specific program goals, and including an appropriate mix of measure types, among other factors.

This is MAP's fourth set of recommendations for the Child Core Set. During this process, MAP reviewed data from the federal fiscal year (FFY) 2015 reporting cycle and recommended changes for the 2018 Child Core Set. The recommendations have been vetted through an opportunity for public comment ([Appendix I](#)). This report summarizes selected states' feedback on collecting and reporting measures, measure-specific recommendations that address high-priority gaps, and prioritized gap areas.

BACKGROUND ON MEDICAID AND THE CHILD CORE SET

Medicaid and CHIP provide much needed health coverage to eligible adults and children. Authorized by the Title XIX of the Social Security Act, Medicaid and Medicare were signed into law in 1965.³ CHIP was signed into law in 1997 and covers children whose family income excludes them from Medicaid, but who cannot afford the cost of private insurance.⁴ The Affordable Care Act (ACA) expanded Medicaid eligibility to cover those under age 65 with incomes below 133 percent of the Federal Poverty Level (FPL). The ACA also standardized the eligibility rules and provided benefits through Medicaid and CHIP.⁵

As of March 2017, over 74 million people are enrolled in Medicaid and CHIP.⁶ Nearly 36 million, or almost 50 percent of people enrolled in Medicaid and CHIP, are children.⁷ States and the federal government jointly fund both programs. Federal guidelines serve as a programmatic roadmap; however, states have the flexibility to modify and administer the program based on their population needs.⁸

Medicaid and CHIP Benefits for Children and Pregnant Women

Medicaid covers nearly 50 percent of all births as well as 40 percent of all children's healthcare. The program thereby ensures that this vulnerable group obtains the necessary services to optimize their care quality. Collaborations between CMS and states provide Medicaid agencies with resources to strengthen and expand services such as prenatal through postpartum care, behavioral healthcare, and early and periodic screening, diagnostic (services), and treatment (EPSDT). All children enrolled in Medicaid are entitled to EPSDT services. This ensures that eligible children under 21 years of age periodically receive a

comprehensive array of medical, dental, vision, and hearing services. Notably, both Medicaid and CHIP provide services focused on maternal health, in addition to providing services for infants and children.⁹

CHIP also provides a comprehensive set of benefits for children, but the benefits package varies depending on the state. Each state can design its CHIP program in one of three ways: as an expansion of the Medicaid program, as a separate program, or as a combination of the two approaches. Medicaid Expansion CHIP programs provide the standard Medicaid benefit package, including EPSDT. Separate CHIP programs can provide either Benchmark coverage, Benchmark-equivalent coverage, or Secretary-approved coverage with tailored benefits to meet the needs of specific Medicaid populations.¹⁰

Health Issues for Children in Medicaid and CHIP

While most children are healthy and their care focuses on tracking development and preventing disease, subsets of children have complex health needs. Approximately 19 percent of children have special healthcare needs, with 43 percent covered under public insurance.^{11,12} Medicaid spends \$33,700 per child using long-term care services versus \$2,700 per child using preventive care services only.¹³

Regarding children with special needs, MAP members focused their attention on children with behavioral health issues, including mental and substance use disorders. Among children two to eight years old, one in seven have a mental, behavioral, or developmental disorder, and one in five children between nine and 17 years of age have a diagnosable psychiatric disorder.¹⁴ Mental

health and substance abuse among adolescents are critical issues since mental health and substance abuse tend to co-occur.¹⁵ Approximately 88 percent of substance-dependent children between 15 and 17 years old had co-occurring mental health issues.¹⁶ Thirteen to 20 percent of children experience a mental disorder in a given year, and suicide is the second leading cause of death among adolescents between 12 and 17 years old.¹⁷ Among this group, the use of psychotropic medications is rising, especially for publicly insured children.^{18,19} Among children between six and 17 years old, 7.5 percent are prescribed medication for emotional and/or behavioral difficulties.²⁰ This is escalating concerns regarding overprescribing of antipsychotic drugs, in part, because of their very serious side effects, which include rapid weight gain and increased risk for the development of diabetes.²¹ Due to the gravity of the issue and concern about antipsychotic prescribing patterns, MAP discussed two measures relating to mental and behavioral issues: NQF #3148 *Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan*, and NQF #2800 *Metabolic Monitoring for Children and Adolescents on Antipsychotics*.

Asthma is another condition with significant burden to patients, families, and society at large. Overall, asthma prevalence among children has plateaued since 2013.²² Asthma still affects 7.8 percent of the U.S. population with the highest burden affecting children 5 to 19 years of age (20%) and those below 100 percent of the FPL (11.1%).²³ In 2013, 1.6 million people visited an emergency department for asthma-related care.²⁴ In 2016, MAP reviewed two asthma measures, NQF #1799 *Medication Management for People with Asthma* and NQF #1800 *Asthma Medication Ratio*. Given that NQF #1799 has lost endorsement, in 2017, MAP re-reviewed and voted on including NQF #1800 *Asthma Medication Ratio* in the Child Core Set.

Across Child Core Set populations, perinatal and postpartum care are integral to the mother and child's health, thereby affecting both the

adult and child Medicaid populations. MAP discussed the downstream negative effects of births resulting from unintended and/or closely spaced pregnancies such as inadequate or delayed prenatal care, premature birth, low birthweight, maternal depression, along with poor developmental and educational outcomes for children, among others.^{25,26} Access to contraceptive care for the duration of a woman's reproductive life prevents unintended and/or closely spaced pregnancies and their negative effects. MAP also discussed the benefits of breastfeeding for the mother and child, which are well documented in the literature.^{27,28} Given the criticality of the perinatal and postpartum period for both the mother and child, MAP discussed multiple measures relating to reproductive and contraceptive care including breastfeeding.

Access to care and care coordination are integral in ensuring adequate and appropriate care for all children, especially the 18 percent of children whose health needs are not adequately met.²⁹ In fact, 40 percent of children with public insurance do not receive needed mental health services, and 16 percent do not receive adequate or any care coordination.³⁰ MAP noted that access to care is the first step in improving care quality. Therefore, MAP emphasized the concept of access to care when deliberating over its recommendations for including or removing measures from the Child Core Set.

Background and Use of the Child Core Set

The Children's Health and Insurance Program Reauthorization Act of 2009 (CHIPRA) provided states with new funding, incentives, and options for covering children under Medicaid and CHIP.³¹ CHIPRA also required HHS to develop standards to measure the quality of children's care. CMS and the Agency for Healthcare Research and Quality (AHRQ) collaborated with experts to fulfill this requirement and identified an initial Core Set of measures for children enrolled in Medicaid and CHIP.³² The initial Child Core Set was released in 2010.

Section 1139A of the Social Security Act, as amended by Section 401(a) of CHIPRA, required CMS to update the initial Core Set annually beginning in January 2013. For the 2017 update, CMS issued changes informed by MAP's 2016 review and input. Following MAP's recommendation, CMS added two measures: NQF #2801 *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* and NQF #2902 *Contraceptive Care - Postpartum Women*. These additions expand the measurement of quality of care for two populations—children prescribed psychotropic drugs and women who have just delivered. CMS also retired NQF #1959 *HPV Vaccination for Female Adolescents*. The measure steward (National Committee for Quality Assurance) retired this measure, and the HPV vaccination set for both males and females, based on the new Advisory Committee on Immunization Practices (ACIP) recommendations, will be included in NQF #1407 *Immunizations for Adolescents*.³³ The 2017 version of the Child Core Set contains a total of 27 measures. The characteristics of the 2017 Child Core Set can be found in [Appendix E](#). Measures in the Child Core Set are relevant to children ages 0 to 18 as well as pregnant women. Notably, Core Set reporting is voluntary, and states submit data on a selection of these measures annually.

CMS goals for the Child Core Set are to increase the number of: (1) states reporting the Child Core Set measures; (2) measures reported by each state; and (3) states using the Child Core Set measures to drive quality improvement. CMS uses the annual data submissions to capture a snapshot of healthcare quality across Medicaid and CHIP. These are presented in publications such as chart packs and *Performance on the Child Core Set Measures*.³⁴

CMS has undertaken many initiatives to improve the benefit structure, strengthen the quality of care, and improve access. A couple of the child quality improvement initiatives of note are as follows:

- **Oral Health Initiative**³⁵: CMS launched this initiative in 2010 to continue improving access

to dental and oral health services for children enrolled in Medicaid and CHIP. Tooth decay is one of the most common yet preventable childhood diseases causing pain as well as leading to infections and, in rare cases, even death. CMS has been working with states to improve access to dental care with the aim of increasing the proportion of Medicaid-enrolled children who receive any preventive dental service (PDENT) by 10 percentage points nationally. Each state has its own baseline and goals for improving access to preventive dental care. CMS is also tracking the proportion of Medicaid-enrolled children ages six to nine at risk for dental caries who receive a sealant on a permanent molar (SEAL). As of FFY 2015, 51 states reported data on PDENT, and 26 states reported data on SEAL in its first year of inclusion in the Child Core Set. Nationally, 46 percent of children received a PDENT in FFY 2015 (a 4 percent increase from baseline) with the goal of reaching 52 percent by FFY 2018.

- **Maternal and Infant Health Initiative**³⁶: CMS launched this initiative in 2014 with the goal of assisting states in exploring program and policy opportunities that improve outcomes and reduce the cost of care for women and infants in Medicaid and CHIP. Postpartum visits provide an opportunity to assess and address any chronic health conditions, mental health status, and family planning goals. The use of contraception can improve pregnancy planning by reducing delayed prenatal care and the risks of preterm birth and low birth weight. In FFY 2015, 34 states reported on the postpartum measure with 58 percent of women having a postpartum visit. This measure is important because it provides an overall picture of postpartum women who have access to contraceptive care. However, no other data is available regarding contraceptive care. In September 2015, CMS awarded 13 states with a grant to collect and report on access to effective methods of contraception.

STATE EXPERIENCE COLLECTING AND REPORTING THE CHILD CORE SET

Presentations from invited states' Medicaid program representatives precede all MAP Medicaid Core Set measure-related discussions and deliberations regarding the addition and removal of measures. These representatives provide an overview of their state Medicaid program as well as an overview of their experience with collecting and reporting on either the Adult or Child Core Set. This process solicits information from the field prior to recommending any changes for either Core Set. The goal is to use experiential data in an effort to provide well-informed and appropriate recommendations.

For the Child Core Set, state Medicaid representatives from New York and Ohio provided the Task Force with an overview of their state Medicaid demographics along with information related to Child Core Set use. This included issues related to reporting and potential strategies for improving Child Core Set measure reporting rates.

Ohio

Mary Applegate, MD, FAAP, FACP, Medical Director, Ohio Department of Medicaid, presented to the combined Adult and Child Task Forces. She focused on the Adult and Child Core Sets from a systems perspective with particular attention to maternity care. Ohio is the seventh largest Medicaid state covering over 3 million individuals. Eighty-nine percent of their enrollees are in managed care, and efforts are underway to enroll the entire Medicaid population in managed care. Ohio Medicaid aims to provide systems of care through patient choice and patient engagement in an evidence-based care management environment. As a Medicaid expansion state, the Ohio program covers over 700,000 individuals through private managed care plans. Overall coverage is split fairly equally between individuals

19-64 years of age (52 percent of total Medicaid) and individuals 19 years of age and younger (43 percent of total Medicaid).

Ohio reports on three-fourths of the measures in both the Adult and Child Core Sets. Funding from the Adult Medicaid Quality (AMQ) grant enabled voluntary reporting on the Adult Core Set measures by providing funds for coding the measures for electronic data collection and submission.³⁷ "Measures that make patients better" mainly drive the decision to report. Given the state's focus on improving the quality of maternity care, the state reports on the following Child and Adult Core Set measures focused on maternity care: *Live Births Weighing Less than 2,500 Grams*, *Well-Child Visits in the First 15 Months of Life*, *Frequency of Ongoing Prenatal Care (>= 81 percent of expected visits)*, *Timeliness of Prenatal Care*, and *Postpartum Care Rate*.

Dr. Applegate noted that additional factors in the decision to report measures include challenges such as the fragmented care system, administrative reporting burden, and provider workload issues. Measurement decisions are based on the impact of measures at the practice level as well as connection to improved patient outcomes. However, the decision not to measure or report can also result from an effort to avoid duplication, especially when other mechanisms of improvement are underway, such as quality efforts based on episodes of care and public health driven mechanisms. The primary focus of Ohio Medicaid is to implement and report measure sets that facilitate and tie into population health management, while assisting with cost containment through better care and budget management. Therefore, all reported measures must be evidence-based and meaningful at the practice level.

For improving Medicaid Core Set measure reporting rates, Dr. Applegate encouraged alignment of measures across programs, as well as increasing the use of administrative data based measures with the goal of making data collection simple. Moreover, there is a desire for data collected to focus on episodes of care. Such data capture all of the processes of care for a given condition, and are relevant for all stakeholders including providers, managed care plans, and health systems. Dr. Applegate encouraged the promotion and adoption of episodes of care measurement, where measures and even composites are built around a series of related services such as prenatal and postpartum care. This approach allows for longitudinal management of patient health at the population-level. Ohio Medicaid aims for every Medicaid patient to be assigned to a primary care clinician who will be responsible for tracking and managing his or her care. This type of data collection is therefore essential to their approach for quality improvement, as poor performance is often related to lack of follow-up.

