Measure Applications Partnership: Expedited Review of the Initial Core Set of Measures for Medicaid-Eligible Adults

REPORT TO HHS

October 15, 2013

NATIONAL QUALITY FORUM

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I, task order 11.

I. Introduction

The Measure Applications Partnership (MAP) is a multi-stakeholder group of public- and private-sector organizations and experts convened by the National Quality Forum (NQF). The Department of Health and Human Services (HHS) recently engaged MAP to provide input on the Initial Core Set of Measures for Medicaid-Eligible Adults (Medicaid Adult Core Set or Core Set, see Appendix A). The MAP Dual Eligible Beneficiaries Workgroup reviewed the Core Set and provided its input to the MAP Coordinating Committee, which is issuing this final input to HHS (see Appendices B and C for workgroup and committee rosters). NQF solicited public comment on draft findings and incorporated additional points into this report (see Appendix D).

In its review of the measures, MAP identified opportunities to revise and strengthen the Medicaid Adult Core Set. MAP offers a mix of general and measure-specific recommendations to improve the accuracy, breadth, and feasibility of reporting the Medicaid Adult Core Set. This report also includes information that was provided to MAP as background to inform its review of the Core Set, specifically an overview of the population of adults enrolled in Medicaid and the purpose and history of the Adult Medicaid Quality Reporting Program (see Appendices E and F).

HHS will use MAP's findings to inform an update of the Medicaid Adult Core Set required by statute to occur in 2014. A MAP Medicaid Task Force will convene in 2014 to provide additional input on future revisions.

II. MAP Review of the Medicaid Adult Core Set

MAP used the MAP Measure Selection Criteria (MSC) (see Appendix G) to evaluate the strength of the Medicaid Adult Core Set. The 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 to complement program-specific statutory and regulatory requirements. The criteria favor the selection of high-quality measures that optimally address the National Quality Strategy, fill critical measurement gaps, and increase alignment across programs.

MAP used the MSC to guide the evaluation of the program measure set and its ability to meet the program goals outlined by CMS. CMS identified a three-part goal: increasing the number of states reporting Medicaid Adult Core Set measures, increasing the number of measures reported by each state, and increasing the number of states using Core Set measures to drive quality improvement. Thus, MAP's review concentrated on issues that affect the feasibility of state participation in the program.

Table 1 describes the properties of the 26 measures included in the Medicaid Adult Core Set. Some characteristics such as care setting and level of analysis are not mutually exclusive. Measures may also be in one or more Federal program(s) or State Dual Eligible Beneficiaries Integration Demonstrations. The majority of measures in the Medicaid Adult Core Set are NQF-endorsed process measures; are most commonly applied to the ambulatory care setting; can be analyzed for health plans and populations; and align with other public and private programs.

Table 1: Medicaid Adult Core Set Measure Properties

Measure Properties	Measure Sub-Properties	Measure Count (Total n=26)
NQF Endorsement	Endorsed	21
	Not Currently Endorsed	5
Measure Type	Outcome	7
	Process	19
Care Setting	Ambulatory Care	21
	Behavioral Health	4
	Hospital/Acute Care	9
	Post-Acute/Long-Term Care	3
	Other (e.g., Pharmacy)	3
Level of Analysis	Clinician	12
	Facility	3
	Health Plan	17
	Integrated Delivery System	9
	Population	15
Alignment	In one or more Federal Programs reviewed by MAP	19
	In one or more State Demonstrations for Dual Eligible Beneficiaries	15
	In one or more of MAP's Families of Measures	12
	In NCQA's HEDIS Program	17

General Recommendations

MAP's recommendations are based on the deliberations of the MAP Dual Eligible Beneficiaries Workgroup, the MAP Coordinating Committee, and additional feedback from public comments. In assessing the Medicaid Adult Core Set with the MAP MSC, MAP found that it is adequate to advance CMS' stated goals for the program. MAP judged the Core Set to have a satisfactory share of outcome measures, to give sufficient attention to the three aims and six priorities of the National Quality Strategy, and to adequately respond to the program's goals and requirements. The Medicaid Adult Core Set is particularly strong in its alignment with other program sets and its parsimonious number of measures.

In selecting measures for the first iteration of the Medicaid Adult Core Set, CMS was limited to those that were available for immediate use at the time. MAP recognizes the investments that have been

made in the current measures and the need for states and CMS to gain experience with their use. Large changes to the measure set in the first two years of the program would be premature and could have the unintended consequence of discouraging states' participation in quality measurement and quality improvement. Therefore, the most important efforts for CMS to undertake now are to address the known challenges in data collection and reporting, monitor the program's continuing development, and consider the measure-specific recommendations later in this report to bolster program feasibility. Public comments also urged further attention to reducing the resources required for data collection, noting that measures collected via administrative methodologies should be prioritized over measures that require hybrid data sources.

While acknowledging the need for continuity, MAP members were vocal in calling for the addition of new measures to strengthen the set over time. MAP recommends that the measure set continue to evolve in parallel with advances in the field of health care quality measurement. One example, noted by a comment, is that the current version of the CAHPS® survey is 5.0, while the Medicaid Adult Core Set still references version 4.0. As revisions are published and additions are considered, MAP encourages CMS to consult MAP's families of measures, including the Family of Measures for Dual Eligible Beneficiaries, for promising measures and measure concepts. In addition, MAP strongly encourages development of new measures in key areas so that they might be added to the program in the future.

Though several measures in the Medicaid Adult Core Set relate to mental health, they are fairly narrow in scope. Behavioral health conditions are highly prevalent in the Medicaid population, yet they go undiagnosed and untreated far too often, warranting more comprehensive screening. They present serious health conditions in and of themselves, while also acting as major and costly barriers to adequate health care access and delivery. MAP suggests that development of a composite measure of mental health screening would be a first step in helping to address this disparity issue—the next step being to link individuals who screen positively to an adequate system of care. The suggested state-level composite measure should include a wide variety of conditions, including depression, schizophrenia, and anxiety disorders. Comments also suggested that CMS consult the Substance Abuse and Mental Health Services Administration's most recent draft of the National Behavioral Health Quality Framework as a source for aligned measures.

MAP noted an additional gap area related to structural measures of access to care. As large numbers of vulnerable individuals gain Medicaid coverage or transition to new delivery models, access will remain a fundamentally important policy issue. In addition, measures of access also touch on key issues related to healthcare disparities and cultural competency. The CAHPS survey in the Core Set contains items related to individuals' experiences accessing care; this data could prove very useful to states seeking to establish a baseline level of performance and evaluate improvement over time.

MAP members and public commenters also discussed social determinants of health and their strong effects on Medicaid enrollees and other types of vulnerable beneficiaries. MAP shares the general view that the health system is not doing enough to address modifiable risk factors upstream and support overall wellness. Stronger partnerships are needed to improve public health outcomes. Short of that, measuring variability in states' provision of wrap-around support services may illustrate marked differences in beneficiaries' ability to access needed supports. These include enrollment assistance and benefit navigation, specialized services for individuals with disabilities, transportation, and translation services.

Finally, and perhaps most importantly, the field lacks performance measures that evaluate goal-directed, person-centered care and outcomes that matter to individuals enrolled in Medicaid. MAP members remarked on the clinical orientation of the measure set and its inability to gauge fundamental concepts such as functional status and quality of life. MAP perceived use of CAHPS survey tools as the bare minimum standard for monitoring and understanding beneficiaries' experience. Comments further noted the importance of developing measures that assess whether individuals feel like they have a say in their own care, whether their rights are respected and promoted, and whether they are well integrated into the larger community. MAP strongly encourages CMS to pursue development activities in these topic areas.

Measure-Specific Recommendations

Application of the MAP MSC also generated a series of measure-specific recommendations to immediately strengthen the Medicaid Adult Core Set. Several relate to MSC #1 and the general principle that the best available NQF-endorsed measures are strongly preferred for use in program measure sets. For measures that have not been endorsed or have had endorsement removed, CMS should consider updates or possible substitutions as detailed below. MAP recommends that Core Set measures not specifically discussed below remain unchanged.

NQF #0031: Breast Cancer Screening

Discussion: Breast Cancer Screening has lost NQF endorsement since the Medicaid Adult Core Set was published. Since that time, the measure steward, the National Committee on Quality Assurance (NCQA), has completed an update of the measure that incorporates new clinical practice guidelines and has included new specifications in the 2014 HEDIS manual. NCQA plans to submit the revised measure at the next endorsement review opportunity offered by NQF.

Recommendation: MAP requires the use of NQF-endorsed measures in program sets, if available, because of their recognized rigor. While this measure is not currently endorsed, MAP supports continued focus on breast cancer screening. MAP recommends that CMS use the most current version of the measure in the Medicaid Adult Core Set and encourages NCQA to submit the updated measure for NQF endorsement. One comment further supported this recommendation.

NQF #0403: Annual HIV/AIDS Medical Visit

Discussion: Annual HIV/AIDS Medical Visit has lost NQF endorsement since the Medicaid Adult Core Set was published. Endorsement was removed during the measure's most recent maintenance review. The measure steward, NCQA, has no intention to edit and resubmit the measure.

Recommendation: In cases when a measure has lost endorsement and it is not updated or replaced, use of the measure should stop. Such a measure should be replaced in the program set by a superior measure on the same topic. HIV/AIDS is a high-impact condition in the Medicaid population and MAP recommends that CMS consider another NQF-endorsed HIV/AIDS measure as a replacement. MAP strongly supports use of measure #2082: Viral Load Suppression because it is a highly meaningful and regularly collected clinical indicator that is predictive of overall outcomes. This measure is also perceived as relatively less burdensome for data collection because it can be drawn from administrative data. The workgroup also supported #2083: Prescription of HIV Antiretroviral Therapy Regardless of Age as a possible alternative.

One comment noted that it is challenging to identify individuals with HIV and ensure that they receive treatment, suggesting a measure of early diagnosis as an alternative to the outcome-oriented measures. Another comment voiced support for use of #2083: Prescription of HIV Antiretroviral Therapy Regardless of Age.

NQF #0021: Annual Monitoring for Patients on Persistent Medications

Discussion: Annual Monitoring for Patients on Persistent Medications has lost NQF endorsement since the Medicaid Adult Core Set was published. The steward, NCQA, withdrew this measure from consideration during its most recent maintenance review. NCQA has not yet determined whether they will revise and resubmit the measure.

Recommendation: The measure should be updated or replaced with an endorsed measure on the same topic. Medication management is critical to achieving high quality care and good health outcomes; measures of this process are therefore very important quality indicators. Measurement should reflect frequent beneficiary-provider interactions and a shared decision-making process about medication choices. Measures that assess a single point in time, one condition, or only one prescription will fail to reflect the quality of attention being paid to medication management in states' Medicaid programs. Unfortunately, currently endorsed measures on this topic tend to focus on single medications (e.g., warfarin) or an older population (65+) and are not as appropriate as the original measure for a broad-based program like the Medicaid Adult Core Set. MAP recommends that CMS retain the measure in the set for the time being, monitor measure development in this topic area, and update or replace the measures as soon as a suitable alternative is available.

A comment from the Pharmacy Quality Alliance suggested several specific measures as possible substitutes. The suggested measures are NQF-endorsed, in use by the Medicare Part D Star Ratings program, and are derived from claims. However, each one is focused on a single condition (e.g., diabetes, asthma, cardiovascular disease).

NQF #0039: Flu Shots for Adults Ages 50-64

Discussion: Flu Shots for Adults Ages 50-64 excludes Medicaid enrollees 18-49, a large portion of the Medicaid population. The Centers for Disease Control and Prevention (CDC) recommends that all adults receive annual vaccination against the flu. Moreover, pregnant women, older adults, and people with certain chronic conditions or disabilities are at higher risk of poor outcomes if they become infected with influenza.

Recommendation: MAP recommends that the measure be expanded to include all adults. The measure steward, NCQA, has completed an update of the measure that broadens the denominator age group to include all individuals age 18 and older and has included new specifications in the 2014 HEDIS manual. MAP strongly encourages NCQA to submit the new specifications to NQF during the measure's annual update process. MAP further recommends that CMS use the most current, expanded version of the measure in the Medicaid Adult Core Set.