Dr. Applegate provided an example of a current public health initiative focused on the infant mortality crisis in Ohio. Ohio is moving towards attributing patients to providers in an effort to address issues with patient follow-up care usage. Certain populations in Ohio do not receive the necessary postpartum follow-up care, which is a known predictor of infant mortality. Social risk factors such as lack of transportation contribute to missed appointments among others. As a mitigation strategy, various postpartum visit settings are being considered for care delivery using a population perspective. Moreover, for the purposes of improving population health, postpartum care for this initiative addresses interpregnancy intervals as well as disparities in infant mortality. Quality improvement for this issue requires an understanding of community-level disparities, consistent patient education, and community-level services focused on patient engagement. Therefore, a lack of connection between measurement and community-level

social risk factors results in measures that do not appropriately capture all factors affecting patient outcomes.

Based on programmatic experience, Dr. Applegate emphasized the need for community and patient engagement through outreach and education. Dr. Applegate also highlighted the need for a systems view of care quality that encompasses all parties involved, including the patients and their community, the provider, the health plan, as well as the state. Any quality-focused initiative requires collaboration, communication, and trust among all relevant parties.

New York

The New York Medicaid representative, Lindsay Cogan, PhD, MS, Director, Division of Quality Measurement, Office of Quality and Patient Safety, New York State Department of Health, presented the state's experience with the Child Core Set. New York State is a Medicaid expansion state with 43 percent of children receiving Medicaid and with the majority (85 percent) under a managed care organization. Most children in New York are healthy; however, 5 to 6 percent of children on Medicaid also receive supplemental security income. These children account for a substantial share of the cost of caring for all children on Medicaid. In 2016, New York reported on 23 of the 26 Child Core Set measures. This high reporting rate was due to the state's quality reporting infrastructure, which leveraged existing outpatient reporting of Healthcare Effectiveness Data and Information Set (HEDIS) measures through New York's Medicaid managed care plans. Dr. Cogan noted that lack of reporting resulted from challenges in obtaining non-HEDIS, provider-based and/or electronic data measures. Consequently, decisions to report measures are based on the balance between the cost of reporting versus the potential benefit of collecting measure-related data.

The data collected drive quality improvement through performance improvement projects, targeted studies of populations through

stratification, and/or research studies. By performing improvement projects and targeted studies, New York is better able to understand the state of quality of care for specific populations, as well as determine where gaps in care continue to exist.

Dr. Cogan commented that maternity care is a focus of New York Medicaid. As part of the Prenatal Care Project, the Medicaid program conducted a multisite study of high-volume prenatal care practices. This project enabled New York to gather information needed to report data on Child Core Set measures. However, while this project resulted in an abundance of information, the project also provided lessons in achieving and

maintaining sustainability due to its labor-intensive nature.

Given the time and resources necessary for measuring quality, Dr. Cogan emphasized “measuring what counts” and selecting measures that are most representative and fit into larger categories such as preventive services, access to care, as well as tracking follow-up of care. She recommended that the Core Set move towards assessing the entire spectrum of care—the system as a whole—and gather actionable information based on episodes of care versus single instances of care quality.

MAP REVIEW OF THE CHILD CORE SET

MAP reviewed the measures in the Child Core Set to provide recommendations to strengthen the measure set in support of CMS goals for the program. MAP's review was guided by its Measure Selection Criteria (MSC) ([Appendix C](#)), a defined decision algorithm ([Appendix D](#)), and state data on the measures reported in FFY 2015. Task Force members submitted measure recommendations to identify the best measures to fill gaps in the Child Core Set, using the measure gap areas identified in the 2016 review as a baseline. NQF staff compiled measures in the following 13 gap areas: behavioral and mental health; substance use; injuries and trauma; care coordination; acute and chronic conditions; maternal and perinatal health; asthma; sickle-cell disease; overuse; patient-reported outcomes; dental care; duration of enrollment and coverage; and cost. Using the decision algorithm, Task Force members reviewed measures in these gap areas.

All MAP Task Force members had the opportunity to propose other available measures for discussion and consideration. MAP examined both NQF-endorsed measures along with other measures in development and/or undergoing the endorsement process. MAP discussed measures recommended by individual Task Force members largely based on the measure specifications, the MSC, and the feasibility of implementing them for statewide quality improvement. Following the discussion of each measure, Medicaid Task Force members voted for measure removal or addition to the Child Core Set.

MAP generally favors measures that can be easily implemented at the state level, encompass a broad population focus, and promote parsimony and alignment. NQF-endorsed measures are also preferred because they have been successfully evaluated through a separate consensus-based process for importance and scientific acceptability,

amongst other rigorous criteria. However, since NQF-endorsed measures do not exist for all relevant topic areas, Task Force members emphasized the imperative to monitor the development of new measures for future annual reviews.

Additionally, CMS has emphasized the importance of including measures in the Core Sets that provide states with multiple options/formats for data collection and reporting (i.e., electronically specified measures, administrative measures, and hybrid measures). Therefore, CMS will include electronic measure specifications and formats, (i.e., e-specification also known as an eMeasure) for measures in the Core Set. CMS will add the e-specification, when available, not as a change but as an enhancement to the Core Set. The e-specifications will be added in the annual update to the Core Sets.

Measure-Specific Recommendations

MAP discussed in detail all measures considered for removal or addition to the Child Core Set. MAP recommended removal of five measures and addition of another five measures. The Task Force examined all measures based on each measure's opportunity to provide contextual information and to move beyond "measuring for measuring's sake." Below are MAP's measure-specific recommendations, with details on the individual measures recommended for addition provided in [Appendix F](#).

Measures for Removal from the Child Core Set

MAP supported all but five of the measures in the 2017 Child Core Set for continued use in the program. In general, MAP considers removing a measure when the following factors are observed:

- Consistently high levels of performance (e.g., >95 percent), indicating little opportunity for additional gains in quality
- Multiple years of very few states reporting a measure, indicating that it is not feasible or a priority topic for improvement
- Change in clinical evidence and/or guidelines have made the measure obsolete
- Measure does not yield actionable information for the state Medicaid program or its network of providers
- Superior measure on the same topic has become available and a substitution would be warranted

MAP emphasized that recommending a measure for removal does not diminish the importance of the measure. Moreover, despite a recommendation for removal, critical issues surrounding the measure should still be prioritized and addressed. MAP also stressed the need for better measures that focus on the quality of care, not just the frequency of care. The ability to maintain stability in the measure set is important. Gradual changes allow states time to transition to new measures in the Core Set, while continuing to gain experience in reporting on current measures.

Public comments generally agreed with MAP's recommendations to remove the following measures from the Child Core Set.

[NQF #1391 Frequency of Ongoing Prenatal Care](#)

MAP also recommended this measure for removal during the 2016 review. Moving forward, MAP recommends focusing on measures that not only address frequency, but also focus on addressing quality. This measure assesses the percentage of Medicaid deliveries that had the following number of expected prenatal visits: less than 21 percent of expected visits; 21 percent to 40 percent of expected visits; 41 percent to 60 percent of expected visits; 61 percent to 80 percent of

expected visits; and greater than or equal to 81 percent of expected visits. MAP noted that this measure does not address quality of care, because the measure does not assess the content of the prenatal care visit. The group noted that frequent visits do not necessarily translate to better outcomes, whereas the content of the visits are key indicators of outcomes. This measure does not capture the content of the visit. The 2015-2016 Perinatal Standing Committee did not recommend this measure for continued endorsement because the Committee determined that it lacked empirical evidence about the association between outcomes and the frequency of prenatal visits. The developer, the National Committee for Quality Assurance, subsequently withdrew the measure from consideration, and NQF endorsement was removed.

[NQF #1517 Prenatal and Postpartum Care-Timeliness of Prenatal Care](#)

This measure is currently in both the Child and Adult Core Sets. This measure, as it applies to the Child Core Set, assesses the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. MAP discussed measuring the gestational age at the first visit as the key component of timeliness of care versus time of enrollment. Gestational age at first visit can provide information such as access to care as well as the ability to identify and treat high-risk pregnancies. MAP noted that this measure still holds value as it provides information on the effectiveness of a program at providing access to prenatal care. Therefore, MAP recommended this measure for removal only if a suitable alternative measure addressing gestational age is available for immediate replacement. The Consensus Standards Approval Committee (CSAC) in 2016 did not recommend this measure for continued endorsement due to a lack of empirical evidence and validity issues. Therefore, endorsement was removed for NQF #1517.

NQF #1799 Medication Management for People with Asthma

This measure addresses the percentage of patients who remained on their asthma treatment for at least 50 percent or 75 percent of their treatment period. Discussion of the measure focused on CSAC's 2016 decision to remove endorsement due to lack of evidence, inaccuracies with the data analysis from new literature, and a long list of allowable medications. Additionally, the measure does not address whether patients are getting the correct medications for their particular type of asthma. MAP considered CSAC's decision as well as potential alternate measures, specifically NQF #1800 *Asthma Medication Ratio*. MAP favored measure NQF #1800 because this measure is supported by evidence and provides information on the quality and appropriateness of asthma care.

NQF #1365 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

This measure assesses suicide risk in children and adolescents with a diagnosis of major depressive disorder. Throughout the MAP meeting, there were multiple discussions on the need for broader measures in behavioral health. NQF #1365 encompasses a smaller subset of the population with depression. MAP noted the small impact of this measure due to the narrowly defined population. Instead, MAP favored NQF #3148 *Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan* as an appropriate alternative measure because of the broader measure focus on persons 12 years and older who are screened for clinical depression. The MAP Coordinating Committee discussed NQF #1365 and agreed with the recommendation to remove this specific measure. However, the Coordinating Committee wanted to emphasize the ongoing importance of suicide prevention for children and adolescents and quality efforts aimed at suicide awareness and prevention.

Behavioral Health Risk Assessment (for Pregnant Women)

MAP regards behavioral risk assessment as an important issue that needs to be prioritized and addressed. However, this specific measure has implementation and data collection challenges and was recommended for removal. MAP discussed payment issues with behavioral health services. If services are not paid for, clinicians are less likely to provide the service and, in turn, there will be less administrative or claims data to provide feedback. Based on the FFY 2015 data on state reporting of the Child Core Set, only four states reported this measure. In addition, the group noted that the measure includes too many components (i.e., depression, alcohol, illicit and prescription drugs, and intimate partner violence screenings). MAP suggested that a streamlined measure coupled with an action plan may be better. The group emphasized the need to address behavioral health for pregnant women but considered this measure inadequate.

Measures for Phased Addition to the Child Core Set

MAP recommends that CMS consider up to five measures for phased addition to the Child Core Set (Exhibit 1, below, and [Appendix F](#)). These measures passed the consensus threshold (>60 percent of voting members) to gain either MAP's full or conditional support. MAP conditionally supported measures for several reasons, including pending endorsement from NQF, pending CMS confirmation of feasibility, etc. MAP recommends that CMS add measures pending NQF endorsement to the programs once they are fully vetted through the NQF endorsement process and the detailed technical specifications are made publicly available.

The use of the recommended measures would strengthen the measure set by promoting measurement of a variety of high-priority quality

issues, including access to care, behavioral health, and asthma. MAP is aware that additional federal and state resources are required for each new measure addition and adoption, thus immediate addition of all measures supported by MAP is highly unlikely. Therefore, MAP rank ordered the measures it supports. Public comments generally agreed with MAP’s recommendations to add the following measures to the Child Core Set. MAP’s measure-specific recommendations are described below.

EXHIBIT 1. MEASURES RECOMMENDED FOR PHASED ADDITION TO THE CHILD CORE SET

Rank	NQF Number and Measure Title
1	NQF #2903 Contraceptive Care: Most & Moderately Effective Methods
	NQF #1800 Asthma Medication Ratio
2	NQF #3154 Informed Participation
3	NQF #3148 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan*
4	NQF #2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics

* Formerly NQF #0418. The measure number is updated to reflect measures with multiple formats.