Comments also supported expansion of the measure's age range as a way to bolster influenza immunization rates in the Medicaid population. Comments also noted concern that references in the measure to flu "shots" were too limiting given the availability of other modes of vaccination such as

nasal spray. Adoption of the measure specifications in the 2014 HEDIS set would address this concern as the measure is now titled "Flu Vaccinations for Adults Ages 18-64."

Other comments stated that this measure is burdensome to health plans as it is difficult to obtain complete data due to patients receiving vaccinations from a variety of sources that are not captured by administrative claims data. NQF notes that the final notice announcing the Core Set described this measure as being collected as part of the HEDIS CAPHS Supplemental Survey. If that is still the case, potential weakness in the measure is more likely to stem from respondents recall ability than it is from health plans' incomplete data. MAP encourages CMS to devote further attention to this feasibility issue once the first round of data from states is available.

NQF# 1690: Adult Body Mass Index (BMI) Assessment

Discussion: Adult Body Mass Index (BMI) Assessment has not been NQF-endorsed. The steward, NCQA, withdrew this measure from consideration during the endorsement process and intends to revise and re-submit the measure for future NQF review.

Recommendation: The measure should be updated or replaced with an endorsed measure on the same topic. Obesity is common in the Medicaid population, and MAP recommends that CMS consider an NQF-endorsed measure as a replacement if NCQA's update is not forthcoming. MAP specifically supports use of measure #0421: Preventive Care and Screening: BMI Screening and Follow-Up, as an alternative. This NQF-endorsed measure complies with the current USPSTF recommendations. Moreover, it is possible to collect measure #0421 from administrative claims data or electronic medical records, an important consideration for the feasibility of implementing this measure in the Medicaid Adult Core Set.

Comments cautioned that Adult BMI Assessment is burdensome to health plans as it requires electronic health record data extraction or medical chart review. CPT-II codes are available for use; however, industry experience shows that codes are not always submitted. Comments also supported MAP's suggestion of an alternative measure.

NQF #1768: Plan All-Cause Readmissions

Discussion: There is not a risk adjustment methodology for the Medicaid population in Plan All-Cause Readmissions. Risk adjustment is necessary to fairly interpret measure results. Without it, one cannot determine if differences in performance are due to overall quality, the characteristics of the denominator population, or randomness due to availability of data and collection methods and extrapolation for analysis. The health of the adult Medicaid population has been shown to be significantly different than the general population and justifies use of an appropriate risk adjustment methodology.

Recommendation: MAP stressed the importance of risk adjustment for the Medicaid population and strongly supports CMS' planned effort to work with the measure steward to develop a Medicaid-specific methodology. Comments underscored MAP's recommendation. MAP also encourages CMS to consider other potential applications of this work to other measurement programs for the Medicaid population.

NQF #0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Discussion: NQF #0647: Transition Record with Specified Elements Received by Discharged Patients and NQF #0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) are paired measures; however, only #0648 is included in the Medicaid Adult Core Set. Safe and effective care transitions after discharge from a hospital environment are highly dependent upon many levels of communication. Transition records need to be effectively shared with providers receiving the hand-off as well as individuals being discharged and their families and caregivers. Participants in the review noted that these measures are specified for the facility level of analysis and therefore are more challenging to collect than those designed for populations or health plans. CMS noted that they are aware of the difficulties and view Timely Transmission of Transition Record as a "stretch" or "aspirational" measure but want to encourage states to build the relationships with providers that are necessary to collect and report this measure.

Recommendation: CMS should consider adding Transition Record with Specified Elements Received by Discharged Patients to the measure set. Doing so would enhance person-centeredness and may also improve the feasibility of data collection for Timely Transmission of Transition Record. MAP noted that these paired measures do not fully address the important issues of care coordination or care management, however Timely Transmission of Transition Record is the only measure in the Medicaid Adult Core Set that directly assesses care coordination, and so it should be preserved.

Because the current care coordination measure is known to be very challenging to implement, MAP discussed the possibility that adding a second similar measure may have limited utility. Comments also remarked upon the burden associated with collecting this measure. However, MAP would prefer that states be encouraged to collect the paired measures and that CMS support their efforts to do so. In the event that more meaningful and/or more feasible measures of care coordination are identified, MAP would support their substitution for the paired measures related to communication upon discharge.

III. Future Activities

In the coming months, CMS and its technical assistance team will work with participating states to complete the first submission of performance measure data to CMS. This data is scheduled to be made publicly available by September 30, 2014. CMS is also planning to begin measure development activities in 2014, moving one step closer to making new measures available to fill key gaps in the Core Set.

MAP will have the opportunity to conduct a second review of the Medicaid Adult Core Set in mid-2014. NQF and MAP will continue to work closely with CMS and its technical assistance providers to monitor implementation challenges and further opportunities for strengthening the Core Set. At the request of MAP members, NQF will support future deliberations by gathering information on data collection methodologies and their relative feasibility at the state level, the testing of scientific properties of any measures altered after endorsement, how states are acting on the performance data they collect to improve quality, and plans for public reporting.

Alignment across programs will continue to be an important theme for MAP's second review of the Medicaid Adult Core Set. Specifically, MAP will examine the Core Set's relationship to the to the Children's Health Insurance Program Reauthorization Act (CHIPRA) Core Set of Children's Health Care

Quality Measures to assess comprehensiveness and alignment between the two programs. MAP will seek lessons learned from the development and implementation of the CHIPRA Core Set and identify best practices that can be generalized to the Medicaid Adult Core Set. In addition, a close comparison of the two program measure sets will provide a more complete picture of the measures available to assess the critical areas of maternity care and birth outcomes.

Appendix A: Initial Core Set of Measures for Medicaid-Eligible Adults

On January 4, 2012, HHS published a final notice in the *Federal Register* to announce the initial core set of health care quality measures for Medicaid-Eligible adults. The table below lists the measures included in the Core Set along with their current NQF endorsement number and status. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's Quality Positioning System.

Measure # and NQF Endorsement Status	Measure Title	Measure Steward
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA
0006 Endorsed	CAHPS Health Plan Survey v 4.0 - Adult questionnaire	AHRQ
0007 Endorsed	NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)	NCQA
0018 Endorsed	Controlling High Blood Pressure	NCQA
0021 Endorsement Removed	Annual monitoring for patients on persistent medications	NCQA
0027 Endorsed	Medical Assistance With Smoking and Tobacco Use Cessation	NCQA
0031 Endorsement Removed	Breast Cancer Screening	NCQA
0032 Endorsed	Cervical Cancer Screening	NCQA
0033 Endorsed	Chlamydia screening in women [ages 21-24 only]	NCQA
0039 Endorsed	Flu shots for Adults Ages 50 and Over	NCQA
0057 Endorsed	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	NCQA
0063 Endorsed	Comprehensive Diabetes Care: LDL-C Screening	NCQA
0105 Endorsed	Antidepressant Medication Management	NCQA
0272 Endorsed	Diabetes Short-Term Complications Admissions Rate (PQI 1)	AHRQ
0275 Endorsed	Chronic obstructive pulmonary disease (PQI 5)	AHRQ
0277 Endorsed	Heart Failure Admission Rate (PQI 8)	AHRQ
0283 Endorsed	Asthma in Younger Adults Admission Rate (PQI 15)	AHRQ
0403 Endorsement Removed	HIV/AIDS: Medical Visit	NCQA
0418 Endorsed	Screening for Clinical Depression	CMS
0469 Endorsed	PC-01 Elective Delivery	The Joint Commission
0476 Endorsed	PC-03 Antenatal Steroids	The Joint Commission
0576 Endorsed	Follow-Up After Hospitalization for Mental Illness	NCQA
0648 Endorsed	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	AMA-PCPI
1517 Endorsed	Prenatal & Postpartum Care [postpartum care rate only]	NCQA
1690 Not Endorsed	Adult BMI Assessment	NCQA
1768 Endorsed	Plan All-Cause Readmissions	NCQA
1879 Endorsed	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	CMS

Appendix B: Roster for the MAP Dual Eligible Beneficiaries Workgroup

CHAIR (VOTING)
Alice Lind, MPH, BSN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	Gwendolen Buhr, MD, MHS, MEd, CMD
America's Essential Hospitals	Steven Counsell, MD
Center for Medicare Advocacy	Alfred J. Chiplin, JD, MDiv
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE
L.A. Care Health Plan	Jennifer Sayles, MD, MPH
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Substance Abuse	Mady Chalk, MSW, PhD
Disability	Anne Cohen, MPH
Emergency Medical Services	James Dunford, MD
Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Medicaid ACO	Ruth Perry, MD
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Jamie Kendall, MPP

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Substance Abuse and Mental Health Services Administration	Lisa Patton, PhD
Veterans Health Administration	Daniel Kivlahan, PhD

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

Appendix C: Roster for the MAP Coordinating Committee

CO-CHAIRS (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Gerry Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip Kahn
LeadingAge	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Shari Davidson
National Partnership for Women and Families	Representative to be determined
Pacific Business Group on Health	William Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher Dezii, RN, MBA,CPHQ

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

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Gail Janes, PhD, MS
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Health Resources and Services Administration (HRSA)	John E. Snyder, MD, MS, MPH (FACP)
Office of Personnel Management/FEHBP (OPM)	Edward Lennard, PharmD, MBA
Office of the National Coordinator for HIT (ONC)	Representative to be determined

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

Appendix D: Public Comments Received on Draft Report

Comment Category	Commenter Name and Organization	Comment
Comments on Population, Program, or MAP's Approach	Carmella Bocchino America's Health Insurance Plans	While we recognize that the current measure set represents a starter set, we would like to encourage CMS to adopt measures that take into account social determinants of health (e.g. education and income) as these factors are important for the Medicaid population.
Comments on Population, Program, or MAP's Approach	Thomas James AmeriHealth Caritas	AmeriHealth Caritas appreciates the opportunity to comment. We agree that the Medicaid population is a special, vulnerable population for which specific measures recognizing the complex social, behavioral, and physical issues are important. The MAP approach to this population was appropriate however due to truncated timelines, AmeriHealth Caritas is concerned that the Work Group was unable to devote the effort toward more in-depth consideration of the impact of social and behavioral forces; nor separate out the different health pattern needs of the non-elderly disabled, CHIP, and the new populations joining via the Marketplace. We encourage a greater exploration of measures to adequately describe the health conditions of the various populations within Medicaid in order to strengthen the Medicaid adult core measure set. Additional comments on areas not addressed in the report but have operational impacts on measure capture: IT: One issue not address in the MAP's recommendations includes IT platform variation. The various states have different IT platforms, different fields in reporting, and gather much of their quality data in different fashions making comparisons across states not valid. Behavioral health: Many states carve out pharmacy, mental health and dental from medical so that measures of medication persistence or follow-up from mental health may not be valid.

Comment Category	Commenter Name and Organization	Comment
Comments on MAP's General Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Phyllis Arthur Biotechnology Industry Organization	The Biotechnology Industry Organization (BIO) appreciates the opportunity to comment on the report entitled: Measure Applications Partnership: Expedited Review of the Core Set of measures for Medicaid-Eligible Adults. BIO represents more than 1,100 biotechnology companies, academic institutions, state biotechnology centers and related organizations across the United States and in more than 30 other nations. BIO members are involved in the research and development of innovative healthcare, agricultural, industrial, and environmental biotechnology products. BIO membership includes both current and future vaccine developers and manufacturers who have worked closely with the public health community to support policies that help ensure access to innovative and life-saving vaccines for all individuals. We feel that the development and testing of quality measures for immunizations across the life span will have a significant impact on immunizations rates for all. BIO strongly supports expansion of NQF #0039 to include Medicaid enrollees ages 18-49 as a way to bolster influenza immunization rates in this population. We are concerned, however, that references in the measure specification to flu "shots" could be misinterpreted as limiting the use of the measure to influenza vaccinations delivered via injection. As NQF may be aware, influenza vaccines are available in alternate routes of administration, including a nasal spray. To ensure that the measure does not inadvertently limit patient access to a choice of routes of administration, we recommend that NQF ensure that references throughout the measure specification refer to "influenza vaccination," rather than "flu shot," and that any other parameters that could be misread as referring only to injectable influenza vaccines are similarly revised. Use of the term "vaccination" is consistent with terminology in the HEDIS 2014 Summary Table of Measures, Product Lines and Changes (see page 7 http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2014/List%20of%20HEDIS%202014%20Measures.pdf.) Conclusion: BIO appreciates the opportunity to comment on this important set of measures. Please do not hesitate to contact us for further information or clarification of our comments. Thank you for your attention to this very important matter.