NQF #2903 Contraceptive Care: Most and Moderately Effective Methods

MAP previously recommended this measure during the 2015 review; however, at that time, the measure was not NQF endorsed. This year, MAP’s prioritization placed the measure at the top of the list, tying with NQF #1800 *Asthma Medication Ratio*. MAP conducted a lengthy discussion regarding this measure. The group noted that contraceptive care is a critical population health issue with an important role in health equity—mainly access to contraceptive care, interpregnancy interval planning, and overall health outcomes. This measure addresses pre-pregnancy and interpregnancy periods, and would complement NQF #2902 *Contraceptive Care – Postpartum*, already included in the Child and Adult Core Sets. Evidence highlights the direct correlation between access to reproductive

health services and maternal outcomes with lack of access disproportionately affecting low-income women. In addition, MAP noted that as an administrative data based measure, implementation would be highly feasible. This measure is already in use in many states, including as a part of the Maternal and Infant Health Initiative mentioned earlier in the report. The group also discussed concerns of coercion as an unintended consequence of implementing the measure. Both CMS and Task Force members emphasized that the intent of the measure is not to reach 100 percent compliance. Consequently, this measure should be focused on quality improvement and should not be tied to any payment incentives. MAP supports this measure for inclusion in both the Child and Adult Core Sets. There was overwhelming support from public comments to include NQF #2903 in the Child Core Set. Commenters remarked on this measure’s value in ensuring that all women have access to the full range of contraceptive methods.

NQF #1800 Asthma Medication Ratio

This measure assesses the percentage of patients five to 64 years of age identified as having persistent asthma and a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Therefore, the measure helps identify patients with inadequate asthma management. MAP discussed this measure alongside measure NQF #1799 *Medication Management for People with Asthma*. Comparing the measures, MAP recommended replacing NQF #1799 *Medication Management for People with Asthma* in the Child Core Set with NQF #1800. MAP noted an advantage of NQF #1800: It does more than collect information on the number of patients with asthma medications; it ascertains the appropriateness of medication management based on the type of asthma, specifically persistent asthma. This measure was also supported for inclusion in the Adult Core Set. Inclusion of the measure in both Core Sets will support measure alignment and promote seamless transition of care across ages and Core Sets.

NQF #3154 Informed Participation

NQF #3154 *Informed Participation*, funded by the AHRQ-CMS Pediatric Quality Measures Program (PQMP) cooperative agreement grant, assesses access to care—an important public policy issue and a critical concern for the Medicaid population. MAP discussed the uniqueness of this measure in relation to other metrics regarding coverage of services. NQF #3154 assesses the continuity of enrollment of children in Medicaid and CHIP, while other measures assess receipt of services post-enrollment only. MAP discussed the increasing relevance of this measure as opportunities to cover children decrease with changes in policy and regulations. NQF endorsed the measure in July 2017, after MAP supported the measure conditionally for addition to the Child Core Set pending ratification of endorsement. Based on the new endorsement status, the Child Task Force fully supports the measure.

NQF #3148 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

MAP discussed NQF #3148 (previously NQF #0418) as a replacement for measure NQF #1365 *Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment*. The group recommended this measure because it covers a broader population than NQF #1365 and includes patients 12 years and older who are screened for clinical depression. This measure requires screening along with a referral for follow-up services, thereby aligning with the U.S. Preventive Services Task Force guidelines. MAP also recommended this measure to promote alignment with the Adult Core Set.

NQF #2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics

This measure assesses the percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Behavioral health conditions among children are a concern due to the high diagnosis rates.³⁸ As providers increasingly

prescribe these medications, it is important to monitor the long-term metabolic effects of these antipsychotic medications. MAP also noted the feasibility of reporting this measure since it is prescription-based and can be easily extracted. If added to the Core Set, this measure would complement the two other antipsychotic medication-related measures already included in the Child Core Set.

The measures that MAP reviewed but did not support at this time are listed in [Appendix G](#). Overarching issues regarding these measures focused on parsimony and the need for actionable measures within the Child Core Set. The Task Force reviewed measures with an emphasis on metrics that have high implementation and data extraction feasibility, high impact, and the ability to influence quality improvement efforts. MAP reiterated the need for measures that move towards understanding long-term outcomes and provide actionable information. Many of the measures discussed but not supported were deemed inadequate with respect to at least one of these considerations.

Remaining High Priority Gaps

Many priorities for quality measurement and improvement lack fully developed metrics. MAP discussed and documented these gaps in current measures to communicate future measurement needs to the developer community. The list of measure gaps is a starting point for future discussions as well as a guide to annual revisions to the Child Core Set. MAP first identified gap areas during its 2014 review. During MAP's 2017 review, the Medicaid Child Task Force began its discussion of gaps by considering NQF's prioritization criteria for the future of measurement (Exhibit 2, below, and [Appendix H](#)). The prioritization of gap areas does not diminish the importance of the various gap areas. Rather, ranking priorities provides CMS with a starting point when deciding on measures to add or remove from the Core Set based on areas highlighted by MAP.

EXHIBIT 2. PRIORITIZATION CRITERIA

Criterion	Description
Outcome-focused	Preference for outcome measures and measures with strong links to improved outcomes and costs
Improvable and actionable	Preference for actionable measures with demonstrated need for improvement and evidence-based strategies for doing so
Meaningful to patients and caregivers	Preference for person-centered measures with meaningful and understandable results for patients and caregivers
Support systemic and integrated view of care	Preference for measures that reflect care that spans settings, providers, and time to ensure that care is improving within and across systems of care

Among the 13 gap areas identified in 2016, MAP considered the following as the five key gap areas.

Child Core Set Measure Gaps

1. Substance Abuse
2. Care Coordination
 - MAP regarded the care coordination aspects of care integration, social services coordination, cross-sector measures, and care coordination for conditions requiring community linkages as the most important.
3. Mental Health
4. Overuse and Medically Unnecessary Care
 - MAP noted that with overuse, underuse is equally important to highlight.
5. Cost Measures

Public commenters supported MAP's assessment of high-priority measure gaps for the Child Medicaid population and the prioritization of measure gap areas.

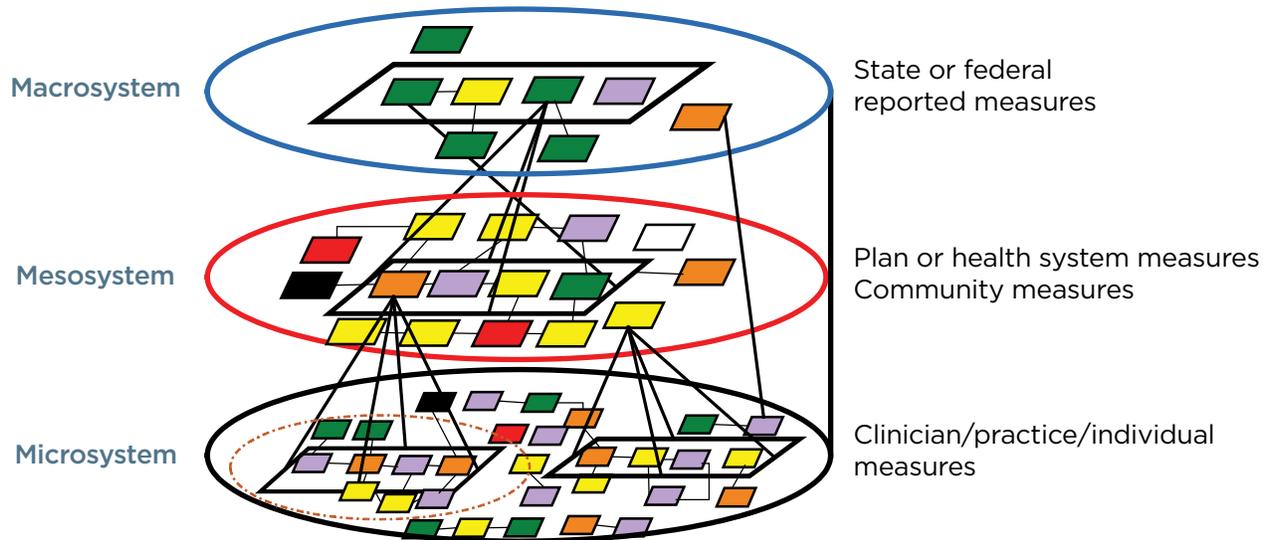
STRATEGIC CONSIDERATIONS FOR STATE-LEVEL QUALITY IMPROVEMENT

The MAP Adult and Child Medicaid Task Forces conducted joint deliberations regarding issues that affect measure-reporting rates along with strategies for increasing overall Core Set reporting rates. These discussions focused on the evolution in quality measurement and included the following topical areas: optimizing data connections; improving integration across programs and data systems; aligning measurement and data requirements; and incorporating methodological paradigm shifts through stratification of data and acknowledging the impact of social complexities on care delivery and outcomes.

Comments from health plans, specialty providers, consumer advocates, and other stakeholders were supportive of these strategic issues. They highlighted and further elaborated on topics such as data challenges related to measurement alignment and integration as well as development of a vital set of measures along with measures for social vulnerability. Public commenters also addressed the need for aligning measures across the healthcare spectrum using a multilevel perspective. The MAP Coordinating Committee also discussed and enthusiastically supported the issue of alignment, specifically with regards to fragmentation of care due to a lack of alignment of measures among and within the varying systems of care. Lastly, commenters acknowledged and emphasized the need for measures that address quality of care and outcomes versus measures that focus on counts and processes.

Alignment

Task Force members and state Medicaid panelists emphasized the continued importance of addressing alignment from a multilevel perspective comprising macro-, meso-, and micro-systems of care (Exhibit 3). The ultimate goal is to connect clinician/practice level measures (microsystem) with plan/health system and community level measures (mesosystem), which then roll up to state or federal level measures (macrosystem). This paradigm shift replaces fragmented data collection and measurement with an integrated system, where a holistic view of quality is promoted and achieved in part through a sense of shared responsibility for each patient and population group. This matrixed paradigm of measurement allows for population health management through coordination of measurement across the healthcare spectrum. Successful integration across systems depends on data integration and coordination of efforts with a population health focus. With this shift in perspective, the goal of measurement is not only to support improvement in individual-level care and health outcomes, but also improvement in the health of the population. Task Force members encouraged continued efforts at aligning measure sets and quality efforts across healthcare.

EXHIBIT 3. SYSTEMS VIEW OF MEASUREMENT^a

a Applegate, M. Ohio Department of Medicaid. MAP Medicaid Joint Adult and Child In-Person Meeting. May 24, 2017. Washington, DC.

Data: Integration and Connection

Both the MAP Adult and Child Task Forces agreed that data challenges represent the most consistent and pervasive barrier to measure reporting. Specifically, this discussion focused on the lack of data system integration. In this environment, care delivery has to be coordinated and optimized using disconnected and fragmented medical, laboratory, and claims data systems. For example, laboratory data systems are not connected to claims databases; therefore, access to laboratory results requires extra release form authorizations from patients, which increases paperwork burden and creates barriers to seamless transmission of care information. Task Force members noted that this issue is also a system-level hindrance with respect to data sharing among public health registries, accreditation bodies, and state/federal agencies.

Both the Ohio and New York state representatives and Task Force members expressed frustration with data lag times and a lack of use of a

universal coding language. For example, public health data often has a lag time of at least two years, and does not use Logical Observations Identifiers, Names, Codes (LOINC[®])—a common language (set of identifiers, names, and codes) for identifying health measurements, observations, and documents. However, CMS data systems are based on LOINC codes. Additionally, a lack of medical and behavioral health integration causes care fragmentation and duplication of services, which is further perpetuated through state-specific behavioral health carve-outs.

MAP Task Force members recommended focusing efforts on working around systems integration issues at the federal level. For example, they recommended that CMS and The Joint Commission should share data related to antenatal steroid use. This will not only reduce data collection and reporting burden for the state Medicaid agencies but also increase Medicaid programmatic efficiency at the federal level by re-purposing data already collected.

Data: Stratification

The discussion about leveraging existing data and increasing efficiency also addressed methodological tools such as data stratification. In general, stratification allows for the parsing and dissection of data based on certain parameters and helps identify care quality trends and patterns. For example, stratifying public health measures based on geographical location can highlight disparities; this knowledge then can be used to address population-level health issues and outcomes.

Task Force members noted that stratification can also help overcome the divide between behavioral health and general medical health, by allowing for the parsing of a medical care measure based on the presence or absence of behavioral health comorbidity (e.g., segmenting individuals with severe mental illness and other especially vulnerable populations). Furthermore, the group recommended that states use stratification to address state-specific quality improvement needs in a transparent manner. Stratification methodologies used should be readily accessible. This sharing of stratification methodologies can also serve as a repository of methodological information as well as provide a learning network where states assist each other with best practices based on previously successful implementation.

Social Risk Factors and Impact on Health

As risk adjustment for social risk factors evolves, stakeholders are becoming aware of the inextricable roles of social risk and medical complexity with regards to care and health quality outcomes at both the individual and population level. Unfortunately, this inextricability is intensified within the Medicaid population, due to persistent social risk factor related vulnerabilities. Dr. Applegate from Ohio Medicaid emphasized this by highlighting infant mortality within the state, while underscoring the need for community education and patient empowerment, since higher education levels lead to fewer early pregnancies and reduce both preterm births and infant mortality as well.

The Task Forces also discussed the concept of health equity. Equity encompasses the communities' relationships with healthcare delivery systems, trust between providers, patients, and community, along with open communication among all stakeholders. The group emphasized that any community-level care quality considerations should acknowledge health equity as well. Given the complexity of social risk factors and health equity, the MAP Task Force members recognized the need to assess and address the impact of these factors on health outcomes and therefore emphasized the need for developing social vulnerability measures.

CONCLUSION

Nearly 40 percent of U.S. children are enrolled in Medicaid and CHIP.^{39,40} In an effort to support states in addressing the needs of this significant and growing population, MAP provided measure recommendations for the 2018 Child Core Set. These recommendations aim to increase the number of states voluntarily reporting on measures included in the Child Core Set, increase the number of measures reported by each state, and increase the number of states using Child Core Set measures to drive quality improvement. MAP's recommendations were informed by state Medicaid representatives' experiences implementing, reporting, and leveraging the Child Core Set measures.

MAP recommended the removal of five measures from the 2017 Child Core Set: *Behavioral Health Risk Assessment (for Pregnant Women)* [not NQF-endorsed], NQF #1799 *Medication Management for People with Asthma*, NQF #1517 *Prenatal and Postpartum Care - Timeliness of Prenatal Care*, NQF #1391 *Frequency of Ongoing Prenatal Care*, and NQF #1365 *Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment*. MAP also recommended the phased addition of five measures which address key gap areas: NQF #2903 *Contraceptive Care: Most and Moderately Effective Methods*, NQF #1800 *Asthma Medication Ratio*, NQF #3154 *Informed Participation*, NQF #3148 *Preventive Care and Screening: Screening for Clinical Depression*

and Follow-Up Plan, and NQF #2800 *Metabolic Monitoring for Children and Adolescents on Antipsychotics*. MAP's recommendations for measure removal and addition reflect Task Force members' prioritization of parsimony and Child Core Set stability during their deliberations. MAP supported the continued use of all remaining measures included in the Child Core Set.

As the Child Core Set evolves, success in improving quality depends on voluntary reporting which encompasses issues of data availability, collection, and reporting burden.

Success also depends on methodological issues such as risk adjustment for social risk factors and measure stratification. Ultimately, education, communication, and collaboration across care systems will be necessary to advance the evolution of Medicaid care quality.

Current changes in billing and reimbursement structures will provide opportunities to leverage emerging strategies such as risk adjustment for social risk factors while transitioning care to a population-based system. Quality measurement has been undergoing these changes gradually and is moving to a "measuring what matters" system. The focus is changing from counting processes to targeting outcomes, and timely and actionable measurement is replacing the traditional focus on counting and checking boxes.

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APPENDIX A:

MAP Background

Purpose

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

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

MAP is designed to facilitate progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable. Accordingly, MAP informs the selection of performance measures to achieve the goal of **improvement, transparency, and value for all**.

MAP’s objectives are to:

1. **Improve outcomes in high-leverage areas for patients and their families.** MAP encourages the use of the best available measures that are

high-impact, relevant, and actionable. MAP has adopted a person-centered approach to measure selection, promoting broader use of patient-reported outcomes, experience, and shared decision making.

2. **Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy based on value.** MAP promotes the use of measures that are aligned across programs and between public and private sectors to provide a comprehensive picture of quality for all parts of the healthcare system.
3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden.** MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decision making, aligning payment with value, rewarding providers and professionals for using health information technology to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing

^a Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014.2010: p.260. Available at <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>. Last accessed August 2015.

these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare. Foundational to the success of all of these efforts is a robust quality enterprise that includes:

Setting priorities and goals. The work of the Measure Applications Partnership is predicated on the National Quality Strategy and its three aims of better care, affordable care, and healthy people/healthy communities. The NQS aims and six priorities provide a guiding framework for the work of MAP, in addition to helping to align it with other quality efforts.

Developing and testing measures. Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies).

Endorsing measures. NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.

Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and

private-sector uses of performance measures.

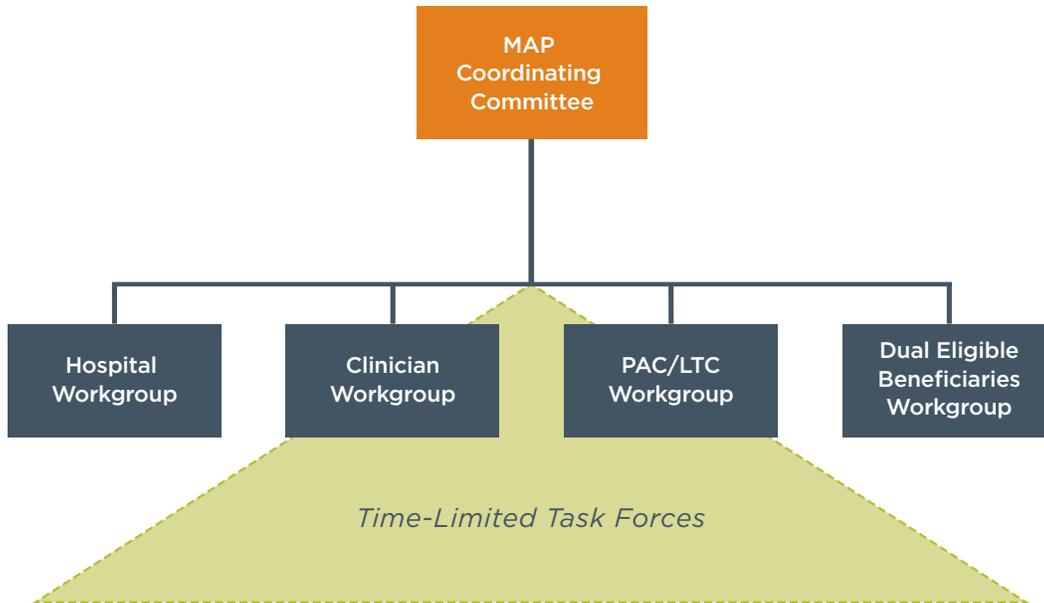
Impact and evaluation. Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate whether measures are having their intended impact and are driving improvement, transparency, and value. Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements. MAP seeks to engage in bidirectional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

Structure

MAP operates through a two-tiered structure (see Exhibit A1). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and provides final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with specific topics provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

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

EXHIBIT A1. MAP STRUCTURE



Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see MAP Pre-Rulemaking Deliberations). Additionally, MAP engages in strategic activities throughout the year to inform MAP’s pre-rulemaking input. To date MAP has issued a series of reports that:

- Developed the **MAP Strategic Plan** to establish MAP’s goal and objectives. This process identified strategies and tactics that will enhance MAP’s input.

- Identified **Families of Measures**—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities—to facilitate coordination of measurement efforts.

Provided input on **program considerations and specific measures** for federal programs that are not included in MAP’s annual pre-rulemaking review, including the Medicaid Adult and Child Core Sets and the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces.

APPENDIX B:

Rosters for the MAP Medicaid Child Task Force and MAP Coordinating Committee

Measure Applications Partnership Medicaid Child Task Force

CHAIRS (VOTING)

Richard Antonelli, MD

ORGANIZATIONAL MEMBERS (VOTING)

American Academy of Pediatrics

Terry Adirim, MD, MPH

American Nurses Association

Gregory Craig, MS, MPA

America's Essential Hospitals

Kathryn Beattie, MD

American Academy of Family Physicians

Roanne Osborne-Gaskin, MD, MBA, FAAFP

Association for Community Affiliated Plans

Deborah Kilstein, RN, MBA, JD

Aetna

Amy Richardson, MD, MBA

Centene Corporation

Amy Poole-Yaeger, MD

Children's Hospital Association

Andrea Benin, MD

National Association of Medicaid Directors

Rachel La Croix, PhD

National Partnership for Women and Families

Carol Sakala, PhD, MSPH

Patient-Centered Primary Care Collaborative

Ann Greiner, MUP

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)

Kim Elliot, PhD, CPHQ

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)

Agency for Healthcare Research and Quality

Kamila Mistry, PhD, MPH

Centers for Medicare & Medicaid Services

Marsha Smith, MD, MPH, FAAP

Health Resources and Services Administration

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Measure Applications Partnership Coordinating Committee

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APPENDIX C: MAP Measure Selection Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

APPENDIX D: MAP Medicaid Preliminary Analysis Algorithm

For the 2016-2017 cycle, to support the Task Force's review of potential measures, NQF staff provided a preliminary analysis of all measures under consideration using the MAP Medicaid Preliminary Analysis Algorithm derived from the Measure Selection Criteria.

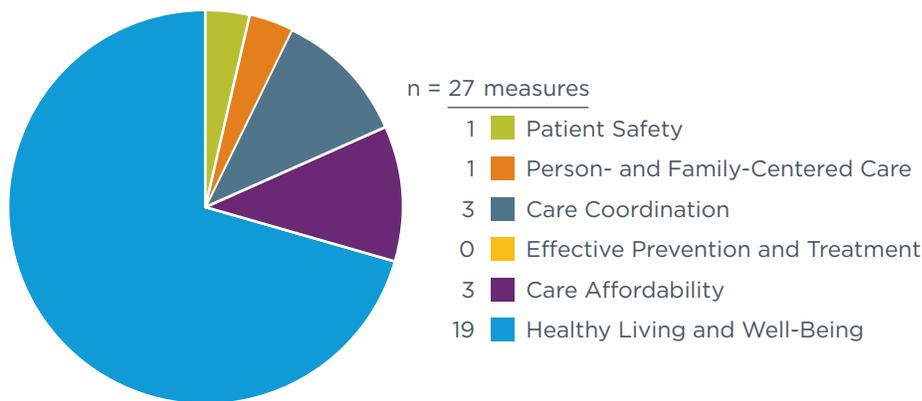
Assessment	Definition	Outcome
1. The measure addresses a critical quality objective not adequately addressed by the measures in the program set.	<ul style="list-style-type: none"> • The measure addresses the broad aims and one or more of the six National Quality Strategy priorities; or • The measure is responsive to specific program goals and statutory or regulatory requirements; or • The measure can distinguish differences in quality, is meaningful to patients and providers, and/or addresses a high-impact area or health condition. • Focus on high-impact areas and health conditions along with gap areas for Medicaid adult and child populations 	<p>Yes: Review can continue.</p> <p>Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization.</p> <p>No: Measure will receive a Do Not Support</p>
2. The measure is evidence-based and is either strongly linked to outcomes or is an outcome measure.	<ul style="list-style-type: none"> • For process and structural measures: The measure has a strong scientific evidence-base to demonstrate that when implemented, it can lead to the desired outcome(s). • For outcome measures: The measure has a scientific evidence-base and a rationale for how the outcome is influenced by healthcare processes or structures. 	<p>Yes: Review can continue</p> <p>Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization.</p> <p>No: Measure will receive a Do Not Support</p>
3. The measure addresses a quality challenge.	<ul style="list-style-type: none"> • The measure addresses a topic with a performance gap or addresses a serious reportable event (i.e., a safety event that should never happen); or • The measure addresses unwarranted or significant variation in care that is evidence of a quality challenge. 	<p>Yes: Review can continue</p> <p>Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization.</p> <p>No: Measure will receive a Do Not Support</p>

Assessment	Definition	Outcome
<p>4. The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.</p>	<ul style="list-style-type: none"> • The measure is either not duplicative of an existing measure or measure under consideration in the program or is superior to an existing measure in the program; or • The measure captures a broad population; or • The measure contributes to alignment between measures in a particular program set (e.g., the measure could be used across programs or is included in a MAP “family of measures”); or • The value to patients/consumers outweighs any burden of implementation; or • Alignment across various non-Medicaid quality-related Core Sets is facilitated, such as CMS Quality Collaborative Core Set-Adult Set. 	<p>Yes: Review can continue</p> <p>Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization.</p> <p>No: Measure will receive a Do Not Support</p>
<p>5. The measure can be feasibly reported.</p>	<ul style="list-style-type: none"> • The measure can be operationalized (e.g., the measure is fully specified, specifications use data found in structured data fields, and data are captured before, during, or after the course of care.) • The measure can be feasibly implemented at the state Medicaid level. • Data for the measure can be collected easily. • The measure does not pose undue resource constraints on the state. • Medicaid agencies at the state level can implement the measure without tweaking it and or changing the level of analysis. 	<p>Yes: Review can continue</p> <p>Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization.</p> <p>No: Measure will receive a Do Not Support</p>
<p>6. The measure is reliable and valid for the level of analysis, program, and/or setting(s) for which it is being considered.</p>	<ul style="list-style-type: none"> • The measure is NQF-endorsed; or • The measure is fully developed and full specifications are provided; and • Measure testing has demonstrated reliability and validity for the level of analysis, program, and/or setting(s) for which it is being considered. 	<p>Yes: Support measure.</p> <p>Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization.</p> <p>No: Measure will receive a Do Not Support</p>
<p>7. If a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified.</p>	<ul style="list-style-type: none"> • Feedback from end users has not identified any unreasonable implementation issues that outweigh the benefits of the measure; or • Feedback from implementers or end users has not identified any negative unintended consequences (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and • Feedback is supported by empirical evidence. 	<p>Yes: Support measure.</p> <p>Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization.</p> <p>No: Measure will receive a Do Not Support</p>

APPENDIX E: Characteristics of the Current Child Core Set

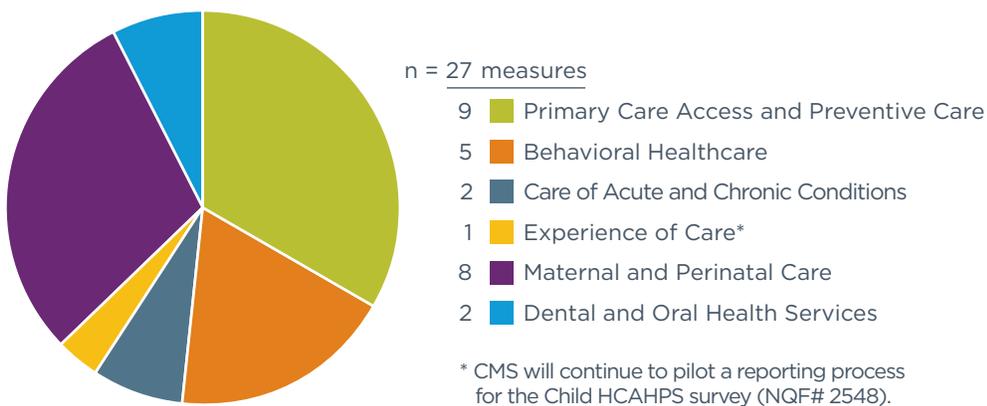
The 2017 Child Core Set measures are concentrated in the National Quality Strategy priority area of Healthy Living and Well-Being (Exhibit 1). Measures are not exclusive to each alignment category and can span across more than one alignment category.