Comment Category	Commenter Name and Organization	Comment
Comments on MAP's General Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Thomas James AmeriHealth Caritas	We have comments under several categories: Disparities of care: None of the 26 measures address disparities of care despite the availability of such measures in the NQF portfolio and inclusion within the MAP Measure Selection Criteria. AmeriHealth Caritas recommends MAP re-evaluate the inclusion of measures that address disparities of care. CAHPS Survey: The listed CAHPS Health Plan Survey measure includes Version 4.0 whereas health plans are currently on Version 5.0. We encourage MAP to revise listing to include Version 5.0. OB Measures: We support inclusion of the two OB measures in the core measure set, and urge MAP to consider measures specific to premature deliveries, where this is of greater concern for the Medicaid population. Such measures as percent of women delivering at term would be important to include within the core measure set. Determinants of health: The core measure set includes measures that improve health outcomes for chronic conditions such as heart disease and diabetes; however there is no inclusion of measures for the social determinants of health, something especially important for this population. Measures such as NQF #0011 Oregon's Promoting Health Development Survey would be models for future measure development. Risk adjustment: There are measures for which health plans do not have data (e.g. flu shots) and ones where it is very much dependent upon which Medicaid programs are enrolled by any one health plan. For example, the TANF population is quite different than the ABD population, so comparing health plans (or providers who see one group disproportionately) can give a biased view of quality. There must be risk adjustment if the measures are to be meaningful.
Comments on MAP's General Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Carmella Bocchino America's Health Insurance Plans	We believe that NQF-endorsed measures should be used to the extent possible, however, in clinical areas where NQF-endorsed measures are not available, we support the use of alternative measures while those measures are considered for NQF endorsement. Additionally, every effort needs to be made to minimize burden of data collection. Measures collected via administrative methodologies should be prioritized over measures that require hybrid data sources – administrative and medical chart review data. While a single measure that requires chart review may not significantly increase burden, a collection of measures that use hybrid data sources can add tremendous burden to providers and health plans. The burden associated with a given measure set needs to be assessed, e.g., using a gradient or scale, prior to implementation. As health information technology is broadly adopted, measures that rely on clinical data sources can be added, if captured in the electronic medical record or other systems, such as clinical registries.

Comment Category	Commenter Name and Organization	Comment
Comments on MAP's Measure-Specific Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Kathy Gans-Brangs AstraZeneca	Page 7: Flu Shots for Adults Ages 18-49. MedImmune, Specialty Care Division of AstraZeneca strongly supports expansion of NQF #0039 to include Medicaid enrollees ages 18-49 as a way to bolster influenza immunization rates in this population. We are concerned, however, that references in the measure specification to flu "shots" could be misinterpreted as limiting the use of the measure to influenza vaccinations delivered via injection. As NQF may be aware, influenza vaccines are available in alternate routes of administration, including a nasal spray. To ensure that the measure does not inadvertently limit patient access to a choice of routes of administration, we recommend that NQF ensure that references throughout the measure specification refer to "influenza vaccination," rather than "flu shot," and that any other parameters that could be misread as referring only to injectable influenza vaccines are similarly revised. Use of the term "vaccination" is consistent with terminology in the HEDIS 2014 Summary Table of Measures, Product Lines and Changes (see http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2014/List%20of%20HEDIS%202014%20Measures.pdf, page 7).
Comments on MAP's Measure-Specific Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Thomas James AmeriHealth Caritas	Seven measures were specifically called out on by the MAP Work Group: • NQF #0031 Breast Cancer Screening—AmeriHealth Caritas supports this measure • NQF #0403 Annual HIV/AIDS Medical Visit—We agree with the Work Group that of the NQF endorsed HIV measures #2083 Prescription of HIV Antiretroviral Therapy is the best measure as it counts visits and Rx. • NQF #0021 Annual Monitoring of patients of persistent medications—We agree with the Work Group that this measure looks at Medicaid enrollees with chronic conditions on long-term therapy. • NQF #0039 Flu Shots for Adults Ages 50-64—We disagree with this measure because of the variety of sources of flu shots so data is not easily available, requiring chart review; and the importance of this measure for this population may be less than other measures especially the AFDC subpopulation. • NQF #1690 Adult Body Mass Index Assessment—We agree with the work group that this is not a good measure for a Medicaid measure. Other measures of obesity management may have a greater impact • NQF #1769: Plan All-Cause Readmission—Considering the wide variations in Medicaid subgroups, this measure is not helpful since it is not risk adjusted • NQF #0648 Timely Transmission of transition records—This is very important but is not part of data captured by Medicaid nor health plans. It is appropriate at the IDS or facility level as recommended

Comment Category	Commenter Name and Organization	Comment
Comments on MAP's Measure-Specific Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Carmella Bocchino America's Health Insurance Plans	*NQF #0403: Annual HIV/AIDS Medical Visit* - We are supportive of the MAP recommendation as it relates to the inclusion of HIV/AIDS as a high-impact condition in the Medicaid population; however, we are concerned with MAP's recommendation to replace #0403 (Annual HIV/AIDS Medical Visit) with #2082 (Viral Load Suppression) or #2083 (Prescription of HIV Antiretroviral Therapy Regardless of Age). Significant barriers currently exist with being able to identify patients with HIV and to ensure that they seek treatment. Given these challenges, initial measurement could focus on early diagnosis and receipt of care, rather than measuring optimal treatment. *NQF #0039: Flu Shots for Adults Ages 50-64* – This measure is burdensome to health plans as it is difficult to obtain complete data due to patients receiving vaccinations from a variety of sources that are not captured by administrative claims data. *NQF #1690: Adult Body Mass Index (BMI) Assessment)* – While we recommend using the updated version of this NCQA measure once it has been revised, we caution that this measure is burdensome to health plans as it requires electronic health record data extraction or medical chart review. CPT-II codes are available for use; however, industry experience shows that codes are not always submitted. Until the updates on #1690 are completed, we recommend using a currently available measure on this same topic. *NQF #0648: Timely Transmission of Transition Record* –This measure is important for the Medicaid population, as they are highly dependent on communication among facilities, providers, and families or caregivers. Industry experience shows that health plans use this measure in pay-for-performance programs; however, as a hospital-centric measure it is burdensome and difficult to collect as it may require electronic health record data extraction or medical chart review.