EXHIBIT E1. MEASURES IN THE CHILD CORE SET BY NATIONAL QUALITY STRATEGY PRIORITY



With respect to measure types, the set contains no structural measures, 24 process measures, three outcome measures, and one experience-of-care measure. Even though the Adult and Child Core Sets do not contain structural measures, they are part of the Medicaid program portfolio in which structural issues are addressed through programs such as home health and patient-centered medical home, among others. Additionally, the Child Core Set is well aligned with other quality and reporting initiatives: 10 of the measures are used in one or more federal programs, including the Adult Core Set and the Merit-Based Incentive Payment System.^a Representing the diverse health needs of the Medicaid and CHIP population, the Child Core Set measures span many clinical topic areas (Exhibit 2).

EXHIBIT E2. MEASURES IN THE CHILD CORE SET BY CLINICAL AREA



a Centers for Medicare & Medicaid Services. CMS Measures Inventory. 2017. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html>. Last accessed June 2017.

APPENDIX F: Current Child Core Set and MAP Recommendations for Addition

There are 27 measures in the 2017 Child Core Set and five measures MAP recommended for phased addition to the 2018 Child Core Set. Exhibit F1 below lists the measures included in the 2017 version of the Child Core Set along with their current NQF endorsement number and status, including rates of state participation in FFY 2015 reporting. The 2016 reporting data were unavailable during the 2017 review. In FFY 2017,

states will be voluntarily collecting the Child Core Set measures using the 2017 Technical Specifications and Resource Manual. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF’s Quality Positioning System. Exhibit F2 lists the measures supported by MAP for potential addition to the Child Core Set.

EXHIBIT F1. 2017 CHILD CORE SET OF MEASURES WITH FFY 2015 REPORTING DATA

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendations and Rationale
0024 Endorsed Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i>	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> • Body mass index (BMI) percentile documentation • Counseling for nutrition • Counseling for physical activity 	33 states reported FFY 2015 Alignment: Merit-Based Incentive Payment System (MIPS), Healthcare Effectiveness Data and Information Set (HEDIS)	Support for continued use in the program
0033 Endorsed Chlamydia Screening in Women (CHL) <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i>	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year	41 states reported FFY 2015 Alignment: MIPS, Medicaid Adult Core Set, HEDIS	Support for continued use in the program
0038 Endorsed Childhood Immunization Status (CIS) <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i>	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B(HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	42 states reported FFY 2015 Alignment: MIPS, HEDIS	Support for continued use in the program

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendations and Rationale
<p>0108 Endorsed</p> <p>Follow-Up Care for Children Prescribed ADHD Medication (ADD)</p> <p><i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.</p> <ul style="list-style-type: none"> • Initiation Phase. The percentage of members 6-12 years of age as of the IPSP with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. • Continuation and Maintenance (C&M) Phase. The percentage of members 6-12 years of age as of the IPSP with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. 	<p>37 states reported FFY 2015</p> <p>Alignment: MIPS, HEDIS</p>	<p>Support for continued use in the program</p>

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendations and Rationale
<p>0139 Endorsed National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure <i>Measure Steward: Centers for Disease Control and Prevention (CDC)</i></p>	<p>Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations:</p> <ul style="list-style-type: none"> • Intensive Care Units (ICUs) • Specialty Care Areas (SCAs) – adult and pediatric: long-term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • Other inpatient locations. (Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long-term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations. 	<p>52 states reported FFY 2014*</p> <p>Alignment: N/A</p> <p>*Data separately collected by CDC’s National Healthcare Safety Network since FFY 2012. States include the District of Columbia and Puerto Rico.</p>	<p>Support for continued use in the program</p>
<p>0471 Endorsed PC-02 Cesarean Birth <i>Measure Steward: Joint Commission</i></p>	<p>This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (<i>PC-01 Elective Delivery, PC-03 Antenatal Steroids, PC-04 Health Care-Associated Bloodstream Infections in Newborns, PC-05 Exclusive Breast Milk Feeding</i>).</p>	<p>15 states reported FFY 2015</p> <p>Alignment: N/A</p>	<p>Support for continued use in the program</p>

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendations and Rationale
<p>0576 Endorsed Follow-Up After Hospitalization for Mental Illness (FUH) <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:</p> <ul style="list-style-type: none"> • The percentage of discharges for which the patient received follow-up within 30 days of discharge • The percentage of discharges for which the patient received follow-up within 7 days of discharge 	<p>35 states reported FFY 2015 Alignment: Inpatient Psychiatric Facility Quality Reporting (IOPFQR), MIPS, HEDIS</p>	<p>Support for continued use in the program</p>
<p>1360 Endorsed Audiological Evaluation No Later Than 3 Months of Age (AUD) <i>Measure Steward: Centers for Disease Control and Prevention (CDC)</i></p>	<p>This measure assesses the percentage of newborns who did not pass hearing screening and have an audiological evaluation no later than 3 months of age.</p>	<p>0 states reported FFY2015 (New for 2016) Alignment: N/A</p>	<p>Support for continued use in the program</p>
<p>1365 Endorsed Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment <i>Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)</i></p>	<p>Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk</p>	<p>1 state reported FFY 2015 Alignment: MIPS</p>	<p>MAP recommends the removal of this measure from the program. Throughout the meeting, MAP had multiple discussions on the need for broader measures; whereas, NQF #1365 encompasses only a small subset of a population with depression. MAP noted the small impact of this measure due to the narrowly defined population.</p>
<p>1382 Endorsed Percentage of Low Birthweight Births <i>Measure Steward: Centers for Disease Control and Prevention (CDC)</i></p>	<p>The percentage of births with birth weight <2,500 grams</p>	<p>28 states reported FFY 2015 Alignment: N/A</p>	<p>Support for continued use in the program</p>

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendations and Rationale
<p>1391 Endorsement Removed Frequency of Ongoing Prenatal Care (FPC) <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits:</p> <ul style="list-style-type: none"> • <21 percent of expected visits • 21 percent–40 percent of expected visits • 41 percent–60 percent of expected visits • 61 percent–80 percent of expected visits • > or =81 percent of expected visits 	<p>29 states reported FFY 2015 Alignment: HEDIS</p>	<p>MAP recommends the removal of this measure from the program. The measure does not address quality of care, because the measure does not assess the content of the prenatal care visit.</p>
<p>1392 Endorsed Well-Child Visits in the First 15 Months of Life <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported:</p> <ul style="list-style-type: none"> • No well-child visits • One well-child visit • Two well-child visits • Three well-child visits • Four well-child visits • Five well-child visits • Six or more well-child visits 	<p>45 states reported FFY 2015 Alignment: HEDIS</p>	<p>Support for continued use in the program</p>
<p>1407 Endorsed Immunizations for Adolescents (IMA)^a <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.</p>	<p>38 states reported FFY 2015 Alignment: MIPS, HEDIS</p>	<p>Support for continued use in the program</p>
<p>1448 Endorsement Removed Developmental Screening in the First Three Years of Life <i>Measure Steward: Oregon Health & Science University</i></p>	<p>The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.</p>	<p>22 states reported FFY 2015 Alignment: N/A</p>	<p>Support for continued use in the program</p>

a The stand-alone HPV Vaccine for Female Adolescents (NQF #1959) has been retired by the measure steward and added to the IMA measure. CMS will retire the stand-alone HPV measure and update the IMA measure accordingly.

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendations and Rationale
<p>1516 Endorsed Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>Percentage of patients 3-6 years of age who received one or more well-child visits with a PCP during the measurement year</p>	<p>47 states reported FFY 2015 Alignment: HEDIS</p>	<p>Support for continued use in the program</p>
<p>1517 Endorsement Removed Prenatal & Postpartum Care (PPC)* Measure Steward: National Committee for Quality Assurance (NCQA) <i>*Child Core Set includes "Timeliness of Prenatal Care" rate only. "Postpartum Care" rate is evaluated in Medicaid Adult Core Set.</i></p>	<p>The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.</p> <ul style="list-style-type: none"> • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. 	<p>38 states reported FFY 2015 Alignment: Medicaid Adult Core Set, HEDIS</p>	<p>MAP recommends the removal of this measure from the program. The measure focuses on time of enrollment. MAP discussed measuring the gestational age at the first visit as the key component of timeliness of care versus time of enrollment. MAP recommends this measure for removal only if a suitable alternative measure addressing gestational age is available for immediate replacement.</p>
<p>1799 Endorsement Removed Medication Management for People with Asthma (MMA) <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported.</p> <ol style="list-style-type: none"> 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period. 	<p>33 states reported FFY 2015 Alignment: MIPS, HEDIS</p>	<p>MAP recommends the removal of this measure from the program. The measure does not address whether patients are getting the correct medications for their particular type of asthma. MAP favored measure #1800 instead of #1799 because #1800 is supported by evidence and provides information on the quality and appropriateness of asthma care.</p>

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendations and Rationale
<p>2508 Endorsed Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk <i>Measure Steward: American Dental Association on behalf of the Dental Quality Alliance</i></p>	<p>Percentage of enrolled children in the age category of 6-9 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth within the reporting year</p>	<p>26 states reported FFY 2015 Alignment: N/A</p>	<p>Support for continued use in the program</p>
<p>2801 Endorsed Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>Percentage of children and adolescents 1-17 years of age with a new prescription for an antipsychotic, but no indication for antipsychotics, who had documentation of psychosocial care as first-line treatment.</p>	<p>New measure added to 2017 Core Set Alignment: HEDIS</p>	<p>Support for continued use in the program</p>
<p>2902 Endorsed Contraceptive Care- Postpartum Women (Ages 15-20) <i>Measure Steward: U.S. Office of Population Affairs</i></p>	<p>Among women ages 15 through 44 who had a live birth, the percentage that is provided:</p> <ol style="list-style-type: none"> 1. A most effective (i.e., sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) method of contraception within 3 and 60 days of delivery. 2. A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. <p>Two time periods are proposed (i.e., within 3 and within 60 days of delivery) because each reflects important clinical recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care.</p>	<p>New measure added to 2017 Core Set Alignment: Medicaid Adult Core Set</p>	<p>Support for continued use in the program</p>

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendations and Rationale
<p>Not NQF-endorsed Behavioral Health Risk Assessment (for Pregnant Women) <i>Measure Steward: formerly AMA-PCPI</i></p>	<p>Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: screening for depression, alcohol use, tobacco use, drug use, and intimate partner violence screening</p>	<p>4 states reported FFY 2015 Alignment: N/A</p>	<p>MAP recommends the removal of this measure from the program. The measure is technically difficult to obtain due to the need for extracting electronic health record (EHR) data. In addition, MAP noted that the measure includes too many components (i.e., depression, alcohol, illicit and prescription drug, as well as intimate partner violence screenings). A streamlined measure coupled with an action plan may be better.</p>
<p>Not NQF-endorsed Children and Adolescents' Access to Primary Care Practitioners <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>The percentage of children 12 months – 19 years of age who had a visit with a primary care practitioner. Four separate percentages are reported: Children 12 through 24 months and children 25 months through 6 years who had a visit with a primary care practitioner during the measurement year; Children 7 through 11 years and adolescents 12 through 19 years who had a visit with a primary care practitioner during the measurement year or the year prior to the measurement year.</p>	<p>45 states reported FFY 2015 Alignment: HEDIS</p>	<p>Support for continued use in the program</p>
<p>Not NQF-endorsed Adolescent Well-Care Visits <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>The percentage of enrolled adolescents 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.</p>	<p>46 states reported FFY 2015 Alignment: HEDIS</p>	<p>Support for continued use in the program</p>

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendations and Rationale
<p>2548 Endorsed Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0, Child Version <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>This measure provides information on parents' experience with their child's healthcare for population of children with chronic conditions. Results include same ratings, composites, and individual question summary rates as reported for the CAHPS Health Plan Survey 4.0, Child Version. Three CCC composites summarize satisfaction with basic components of care essential treatment, management and support of children with chronic conditions. 1. Access to Specialized Services; 2. Family Centered Care: Personal Doctor Who Knows Child; 3. Coordination of Care for CCC. Question summary rates also reported individually for summarizing the following two concepts: 1. Access to Prescription Medicines; 2. Family Centered Care: Getting Needed Information. Five composite scores summarize responses in key areas: 1. Customer Service; 2. Getting Care Quickly; 3. Getting Needed Care; 4. How Well Doctors Communicate; 5. Shared Decision Making.</p>	<p>42 states reported FFY 2015 Alignment: HEDIS</p>	<p>Support for continued use in the program</p>
<p>Not NQF-endorsed Percentage of Eligible Children Who Received Preventive Dental Services <i>Measure Steward: Centers for Medicare & Medicaid Services (CMS)</i></p>	<p>The percentage of individuals ages one to twenty years old eligible for Medicaid or CHIP Medicaid Expansion programs (that is, individuals eligible to receive EPSDT services) who received preventive dental services</p>	<p>51 states reported FFY 2015 Alignment: N/A</p>	<p>Support for continued use in the program</p>
<p>Not NQF-endorsed Ambulatory Care: Emergency Department Visits <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>The rate of emergency department visits per 1,000 member months among children up to age 19</p>	<p>40 states reported FFY 2015 Alignment: N/A</p>	<p>Support for continued use in the program</p>
<p>Not NQF-endorsed Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC) <i>Measure Steward: Agency for Healthcare Research and Quality (AHRQ)-CMS CHIPRA National Collaborative for Innovation in Quality Measurement (NCINQ)</i></p>	<p>The percentage of children and adolescents 1-17 years of age who were on two or more concurrent antipsychotic medications.</p>	<p>0 states reported FFY 2015 (New for 2016) Alignment: HEDIS</p>	<p>Support for continued use in the program</p>

EXHIBIT F2. MEASURES SUPPORTED BY MAP FOR PHASED ADDITION TO THE CHILD CORE SET

Measures in the table are listed in the order in which MAP prioritized them for inclusion.

Measure #, NQF Status, Title, and Steward	Measure Description	Alignment	MAP Recommendation and Rationale
<p>2903 Endorsed Contraceptive Care: Most & Moderately Effective Methods <i>Measure Steward: U.S. Office of Population Affairs</i></p>	<p>The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception.</p> <p>The proposed measure is an intermediate outcome measure because it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman will use, and because of the strong association between type of contraceptive method used and risk of unintended pregnancy.</p>	N/A	<p>Support addition of this measure to the program. Due to concerns of coercion, MAP emphasized that the intent of the measure is not to reach 100 percent compliance. This measure should be focused on quality improvement and should not be tied to any payment incentives.</p>
<p>1800 Endorsed Asthma Medication Ratio <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>The percentage of patients 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year</p>	HEDIS	<p>Support addition of this measure to the program. This measure not only has the ability to collect information on the number of patients with asthma medications, but also to ascertain the appropriateness of medication management based on the type of asthma, specifically persistent asthma. Therefore, the measure helps identify patients with inadequate asthma management.</p>

Measure #, NQF Status, Title, and Steward	Measure Description	Alignment	MAP Recommendation and Rationale
<p>3154 Endorsed Informed Participation <i>Measure Steward: The Children’s Hospital of Philadelphia</i></p>	<p>Improved measurement of the continuity of insurance coverage in the Medicaid and CHIP population is needed to help maximize insurance continuity and coverage for vulnerable children. To further this goal, the AHRQ-CMS CHIPRA PQMP Center of Excellence at the Children’s Hospital of Philadelphia developed the metric Informed Coverage. The metric is designed to more accurately measure coverage among children enrolled in Medicaid or CHIP at the state level and overcome the current inability in the Medicaid Analytic eXtract (MAX) dataset to determine whether a child disenrolled from Medicaid and CHIP due to loss of eligibility (such as due to parental income increase or the acquisition of employer-sponsored insurance, a “good” reason) or failure to appropriately re-enroll (a “bad” reason). This measure can help federal and state programs develop strategies to retain children eligible for coverage and minimize gaps that can occur during the renewal process. Informed Coverage assesses the continuity of enrollment of children in publicly financed insurance programs (Medicaid and CHIP), as defined by the ratio of enrolled month to eligible months over an 18 month observation window. Informed Coverage uses a natural experiment based on the random event of appendicitis to “inform” the estimate of coverage in a given state, bounded by two extreme assumptions regarding unknown eligibility information: Coverage Presumed Eligible (PE) and Coverage Presumed Ineligible (PI).</p>	<p>N/A</p>	<p>Support addition of this measure to the program. MAP discussed the uniqueness of this measure in relation to other metrics regarding coverage of services. This measure assesses the continuity of enrollment of children in Medicaid and CHIP, while other measures assess receipt of services post-enrollment only.</p>

Measure #, NQF Status, Title, and Steward	Measure Description	Alignment	MAP Recommendation and Rationale
<p>3148 (formerly 0418) Endorsed Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan <i>Measure Steward: Centers for Medicare & Medicaid Services (CMS)</i></p>	<p>Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented</p>	<p>Medicaid Adult Core Set, Medicare Shared Savings Program (MSSP), MIPS</p>	<p>Support addition of this measure to the program. The measure covers a broader population than NQF #1365, and includes patients 12 years and older who are screened for clinical depression. This measure requires screening along with a referral for follow-up services, thereby aligning with the U.S. Preventive Services Task Force guidelines.</p>
<p>2800 Endorsed Metabolic Monitoring for Children and Adolescents on Antipsychotics <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.</p>	<p>N/A</p>	<p>Support addition of this measure to the program. As the use of medications for behavioral health conditions is increasing among the Medicaid population, it is important to monitor the long-term metabolic effects of these prescriptions. MAP also noted the feasibility of reporting this measure since it is prescription-based and can be easily extracted.</p>

APPENDIX G: Additional Measures Considered

MAP considered several measures that did not pass the consensus threshold (>60 percent of voting members) to gain MAP’s support or conditional support for use in or removal from the Child Core Set. MAP needed to limit the number of measures it supported for the sake of parsimony and practicality. These and other measures could be reconsidered during a future review of the Child Core Set.

EXHIBIT G1. MEASURES VOTED FOR ADDITION TO THE CHILD CORE SET

Measure #	Measure Title	Measure Steward
1659	Influenza Immunization	Centers for Medicare & Medicaid Services
2842	Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator	Seattle Children’s Research Institute
2843	Family Experiences with Coordination of Care (FECC)-3: Care coordinator helped to obtain community services	
2844	Family Experiences with Coordination of Care (FECC)-5: Care coordinator asked about concerns and health	
2845	Family Experiences with Coordination of Care (FECC)-7: Care coordinator assisted with specialist service referrals	
2846	Family Experiences with Coordination of Care (FECC)-8: Care coordinator was knowledgeable, supportive and advocated for child’s needs	
2847	Family Experiences with Coordination of Care (FECC)-9: Appropriate written visit summary content	
2849	Family Experiences with Coordination of Care (FECC)-15: Caregiver has access to medical interpreter when needed	
2850	Family Experiences with Coordination of Care (FECC)-16: Child has shared care plan	
3041	PC-05 Exclusive Breast Milk Feeding	
N/A	Antibiotic Prophylaxis Among Children with Sickle Cell Anemia*	QMetric

*Undergoing NQF endorsement process

EXHIBIT G2. MEASURES VOTED FOR REMOVAL FROM THE CHILD CORE SET

Measure #	Measure Title	Measure Steward
1448	Developmental Screening in the First Three Years of Life	Oregon Health & Science University
N/A	Child and Adolescent Access to Primary Care Practitioners	National Committee for Quality Assurance

APPENDIX H: Gap Areas in the Child Core Set

In 2016, MAP identified several gap areas in the Child Core Set of measures. The gap areas listed below are based on MAP's order of prioritization in this current cycle.

Substance Abuse

Care Coordination

- Home and community-based care
- Social services coordination
- Cross-sector measures that would foster joint accountability with the education and criminal justice systems
- Care integration to assess efficacy and outcomes from integrated behavioral health in primary care Medical Homes, as well as collaborative care between primary and subspecialty care providers for patients with chronic conditions
- Adolescent Preparation for Transition to Adult-Focused Healthcare
- Care coordination for conditions requiring community linkages

Mental Health

- Access to outpatient and ambulatory mental health services
- Emergency department use for behavioral health
- Behavioral health functional outcomes that stem from trauma-informed care

Overuse/Medically Unnecessary Care

- Appropriate use of CT scans
- Measures that assess appropriate use, misuse, and overuse

Cost Measures

- Targeting people with chronic needs
- Families' out-of-pocket spending

Duration Of Children's Health Insurance Coverage Over A 12-Month Period

Patient-Reported Outcome Measures

Exposure To Adverse Childhood Experiences (ACEs)

Screening for Abuse and Neglect Injuries and Trauma

- Trauma specifically, since trauma in adolescents is one of the leading causes of death

Dental Care Access for Children with Disabilities

Sickle Cell Disease

Durable Medical Equipment (DME)

APPENDIX I: Public Comments

General Comments

Adventist Health System

Michael Griffin

AHS supports the general recommendations included in the Child Core Set report and believe this is a step in the right direction. However, we were disappointed to see that the additional measures (adopted for the adult core set) on care coordination were not considered for the Child Core Set. We believe that it is important that Medicaid, in addition to providers, be measured on care coordination. As we move toward a system rooted in value-based care, all stakeholders must bear responsibility. As it stands, providers bear responsibility. This needs to be shared with the Medicaid program.

American Psychiatric Association

Samantha Shugarman

The American Psychiatric Association (APA) is an organization of over 37,000 psychiatrist members working together to ensure humane care and effective treatment for all persons with mental illness, including substance use disorders. As the “voice and conscience of modern psychiatry,” the APA’s “vision is a society that has available, accessible quality psychiatric diagnosis and treatment.” As such, we are pleased with majority of the recommendations reported in the MAP-convened Medicaid Task Force’s draft reports of the “Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid CHIP, 2017” and for the “Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid CHIP, 2017.” Reinforced in these draft reports, Medicaid enrollees (e.g., child and adult) maintain a high prevalence of “behavioral health” (i.e., mental illnesses and substance use disorders) conditions. Notably beneficiaries aged 2-17, maintain anywhere from 13 to 20 percent experience a mental disorder, annually. Alarming, suicide is recognized as the second leading cause of death among these beneficiaries. Therefore, it is justifiable that the prevalence of

psychotropic medication prescriptions, for publicly insured children is increasing. However, due to barriers to care, discrepancies in the provision of evidence-based care and prescribing practices, it is important to examine state level quality measurement data for this patient population.

APA agrees that it is more valuable to measure the “aspects of care” administered, compared to the “frequency of care.” However, until the provision of evidence-based standards of care consistently occurs, and psychiatric outcomes are broadly identified, it is necessary to track care administration frequency. By elucidating variation in treatment frequency, Medicaid and CHIP programs can better determine how and where to utilize their resources (e.g., regional disparities; or education for care givers, patients, and/or providers, etc.).

The APA applauds the MAP for continued acknowledgement that gaps in behavioral health care persist for adults and children. Considering this assertion, we support the Task Force’s suggestion to phase in two new behavioral health measures, out of the five-total recommended into the Child Core Set, and one new behavioral health measure into the Adult Core Set.

Anthem, Inc.

Amy Ingham

General Comments: Anthem appreciates the work that MAP and CMS have undertaken to produce its 2017 report. We believe that the success of quality measurement and improvement is best achieved through ensuring a stable, concise set of targeted and meaningful measures from which states may choose. Generally, we strongly encourage that MAP’s decision-making continue to be grounded in the implementation experience of state agencies and health plans. Furthermore, we believe that a parsimonious approach to the addition of new measures assists in increasing collections of those

measures already included in the set. Lastly, we recommend that MAP consider further prioritizing measures in the future so that there is more emphasis on fewer, more targeted measure sets. One recommendation is that MAP consider development of a set of the “vital few” measures that can be used to help CMS and states prioritize the most valuable measures from which to select.

Children’s Hospital Association**Sally Turbyville**

The Children’s Hospital Association (CHA) would like to thank the MAP for the hard work and appreciates the opportunity to comment on the 2017 MAP Medicaid Child draft report.