Comment Category	Commenter Name and Organization	Comment
General Comments	E. Clarke Ross American Association on Health and Disability	AAHD has coordinated our comments with Leo Cuello, workgroup member and National Health Law Project (NHeLP); Jamie Kendall and Shawn Terrill, Administration for Community Living (ACL); and Maureen Fitzgerald, the Arc and a co-chair of the Consortium for Citizens with Disabilities (CCD) Task Force on Long Term Services and Supports. As observed by the NHeLP, we 1. Commend the general recommendation for broader mental health screening (2nd para page 6). 2. Commend the access to care concept (3rd para page 6). 3. Commend but needed are expansions to patient-centeredness (4th para page 6). 4. Need for more care coordination measures and acitivites (in context of #0648, page 8), and tying this to care management for vulnerable populations. 5. Need to more explicitly address Gaps. As discussed on the September 27 call: The NQF tentative report attempts to address a major CMS omission - the consumer (patient) experience. CAPHS and the findings from the CMS HCBS experience survey, when available, should be stressed in the report. [Although, the disability community has concerns with the prohibition of proxy responses for some individuals in the HCBS experience survey.] Page 6 of the public comment document acknowledges a major gap: "goal-directed, person-centered care, and outcomes that matter to individuals enrolled in Medicaid." We commend the observation and ask that this acknowledgement also expressly "include a focus on community integration." We believe that a frequent medication monitoring process be expected. Page 7 of the public comment document recommends an "annual" medication monitoring. This is not sufficient. We do not have a suggested alternative measure but this an annual requirement is inadequate. We believe that the Medicaid adult measures must reference the July-August NQF recommended 15 starter-set measures for persons dually eligible for Medicare and Medicaid. NQF and CMS should clearly explain why any of these 15 measures are not appropriate for inclusion in the Medicaid adult measures. We reinforce the observations made on our September 27 call: The NQF report should emphasize personal experience, personal preference, functional status, community integration, social determinants of health, and why the mental health measures were narrowly focused on a few distinct diagnoses. We appreciate that page 6 of the public comment document identified most these area as gaps. We suggest that the NQF and CMS measures reference and use the SAMHSA behavioral health quality framework. However, the SAMHSA framework contains many of the same gaps and omissions contained in these measures.

Comment Category	Commenter Name and Organization	Comment
General Comments	Thomas James AmeriHealth Caritas	AmeriHealth Caritas appreciates the opportunity to reinforce our belief that Measures of Quality, especially for vulnerable populations must address the five determinants of population health (as adapted from Beltran VM et al, Public Health Reports, 126, Sup 3 Pg41, 2011): Biology and Genetics (Gender, ethnicity, intellectual, behavioral and physical conditions, etc.) Individual Behavior (risky behaviors) Social determinants of health (education, income, discrimination, etc.) Physical Environment (Safety, crowding, exposures) Access to appropriate health services, including physical and behavioral. The five determinants are cross functional with impacts on one determinant coming from others. These Adult Core Measures for Medicaid address only number 5 (access to appropriate health services), placing results of the efforts by physicians, hospitals, health plans and other providers as dependent upon the other for determinants. MAP should encourage the development of measures for communities to address how they can manage their own populations.

Comment Category	Commenter Name and Organization	Comment
General Comments	Emily Spitzer National Health Law Program	The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We write to provide comments to the draft report "Expedited Review of the Initial Core Set of Measures for Medicaid-Eligible Adults." In addition to our comments, provided below, we would like to support the recommendations regarding annual medication monitoring (annual is insufficient), measurement gaps, and SAMHSA's behavioral health quality framework filed on behalf of the American Association on Health and Disability. We strongly commend the general recommendation, on page 6 of the report, for measures of broader mental health screening. We believe this is critical because mental health conditions are insufficiently diagnosed (and treated), they present serious health conditions in and of themselves, and they act as a major and costly barrier to adequate physical and functional health care access and delivery. We also strongly commend the general recommendation, on page 6, for measures related to access to care. Such measures are vital to assessing systemic causes of health disparities and will be particularly important as large numbers of vulnerable enrollees transition to new care management models changing the way care is accessed. With delivery system reform, we must be able to answer the question: are people accessing the care they need? Similarly, we strongly support the general recommendation, on page 6, for measures that promote patient-centeredness. We urge development of measures that assess whether individuals feel like they have a say in their own care, whether their rights are respected and promoted, and whether they are well integrated into the larger community. We also believe that patient-centered care is a gateway to achieving other challenging health system objectives, such as promoting quality of life and maximizing function. The discussion of measure #0648 on page 8 raises the broad concern about whether we have the measurement tools to effectively measure care coordination. We agree that, in the narrow but important context of discharges, it is also important to provide consumers (in addition to providers) with a timely transition record – we support this recommendation and believe it is a prerequisite to providing patient-centered care. But we also agree that even both the provider and consumer measures together represent only a small piece of the care coordination puzzle. Millions of vulnerable Medicaid enrollees are being transitioned into new care management models, and we desperately need measures to assess whether their care is being well-managed. If new delivery systems achieve savings, we need broad care coordination measures which can tell us whether the savings are the result of care efficiently coordinated or repeatedly denied. While this is a core set for "adults" broadly, we believe great care coordination measures would benefit all Medicaid recipients, particularly seniors and persons with disabilities who may have complex medical conditions that need well-coordinated care to be well managed.

Comment Category	Commenter Name and Organization	Comment
General Comments	Emily Spitzer National Health Law Program	[continued] Finally, we urge aggressive focus on measures targeting the many measurement gaps that exist today. Some of these have already been alluded to above. But it bears repeating that millions of consumers will undergo major changes to their health care delivery, and to the extent measurement can protect them, we urge the MAP to address measure gap areas including: care coordination, access to care, patient experience, patient-centeredness, patient preferences, functional status, community integration, quality of life, and broad screening and treatment for mental health needs. In sum, we are encouraged that many issues that are important to health care consumers are addressed in the draft report, and we hope our suggestions will be of use for addressing additional issues in on-going measure development. Thank you for consideration.

Comment Category	Commenter Name and Organization	Comment
General Comments	Julie Kuhle on behalf of Laura Cranston Pharmacy Quality Alliance, Inc.	The Pharmacy Quality Alliance (PQA) appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) Expedited Review of the Medicaid Adult Core Set of Measures. Established in 2006, PQA is a multi-stakeholder, consensus-based membership organization that collaboratively promotes appropriate medication use and develops strategies for measuring and reporting performance information related to medications. Assessment of quality in medication use and management throughout the healthcare delivery continuum leads to improved health. With only two NQF endorsed measures in the Initial Core Set having a focus on medication use (Adherence to Antipsychotics for Individuals with Schizophrenia and Antidepressant Medication Management), PQA suggests that the MAP consider the following additional medication measures. • Certain measures included in the original list of 43 measures that did not make the final Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid should be reconsidered for inclusion. PQA recommends adding three PQA and NQF-endorsed medication adherence measures: Adherence to Renin Angiotensin System (RAS) Antagonists, Adherence to Oral Medications for Diabetes and Adherence to Statin Medications. These measures are focused on cardio-vascular disease, are NQF-endorsed and are used by CMS in the Medicare Part D Star Ratings program. Other measures for consideration include the following: • NQF endorsed measure - Appropriate Treatment of Hypertension in Patients with Diabetes assesses the percentage of patients who are receiving appropriate therapy per the American Diabetes Association guidelines with either an ACE-Inhibitor, ARB or direct renin inhibitor medication. • NQF endorsed measure - Medication Therapy for Persons with Asthma. Two measures have been developed for patients with asthma to assess the percentage of patients with suboptimal asthma control and percentage of patients lacking controller therapy. All above PQA measures are calculated using prescription claims data and therefore add little to the burden of data collection. PQA uses a rigorous consensus-driven process to develop, test, and endorse high-priority measures of medication-use quality. We would welcome the opportunity to discuss the inclusion of the PQA measures in the Adult Medicaid Core Set of measures.

Appendix E: The Adult Medicaid Population

Since 1965, Medicaid has been an important source of health coverage for low-income adults and children. Following Medicaid expansion under the Affordable Care Act (ACA), enrollment is projected to rise from 15 percent of the country's population in 2010 to 25 percent in 2020.[1] At last count (2009), 62.7 million people were covered by Medicaid, including 30.7 million children, 16.3 million adults, and 15.6 million elderly or disabled individuals.[2]

Average Medicaid spending per enrollee varies sharply by eligibility group. In 2009, average annual payments totaled $2,300 per child, $2,900 per non-elderly adult, $15,840 per disabled enrollee, and $13,150 per elderly enrollee.[3] While non-elderly, non-disabled adults consume relatively fewer resources than individuals who receive long-term supports and services, their healthcare needs can still be significant. In particular, adults' access to high-quality preventive care and chronic disease management can greatly affect lifetime health outcomes.

MAP considered the overall health status of adult Medicaid enrollees and conditions that are common in the population to ensure that measures in the Adult Core Set were appropriately tailored. Overall, it is important to note that approximately one in five adults younger than 65 on Medicaid reports fair or poor physical health; approximately one in seven reports fair or poor mental health.[4,5] In addition, Medicaid plays a dominant role in covering reproductive health services. Nearly two in three adult women on Medicaid are in their reproductive years (19-44) and an estimated 48 percent of births in the U.S. were paid for by Medicaid in 2010.[6] Finally, an estimated 57% of adults covered by Medicaid are overweight, diabetic, hypertensive, have high cholesterol, or a combination of these conditions.[7]

New adult Medicaid enrollees have a slightly different profile, and MAP also considered this in its review. Potentially eligible adults under ACA expansion are projected to have better or equal health status than current enrollees, with lower rates of obesity and depression.[8] However, the prevalence of other behavioral health conditions may be higher. In addition, 49% of potentially eligible adults report using tobacco and 22% report high or moderate alcohol use.[9] These use rates are significantly higher among new enrollees than current enrollees and underline the importance of addressing these and other modifiable risk factors.

MAP also considered demographic factors and social determinants of health. Adults covered by Medicaid tend to be non-white, unmarried, and to have less than a high school level of education.[10] Medicaid enrollees are affected by disparities in health and healthcare, often facing barriers to accessing needed services.

Appendix F: Overview of the Medicaid Adult Core Set Program

Statutory Authority

The Affordable Care Act (ACA, section 1139B) requires that the Secretary of HHS identify and publish for public comment a recommended initial core set of health care quality measures for Medicaid-eligible adults.[11] The statute requires the initial core set to be comprised of "existing adult health care quality measures in use under public and privately sponsored health care coverage arrangements or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time and that may be applicable to Medicaid-eligible adults."[12]

To assess the quality of care for adults enrolled in Medicaid, the law calls for HHS to:

1. Develop a standardized reporting format for the core set of measures;
2. Establish an adult quality measurement program;
3. Issue an annual report by the Secretary on the reporting of adult Medicaid quality of care information and a Report to Congress every three years; and
4. Publish updates to the initial core set of adult health quality measures that reflect new or enhanced quality measures.[13]

Process for Compiling the Initial Core Set of Measures for Medicaid-Eligible Adults

In 2010, the Centers for Medicare & Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ), and developed a subcommittee to the National Advisory Council for Healthcare Research and Quality. The subcommittee was charged with considering the health care quality needs of adults ages 18 and older enrolled in Medicaid. Members represented a broad range of experts and stakeholders, including multiple individuals who also serve on MAP.