Please clarify the status and plan for Core Set measures previously prioritized and recommended by the MAP, but not yet implemented. For example the Child-HCAHPS

There are few measures that assess care outside of the ambulatory setting and for those children with high medical complexity. CHA applauds the MAP and CMS for shining a light on children with special needs. We would like to note that measurement gaps for children with medical complexities (a subset of those with special needs who are the most medically complex) remain something that measure developers, including the PQMPs, continue to fill in. We look forward to the MAP continuing to consider measures that address the quality of care and outcomes for this very vulnerable population and their families.

Measure-Specific Comments

Adventist Health System

Michael Griffin

Child Core Set

NQF-Endorsed Measures

#1800 AHS supports the measure. We believe it is important that the measure collects information on not just the numbers of patients with asthma medications, but also determines the appropriateness of medication management based on the type of asthma.

#2903 AHS supports this measure but believes that it should be revised. The denominator should be limited to women who do not want to become pregnant.

#0418 AHS supports this measure. However, we recommend that the measure lower the current stated age from 12 to 10 years old. Additionally, we encourage the NQF to look at how measures can help identify the root cause of clinical depression. For example, bullying. We are curious as to whether root causes, such as bullying, are addressed within the measures guidelines. Additionally, there needs to be more clarification on what prompts the use of the screening. For example, will the screening be applied to all children or only those with certain medical indicators?

#2800 AHS supports the measure but believes the measure is not actionable.

Not NQF-Endorsed Measures

Informed Coverage AHS conditionally supports the measure, pending NQF endorsement. AHS believes there should be clarification in terms of who is actually reporting this measure and whether continuity of insurance coverage is a feasible measure.

American College of Obstetricians and Gynecologists

Sean Currihan

On behalf of the American Congress of Obstetricians and Gynecologists (ACOG), a professional organization representing more than 58,000 physicians and partners in women's health, we continue to support the three nationally endorsed

measures in contraceptive health care (most and mod, LARC access, and postpartum contraception). We encourage CMS and state Medicaid agencies to work on improving access to effective contraception and family planning.

American Occupational Therapy Association

Jeremy Furniss

Child Report

Removing NQF #1365: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

AOTA supports the removal of #1365 only if it is replaced with measure #0418 at the same time as it is removed. It is very important to continue to measure quality of services related to depression in this population.

Adding NQF #0418 Screening for Clinical Depression and Follow-Up

While there are limitations to this measure, AOTA supports the replacement of NQF #1365 with NQF #0418. Occupational therapists currently report measure #0418 with adult clients and find it useful to ensure that depression screening is completed and a follow-up plan is created if needed during the evaluation process. The use of NQF #0418 in both core sets creates an alignment in the Medicaid program and encourages parsimony. Although #0148 does capture a wider population, it does omit some people who are included in #1365 (people between the ages of 6-11) which should be noted.

NQF #1800 Asthma Medication Ratio

AOTA commends the MAP on identifying a measure that can cross from the child to adult core measure set and provide value in identifying and improving quality services.

American Psychiatric Association

Samantha Shugarman

For future comment periods please provide each report its own comment forms. APA supports the Task Force suggesting to phase in 2 new behavioral health measures, of the 5 recommended in the Child Set. We suggest a higher ranking score of

NQF #2800, considering concerns of oversight of increased prescribing of psychotropic medications. We support implementing measures for a broader set of enrollees. If had to include 1 measure in Core Set vs the other, we support the replacement of NQF #1365 with #418 because it will touch on a greater number of beneficiaries. Though suicide the 2nd leading cause of child and adolescent deaths, it's relevant for data capture of this high-risk population. We have concerns with #418 weak scientific acceptability findings. Reliability of this measure was determined using a random sample of records from about 150 providers, all identified by NPI. Of this pool of about 150 providers, about 600 claims were randomly selected and then stratified by business location address. The provider type is not specified. Other issues with reliability can be seen in the provider response rate for the final sample of 45.9% for records requested, and 51% participation rate of providers. Final sample was 275 claims (at times referred to as cases), and 77 providers. The time period for this study was three months. Final sample=240 cases. We assume the independent reviewer abstracted data from the medical record and found agreement of 79% of cases for numerator, and 100% for denominator. Validity, an environmental scan and TEP review, based on face validity but review method not described. Potential threats to validity: agreement reported among the 35 cases (12.7%) had denominator exclusions. These cases, they report 93% agreement in claims reliability, and 66.5% for inter-rater reliability. Why didn't developer include risk adjustment strategy, despite description of disparities in race/ethnicity & urban/rural. Explain "aggregate measure performance rate" was calculated. Was the reported 83% of total # of claims across the 77 providers? Did developers adjust for clustering by providers when calculating measure adherence rate? In this sample of providers, developers found that minority vs white=78.2% versus 83.7%. Is this based on the number of claims reviewed, as preliminarily appears? "Minority" percentage of claims could be small. In this sample of providers, findings show urban v rural equated to 82.5% v 92.3%. When stratifying by age, all under 50 years old were lumped together. This measure recommended to the Child Set, how many children/teens in the final case samples? We appreciate flexibility in measure (e.g., not

prescribing the number of standardized screenings required to ascertain diagnosis). Guidelines defining follow-up plan are broad, are operational definitions missing? Should we assume CMS codes illustrating language that otherwise lack definitions? Data not presented supporting feasibility of using these codes.

Anthem, Inc.

Amy Ingham

Child Core Set

Contraceptive Care: Most & Moderately Effective Methods: Same comments as in Adult Core Set.

Asthma Medication Ratio: Anthem supports this measure. We note that reporting this measure at the individual provider level often involves low denominators and less meaningful results, and so we recommend development of a solution.

Informed Coverage: Anthem supports the addition of this measure based on NQF endorsement and CMS evidence of feasibility.

Screening for Clinical Depression and Follow-Up: Anthem does not support including this measure as it is designed.

Metabolic Screening for Children and Adolescents Newly on Antipsychotics: Anthem does not support adding this measure. The Set already includes antipsychotic use measures, and we are concerned that this similar measure would result in an inappropriate emphasis.

Frequency of Ongoing Prenatal Care: Anthem does not support the removal of prenatal care measures.

Prenatal and Postpartum Care – Timeliness of Prenatal Care: Same comments as above.

Medication Management for People with Asthma: Anthem is in support of the removal of this measure.

Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment: Anthem supports removing this measure. However, we do not support replacing this measure with the Screening for Clinical Depression and Follow-Up measure.

Behavioral Health Risk Assessment (for Pregnant Women): Anthem supports removing this measure.

Boston Children’s Hospital

Richard Antonelli

#1448, Developmental Screening in the First Three Years of Life. Measure Steward: Oregon Health & Science University.

In the Medicaid Child Task Force, there was much discussion about this measure. Due to lack of resources, the necessary effort to prepare the measure for consideration of continued NQF endorsement was not feasible for the measure steward. Therefore, NQF endorsement was withdrawn. The Task Force felt strongly that CMS should not infer that removal of NQF endorsement for this reason is tantamount to recommendation of not including this in the core set. There is no doubt that this is an essential quality measure in child health care delivery.

CVS/Caremark (Corporate HQ)

Alex Crawford

NQF is seeking comments on its recommendations to fill identified gaps in the Medicaid Adult and Child core sets of measures.

On behalf CVS Health, we appreciate NQF’s consideration of measures to strengthen Medicaid quality for children and adults and are pleased to provide comments. PBMs, Pharmacies, and pharmacists play an integral role in health quality outcomes yet there are relatively few quality measures today that are pharmacy-related (e.g., Antidepressant Prescription Management). Prescription medications, medication therapy management and pharmacy counseling can drive meaningful results and should be considered in the Adult and Child core set of measures.

With regard to specific measures, CVS Health supports “NQF #1800 Asthma Medication Ratio,” which assesses the percentage of patients 5–64 years of age identified as having persistent asthma and a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Conditions such as asthma are also highly prevalent in Medicaid populations, and it is a measure that that would help to fill a gap in the Adult core set of measures. We also support this measure for inclusion in the Child Core Set of measures and as a replacement to the measure

“Medication Management for people with Asthma” - which has lost NQF endorsement. Inclusion of the measure in both Sets would support CMS’ efforts for alignment when appropriate for the populations served and facilitates a more seamless care and measurement transition across the two Core Sets.

CVS Health also supports the Measure Application Partnership’s (MAP) recommendation to include the “Concurrent Use of Opioids and Benzodiazepines” measure for inclusion in the Medicaid Adult Core Measure Set. The measure was developed by the Pharmacy Quality Alliance (PQA) and examines the percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines. MAP recommended the inclusion of this measure since it addresses two gap areas simultaneously: early opioid use and polypharmacy and noted that in the United States, deaths from co-prescribed opioids and benzodiazepines increased 14 percent per year from 2006 to 2011. CVS Health recognizes that CMS is currently monitoring concurrent use of opioids and benzodiazepines among Medicare Part D enrollees, and inclusion of the measure in the Adult Core Set is important for the future oversight and care for Medicaid beneficiaries.

Thank you for the opportunity to provide comments in support of NQF’s inclusion of NCQA’s measure “Asthma Medication Ratio” and the inclusion of PQA’s measure “Concurrent Use of Opioids and Benzodiazepines.”

Federation of American Hospitals

Jayne Chambers

The Federation of American Hospitals (FAH) appreciates the opportunity to comment on the National Quality Forum’s Measure Applications Partnerships (MAP) draft 2017 report on the core set of healthcare quality measures for children enrolled in Medicaid and CHIP. Except for measure #1571, the FAH generally supports the proposed refinements to the draft set. The FAH notes that a number of states currently report many of the measures, and the measures offer the potential to improve the quality of care provided to children. FAH is concerned about the report’s caveat on the removal of #1517: Prenatal and Postpartum Care – Timeliness of Prenatal Care

measure. The removal caveat appears based on the recommendation outlined on page 12 of the report that the measure is recommended for removal only if a suitable alternative is available. The NQF endorsement of this measure was removed due to the lack of evidence to support the measure's focus and questions over the validity of the measure. Given the removal of endorsement and the underlying reasons for that removal, the FAH does not agree that the measure should be used until such time that a different measure is available. Measures that are included in the Medicaid set must be evidence based and produce reliable and valid results. The FAH supports the complete removal of this measure regardless of the availability of replacement measures.

National Partnership for Women & Families

Debra Ness

The 2017 MAP Medicaid Adult and Child draft reports recommend adding NQF #2903 Contraceptive Care – Most and Moderately Effective Methods to the Adult and Child Core Sets. The National Partnership for Women & Families strongly supports this recommendation. It is highly appropriate to include a newly available measure of this foundational preventive service that is relevant to nearly the entire population of reproductive age women and girls in both of the Core Sets. This would help increase the proportion of adolescents and women who are provided with an informed choice of more effective methods of contraception, reduce unintended pregnancies, and provide an important tool for identifying gaps and disparities to remedy. The NQF Perinatal and Reproductive Health Standing Committee strongly supported this measure in its 2016 consensus development process cycle. This would be an important complement to #2902 Contraceptive Care – Postpartum, which has just been added to the Medicaid core sets. These are aligned in employing informed choice among most and moderately effective methods. In 2016, NQF endorsed three first-ever contraceptive care measures, and #2903 provides an important opportunity to improve the care and outcomes of the Medicaid population. Because of the singular importance of autonomy and informed choice in reproductive decision making, and the history of reproductive coercion of low-income women,

we urge the adoption of this measure in strict compliance with its design, in order to guard against misuse or coercion.

The 2017 MAP Medicaid Child Task Force report recommends the addition of NQF #0418 Screening for Clinical Depression and Follow-Up. The National Partnership for Women & Families strongly encourages the inclusion of a depression screening and follow-up measure in this measure set. For 2018, CMS has revised the sample list of screening tools to include additional tools, including those for perinatal depression to align with clinical guideline recommendations. Depression is a major issue for both pregnant and postpartum women, with notable consequences for women, their infants and other family members. Recent recommendations by the U.S Preventive Services Task Force underscore the value and priority of depression screening and follow up in this population. We appreciate inclusion of this population in the measure. However, to improve mental health care of this population, it is important to stratify the measure to be able to separately measure and improve maternity care performance.

NCQA has a HEDIS Depression Screening and Follow-up for Adolescents and Adults (DSF) measure that is new for 2018. It is inclusive of childbearing women and references relevant validated screening tools for this population. An effort is under way to rapidly test this measure when stratified for this population to support maternity care providers in advancing high-value maternity care. This would also help replace legacy HEDIS maternity measures – including the proposed retirement of the Frequency of Prenatal Care HEDIS measure – with those that are likely to be more robust and impactful. As Medicaid covers nearly half of all births in the U.S., a measure with this stratification would be preferable for the Child Core Set (and the Adult Core set, which currently includes #0418). As with NQF #0418, the new HEDIS measure covers adolescents through adults. We strongly encourage CMS to add the depression and follow up measure concept to the Child Core Set, but to consider including a measure with the ability to stratify for childbearing women to enable the additional measure to include accountability with maternity care providers and contribute to the well being of childbearing women and their families. This would also be optimal for the screening and follow-up measure in the Adult Core Set as well. This could be the stratified HEDIS

depression and follow-up measure, and we encourage CMS to stratify, test and revise #0418 so that it can separately measure maternity care.