The subcommittee focused on four dimensions of health care related to adults enrolled in Medicaid: adult health, maternal/reproductive health, complex health care needs, and mental health and substance use. Starting from approximately 1,000 measures drawn from nationally recognized sources, the group deliberated and identified 51 measures for public comment.

Public comments commonly remarked upon the large size of the measure set and suggested that it be aligned with existing reporting programs to reduce data collection and reporting burden. Other, less frequent comments suggested: 1) avoiding measures that require medical record review, 2) using only measures endorsed by NQF, 3) re-examining the appropriateness of some proposed measures, and 4) including measures related to the topics of patient safety and rehabilitation. Additionally, comments cumulatively suggested that 43 measures be considered for addition to the set, many of which had been previously considered.

Following public comment, CMS considered how to reduce the size of the measure set utilizing five criteria identified based on NQF's endorsement criteria: importance, scientific evidence supporting the measure, scientific soundness of the measure, current use in and alignment with existing Federal programs, and feasibility for state reporting. In January 2012, CMS published the final rule with a total of 26 measures for voluntary use by states as the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid.[14]

State Experience in Collecting the Medicaid Adult Core Set Measures: Adult Medicaid Quality Grants

CMS has identified a three-part goal for this quality reporting program: increasing the number of states reporting Medicaid Adult Core Set measures, increasing the number of measures reported by each state, and increasing the number of states using Core Set measures to drive quality improvement.

To assist in understanding how well the Medicaid Adult Core Set measures and their technical specifications could be collected by states, CMS launched a two-year grant program in December 2012. All state were given an opportunity to participate, and grants were made to 26 Medicaid agencies for the development of staff capacity to collect, report, and analyze data on the Medicaid Adult Core Set. In addition, the grantees are required to conduct two quality improvement projects using measures from the Core Set. States receive technical assistance and analytic support as part of the grant program.

The 26 grantee states collectively enroll approximately 23 million adults, roughly 69% of the adults currently in Medicaid. Non-grantee states are also encouraged to voluntarily report the Medicaid Adult Core Set measures. Broad participation in the program will provide better understanding of the experience of applying measures and allow for sharing of best practices among state Medicaid agencies.

Early feedback from the grantees has provided better understanding of the feasibility of implementing the measures in the Medicaid Adult Core Set. Specific challenges have included reporting physician-level and hospital-level measures at the state level, difficulties with measures that require medical record review, and the need for more detailed and straightforward technical specifications. Grantee feedback will continue to be monitored and shared with MAP for future decision-making.

Future Activities

Voluntary reporting of Medicaid Adult Core Set measure data to CMS is scheduled to begin at the end of 2013.[15] By January 1, 2014, HHS will annually publish recommended changes to the Core Set that reflect the results of the testing, validation, and consensus process for the development of adult health quality measures. By September 30, 2014, HHS will collect, analyze, and make publicly available the information reported by the states as required in section 1139B(d)(1) of the Act.[16] HHS will also include information on adult health quality in a mandated report to Congress, to be published every 3 years in accordance with the statute.

Appendix G: MAP Measure Selection Criteria

(Version used at time of Workgroup Review)

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 to 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.

Criteria

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.

Sub-criterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need
Sub-criterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs
Sub-criterion 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:

Sub-criterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

Sub-criterion 2.2 Healthy people/healthy communities, demonstrated by prevention and well-being

Sub-criterion 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.

Sub-criterion 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)

Sub-criterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Sub-criterion 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)

Sub-criterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program.

Sub-criterion 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.

Sub-criterion 4.1 In general, preference should be given to measure types that address specific program needs

Sub-criterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

Sub-criterion 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

Sub-criterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

Sub-criterion 5.2 Measure set addresses shared decision-making, such as for care and service planning and establishing advance directives

Sub-criterion 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).

Sub-criterion 6.1 Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

Sub-criterion 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.

Sub-criterion 7.1 Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)

Sub-criterion 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 [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

References

[1] Center for Health Care Strategies. *Toward 2014: Perspectives on Shaping Medicaid's Future*. May 2013. Available at http://www.chcs.org/usr_doc/Medicaid_Matters_130514.pdf. Last accessed September 2013.
[2] Kaiser Commission on Medicaid and the Uninsured. *Medicaid Primer: Key Information on the Nation's Health Coverage Program for Low-Income People*. March 2013. Available at http://kff.org/medicaid/issue-brief/medicaid-a-primer/. Last accessed September 2013.
[3] *Ibid*.
[4] Medicaid and CHIP Payment and Access Commission (MACPAC). *Report to Congress on Medicaid and CHIP*. June 2012. Available at http://www.macpac.gov/reports. Last accessed September 2013.
[5] Kaiser Family Foundation: Low-Income Adults Under Age 65-Many are Poor, Sick, and Uninsured, June 2009. Available at http://kff.org/health-reform/issue-brief/low-income-adults-under-age-65-many-are-poor-sick-and-uninsured/. Last accessed September 2013.
[6] Markus AR, et al. "Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform." Women's Health Issues 23.5 (2013): e273-e280.
[7] Government Office on Accountability: Study on Medicaid Preventive Services, August 2009.
[8] Chang T and Davis M. "Potential Adult Medicaid Beneficiaries Under the Patient Protection and Affordable Care Act Compared with Current Adult Medicaid Beneficiaries." *Ann Fam Med* September/October 2013 vol. 11 no. 5 406-411.
[9] *Ibid.*
[10] MACPAC. Report to Congress on Medicaid and CHIP. June 2012.
[11] Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults. *Fed Regist*. 2012;77(2):286-291. Available at http://www.gpo.gov/fdsys/pkg/FR-2012-01-04/html/2011-33756.htm. Last accessed September 2013.
[12] *Fed Regist*. 2012;77(2):286-291.
[13] Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services (CMS). *Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2013*. Baltimore, MD:CMS; 2013. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-%E2%80%93PM-Adult-Health-Care-Quality-Measures.html. Last accessed September 2013.
[14] *Fed Regist*. 2012;77(2):286-291.
[15] Quality of Care. Medicaid.gov. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Quality-Grants-FAQ.pdf. Last accessed September 2013.
[16] *Fed Registr*. 2012;77(2):286-291.

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Contract HHSM-500-2012-00009I
Task order 11

ISBN 978-1-933875-56-9