The 2017 MAP Medicaid Child draft report recommends removing Behavioral Health Risk Assessment (for pregnant women) from the Child Core Set. The National Partnership for Women & Families strongly supports this recommendation. While this composite screening measure addresses five crucial issues for childbearing women and families and for prenatal care services, problems have been identified with this measure, and further development is needed on the concepts embodied in it – depression, alcohol use, tobacco use, drug use and intimate partner violence.

This measure was selected from the ACOG-NCQA-AMA-PCPI maternity care set of much-needed clinician- and group-level maternity measures that was issued in 2012. It was neither adequately tested by developers nor endorsed by NQF. Actual implementation identified challenges with measure collection. About two years ago, Dr. Rebecca Gee, as Medicaid Medical Director for Louisiana, discussed this measure in her presentation to the Task Forces. Even with the benefit of a grant to advance measure collection in Louisiana, she encountered insurmountable problems with the feasibility of collecting some components of this all-or-none composite. During its 2017 deliberations, the Child Task Force raised another concern with this measure: it documents screening but neither whether women who screened positive received help nor whether they improved. Not surprisingly, very few states have added this measure to Medicaid Core Set measures that they collect and report.

Leaving this measure in the Child Core Set may be an impediment to the development and broad use of more robust, impactful measures for these important issues.

The 2017 MAP Medicaid Child draft report recommends removing Prenatal and Postpartum Care – Timeliness of Prenatal Care from the Child Core Set. And the 2017 MAP Medicaid Adult draft report recommends removing Prenatal and Postpartum Care – Postpartum Care Rate from the Adult Core Set. Together, these are two component of a legacy HEDIS measure that lost endorsement during the 2016 consensus development process

cycle of the NQF Perinatal and Reproductive Health Standing Committee. The National Partnership for Women & Families strongly supports removal of these sub-measures from the Medicaid Core Sets.

The measurement enterprise has evolved in important respects. The developer identified expert consensus, typically understood to be the lowest level of evidence, as support for this measure. This does not meet current standards of the National Quality Forum, which recommends the much higher bar of evidence at the level of a systematic review.

The measurement enterprise is also evolving to emphasize a parsimonious number of robust measures that clearly advance high-value care. This measure merely identifies the fact of a visit at a particular time (which for the postpartum visit is problematic; see below). The fact of a visit provides no information about the care provided, the outcome of care, the woman's experience, resources used or other more meaningful indicators. The results are thus difficult to interpret. Instead, we need measures that encourage provision of known high-value elements of prenatal, intrapartum and postpartum care, as well as achievement of optimal maternal and newborn outcomes, experiences and resource use.

In a cost-constrained environment, this measure also raises concerns about appropriate use of resources. In addition to resources used to collect and report this measure, some health plans spend large sums to enhance their performance on this measure. As results are difficult to interpret, the National Partnership prefers that the various stakeholders invest resources in more meaningful measures.

The postpartum component is especially problematic for two reasons. First due to use of global billing codes, it is undercounted, so again, difficult to interpret. Second, the measure only counts if the visit is after 21 days postpartum, which is a disincentive in some settings for getting appropriate earlier care, for example, for breastfeeding support or for cesarean or perineal wound issues.

We hope that removal of this measure from the Medicaid Core Sets and other measure sets will expedite the process of putting in its place much-needed measures with a stronger, clearer relationship to high-value maternal-newborn care.

The 2017 MAP Medicaid Child draft report recommends removal of Frequency of Ongoing Core

Prenatal Care from the Child Core Set. The National Partnership for Women & Families strongly supports removal of this measure from the Child Core Set.

This is a legacy measure, and the measurement enterprise has evolved in important respects. The developer identified expert consensus, typically understood to be the lowest level of evidence, as support for this measure. This does not meet current standards of the National Quality Forum, which recommends the much higher bar of evidence at the level of a systematic review. This is one reason why NQF's Perinatal and Reproductive Health Standing Committee decided not to recommend continued endorsement of this measure in its 2016 review cycle. NCQA subsequently withdrew this measure, which has lost endorsement. NCQA also recently closed a comment period requesting feedback on its proposal to retire this measure from HEDIS.

The measurement enterprise is also evolving to emphasize a parsimonious number of robust measures that clearly advance high-value care. This measure merely measures visits. The fact of a visit provides no information about the care provided, the outcome of care, the woman's experience, resources used or other more meaningful indicators. The results are thus difficult to interpret. Instead, we need measures that encourage provision of known high-value elements of prenatal, intrapartum and postpartum care, as well as achievement of optimal maternal and newborn outcomes, experiences and resource use.

In a cost-constrained environment, this measure also raises concerns about appropriate use of resources. In addition to resources used to collect and report this measure, some health plans spend large sums to enhance their performance on this measure. As results are difficult to interpret, the National Partnership prefers that the various stakeholders invest resources in more meaningful measures.

We hope that removal of this measure from the Medicaid Child Core Set and other measure sets will expedite the process of putting in its place in HEDIS, alternate payment models and other measure sets much-needed measures with a stronger, clearer relationship to high-value maternal-newborn care.

Pfizer

Vincenzia Snow

NQF 0038 should be refined to account for timing. Specifically, the Center for Disease Control's Advisory Committee on Immunization Practices recommends the following schedule for childhood vaccinations as published in the Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, 2017. Timing of vaccinations has yet to be included in any measures and we believe it fits within NQFs objectives for better care as evidenced by coordination and effective treatment. Recent data from the CDC's National Immunization Survey shows that series completion rates for several childhood vaccines remains below Healthy People 2020 goals and also indicates disparity in some cases between privately insured children and publicly insured children. Source: NIS 2015 Vaccination Coverage.

Planned Parenthood Federation of America

Emily Stewart

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") are pleased to submit these comments in response to two draft reports for public comment regarding core sets of health care quality measures for adults and children enrolled in Medicaid. We appreciate this opportunity to provide feedback on the draft proposal to recommend inclusion of contraceptive care measure NQF#2903, which was endorsed by the NQF in 2016.

We support MAP's recommendation to add this measure to both sets. NQF#2903 measures the provision of a most or moderately effective method of contraception to women at risk for unintended pregnancy. This is an important measure for assessing the quality of health care women are receiving and is appropriate for use in the Medicaid program. Medicaid plays a critical role for women and their families. The vast majority of women enrolled in Medicaid are of reproductive age (18-44) and Medicaid funds nearly half of U.S. births. Measuring and improving access to the full range of contraceptive methods will fill a significant gap in health care quality efforts in Medicaid and across the health care system.

Around half of U.S. pregnancies are unintended, often contributing to poor maternal and child outcomes. The 2015 Institute of Medicine/National Academy

of Medicine (IOM) report, *Vital Signs: Core Metrics for Health and Health Care Progress*, identified unintended pregnancy as a “significant challenge for both individual and community health,” and recommended that contraceptive care be included as a core quality measure in the health care system. Indeed each woman should have the opportunity to select the method of contraception that best meets her needs, including with respect to her medical history, age, and lifestyle. NQF#2903 is appropriately defined to include various effective methods so that women are not inadvertently pressured toward a specific contraceptive method.

Adding these measures to the core sets will improve access to the care women need, and promote quality improvement efforts in Medicaid that address the majority of the program’s population. We thank MAP for its thoughtful consideration and recommendation for the Medicaid core measure sets.

Raising Women’s Voices for the Health Care We Need

Sarah Christopherson

Raising Women’s Voices for the Health Care We Need is a national initiative working to ensure that the health care needs of women and our families are addressed in federal and state health policies. We have a special mission of engaging women who are not often invited into health policy discussions: women of color, low-income women, immigrant women, young women, women with disabilities, and members of the LGBTQ community.

We support recommending to CMS that it add NQF #2903, measuring access to most or moderately-effective contraceptive methods, to the Medicaid core measure sets for 2018. The measure covers a range of contraceptive methods, promoting patient choice and guarding against coercion, and will improve maternal and infant outcomes and address disparities in women’s access to quality care.

Access to the full range of contraceptive methods and counseling is essential preventive health care for women, and has lifelong benefits for women’s economic security as well. Too often, a woman’s interaction with her provider is a missed opportunity for her to access this essential preventive health care. CMS recognition could lead to more providers screening women for their pregnancy intentions,

providing patient-centered contraceptive counseling, and providing the full range of contraceptive methods so that women may choose the method that best suits their individual needs and goals.

Statewide Parent Advocacy Network

Diana Autin

Agree with removing prenatal care frequency since didn’t address quality/outcomes

Agree with removing timeliness of prenatal care only if can replace w/ measure using gestational age 1st visit to capture high risk pregnancies

Agree with removing meds./asthma due to lack of evidence

Agree with removing teen depression/suicide risk- too narrowly defined as major depressive disorder; using broader depression screening/risk

Agree with removing mental health/pregnancy as too broad, only 4 states collecting data

- adding effective contraception-same as adult set
- adding asthma meds.-same as adult set

adding informed coverage as addresses continuity of care-strongly agree

adding depression screening/suicide risk to replace measure above-strongly agree

adding metabolic screening teens/antipsychotics-strongly agree as meds. have side effects such as obesity

The National Campaign to Prevent Teen and Unplanned Pregnancy

Andrea Kane

Measure 2902 Contraceptive Care - Postpartum Women Ages 15-20

Measure 2903 Contraceptive Care - Most & Moderately Effective Methods

The National Campaign to Prevent Teen and Unplanned Pregnancy applauds the careful work that went into developing these measures and is pleased that they are now NQF-endorsed. We believe they can be a valuable tool that contributes to ensuring that all women have access to the full range of contraceptive methods, including the most effective ones for them. This includes being offered contraception post-partum, as well as at other times that are appropriate for an individual woman.

Strategic Comments

Adventist Health System

Michael Griffin

In both the Adult and the Child Core Set reports, the MAP identifies certain areas of focus for quality measurement. These areas include: optimizing data connections; improving integration across programs and data systems; aligning measurement and data requirements; as well as incorporating methodological paradigm shifts through stratification of data and acknowledging the impact of social complexities on care delivery and outcomes.

AHS supports the NQF's emphasis on these areas and believes they are essential for quality measurement and the move towards value-based care. Seeking the alignment of measures across the Adult and Child Core Sets, especially for high-impact conditions like reproductive and behavioral health, is necessary for the successful integration of care. Identifying measures that overlap and eliminating duplication can improve the delivery of care by reducing the data collection and reporting burden placed on providers.

Additionally, AHS supports the development of social vulnerability measures because of the complex role of social risk factors at both the individual and population level. The adoption of these measures will likely help improve patient outcomes for vulnerable populations.

Anthem, Inc.

Amy Ingham

We thank MAP for seeking to ensure alignment with NCQA HEDIS measures.

Anthem agrees that reporting should be voluntary and not mandatory. While health plans have experience to report internally and externally (when states require it), the burden of collecting data is very high, especially for non-HEDIS measures where either medical record review or eRecord are expected. In several measures, such as elective deliveries, health plans may need to use much higher sample sizes than with HEDIS measures in order to achieve the right denominator (members in the right gestational age to fit the denominator definition). Now that more

measures of this kind have been added, we support phasing in adoption to alleviate operational burdens.

Additionally, these measures also tend to have extra medical record burden just to find the right denominator. When looking at the Adult Core Set – Elective Delivery measure – we need to include many more individuals than necessary in the sample. This measure looks at members who delivered at 37 – 39 gestational weeks. However, this information is not provided by claims data. To ensure our sample is appropriate, we need to oversample by 60 percent to ensure we have enough individuals included in the measure denominator.

Measures should include detailed technical specifications -

- If claims information should be used, then Dx/CPT codes should be provided,
- If medical record review should be used, then denominator/numerator components of medical record review should be defined,
- Specific definitions and clear guidelines should always be provided.

We recommend better alignment with the HEDIS and the Children's and Adult Core sets. Anthem agrees that the measures across the Child and Adult Core Sets are aligned. Alignment across these two sets will also ease the feasibility of data collection. Overall, Anthem supports MAP's focus on parsimony and alignment of measures and we emphasize that alignment of measures for ease in collection by providers and health plans would result in overall healthcare improvements.

We also recommend that measures track quality improvement and quality of care in the most efficient and accurate manners. Medical record review is unduly burdensome and vital statistics data is often not available or not timely. These barriers result in a lack of timely and complete data, which is necessary for effective interventions. For example, Elective Delivery in the Adult Core Set.

Children's Hospital Association**Sally Turbyville**

The Children's Hospital Association (CHA) appreciates the opportunity to comment on the 2017 MAP Medicaid Child draft report.

We applaud CMS' work in aligning core set measures. We encourage CMS to continue this work, and consider a map that lays out this alignment (both current and anticipated). We understand the challenges associated with measure feasibility, and support CMS and AHRQ's efforts (e.g., in the PQMP program) to implement measures that are more telling of the quality of care and outcomes than some of the existing claims-based process measures.

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