Strengthening the Medicaid and CHIP (MAC) Scorecard

FINAL REPORT

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NATIONAL QUALITY FORUM

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EXECUTIVE SUMMARY

Medicaid and the Children's Health Insurance Program (CHIP) cover 73 million lives or roughly 23 percent of the United States population.[1] Nearly 51 percent of individuals enrolled in Medicaid and the Children's Health Insurance Program (CHIP) are children, and approximately two-thirds of women enrolled in Medicaid are in their child-bearing years.[1,2] Both programs are responsible for delivering healthcare to a significant proportion of Americans, and especially to those who are among the most economically and medically vulnerable including low-income children and the elderly, and persons with marked disability.[3]

Many federal efforts and programs promote quality of care and health for the Medicaid population. In June 2018, the Centers for Medicare and Medicaid Services (CMS) released its first version of the Medicaid and CHIP (MAC) Scorecard.[4] The Scorecard is designed to increase the public's access to performance data for the Medicaid and CHIP programs including health outcomes experienced by enrollees.[5] The Scorecard has three pillars, each consisting of a set of measures selected to reflect the performance of the units that support the Medicaid and CHIP programs: state health system performance, state administrative accountability, and federal administrative accountability.

NQF convened the multistakeholder MAC Scorecard Committee, charged with providing input on the pre-populated Scorecard version 1.0 for the state health system performance pillar. Specifically, the Committee was tasked with determining which measures should be recommended for addition to—and removal from—the current version of the Scorecard. In an effort to facilitate adoption and implementation of the Scorecard, the state pillar draws on measures from the Medicaid Adult and Child Core Sets. This pillar is designed to examine how states serve Medicaid and CHIP beneficiaries throughout different measurement domains including, but not limited to, Communicating and Coordinating Care, Reducing Harm Caused in Care Delivery, and Making Care Affordable.

The Committee first evaluated the current measures in the state health system performance pillar of the Scorecard to identify high need and gap areas such as behavioral health. Subsequently, the Committee assessed measures in the 2018 Adult and Child Core Sets to identify potential measures to recommend for addition to the Scorecard in future iterations. The Committee recommended one measure for removal, *Use of Multiple Concurrent Antipsychotics: Ages 1-17,* and the addition of four measures listed below in order of priority (Exhibit ES1). These measures would strengthen the measure set by promoting measurement of high-priority quality issues and addressing childhood immunization, preventive care for children, and behavioral health. At the request of CMS, additions were limited to the Core Sets only.

EXHIBIT ES1. MEASURES RECOMMENDED BY THE MAC SCORECARD COMMITTEE FOR THE MAC SCORECARD 2.0

Rank	NQF Number and Measure Title
1	1448 Developmental Screening in the First Three Years of Life
2	1768 Plan All-Cause Readmissions
3	0038 Childhood Immunization Status
	*Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

*The Adult Core Set and MAC Scorecard include the NCQA version of this measure, which is adapted from the CMS measure (NQF 1879).

Public commenters unanimously supported three of the four measures recommended for addition to, removal from, or retention on the Scorecard. However, NQF 2940 *Use of Opioids at High Dosage in Persons Without Cancer*—which was recommended by the Committee for retention—received comments both in support of and against retaining the measure on the Scorecard.

The MAC Scorecard Committee also discussed the future direction of the Scorecard and provided guidance on future measure set curation, as well as best practices to promote reporting. The Committee emphasized the importance of harnessing performance measurement results to drive health system change and improvements in care delivery. In order to promote measure reporting, the Committee suggested that states implement payment incentives or leverage value-based payment models in the Scorecard's early stages of development. Given the new and iterative nature of the Scorecard, the Committee encouraged the Center for Medicaid and CHIP Services (CMCS) to structure the Scorecard's evolution in two phases focused on refinement and feedback. In the short term, the Committee emphasized the importance of refinement to optimize the Scorecard measure set. For the long term, the Committee recommended that CMCS solicit and leverage continuous feedback and performance data from states to prioritize use of measures that have the greatest utility.

In general, public commenters echoed the recommendations of the Committee. They reiterated the need for alignment and parsimony by emphasizing fewer, but more cross-cutting high impact measures that address the lifespan of Medicaid and CHIP beneficiaries. They also suggested a re-evaluation of how measures are selected for the Scorecard. Issues related to system performance evolution were further discussed with key informants, including Medicaid Medical Directors on the Committee, and the Committee at large. However, the Committee did not put forth formal decisions and recommendations during these conversations.

BACKGROUND

As of October 2018, approximately 73 million people were enrolled in Medicaid and CHIP, 66 million enrolled in Medicaid, and 6.5 million enrolled in CHIP.[1] Approximately one in seven adults (19 to 64 years of age) are covered by Medicaid, and nearly 51 percent of individuals enrolled in Medicaid and CHIP are children. Roughly two-thirds of women enrolled in Medicaid are in their child-bearing years.[1,2] Medicaid covers approximately 45 percent of all births and nearly 23 percent of the entire population. The program plays a dominant role in covering socially and medically vulnerable populations including 61 percent of U.S. nonelderly persons earning less than 100 percent of the federal poverty level (FPL), 83 percent of children in families below that same FPL, 62 percent of nursing home residents, and 45 percent of nonelderly adults with a disability.[3] Moreover, Medicaid, compared to private insurance and Medicare, has long been disproportionately responsible for treating persons with some of the most debilitating and chronic conditions including major mental and substance use disorders.[6,7] The program thus plays a substantial role in maintaining our nation's health.[2]

The Center for Medicaid and CHIP Services (CMCS) is the principal federal agency responsible for the operations of Medicaid and CHIP.[8] Because the program is administered jointly with each state, CMCS works closely with states to structure and monitor Medicaid and CHIP benefits, which typically include a broad (but locally diverse)

array of medical and related services, covering preventive services, mental health and substance use disorders, maternal and infant health, and services for children who need early and periodic screening, diagnostic, and treatment (EPSDT) services.[9] CMCS employs multiple mechanisms for monitoring the service delivery, health, and well-being of its beneficiaries. For example, the Adult and Child Core Sets of measures were identified to provide the health system with information it needs to monitor quality and undertake improvement activities when needed. The newest mechanism for monitoring service delivery is the MAC Scorecard which draws from measures in the Medicaid Adult and Child Core Sets. The Scorecard Committee's recommendations will be considered for implementation in Scorecard version 2.0, expected to roll out in fall 2019.

Use of the MAC Scorecard

In June 2018, CMCS released the first version of the MAC Scorecard.[4] The MAC Scorecard is designed to increase public transparency and accountability for Medicaid and CHIP outcomes while enabling states and CMS to collaboratively improve healthcare outcomes and program administration.[5] The MAC Scorecard is a public reporting mechanism not driven by statue. It includes measures voluntarily reported by states as well as federally reported measures in three main focus areas also known as pillars: state health system performance, state administrative accountability, and federal administrative accountability.

The MAC Scorecard Committee is charged with exploring the Adult and Child Core Sets and determining which measures should be recommended for addition to—and removal from—the MAC Scorecard's state health system performance pillar. This pillar is designed to demonstrate state performance on meeting the healthcare needs of Medicaid and CHIP beneficiaries through various measurement domains, which focus on key elements of care delivery including care coordination and reducing harm. This work is designed to build upon a flexible framework which will facilitate seamless expansion or reduction of measures on the Scorecard. The pillar further aims to promote the evolution of the Scorecard through incremental changes that will foster analysis of trends.

The MAC Scorecard state health system performance pillar contains 13 measures, which are categorized into six domains (**Appendix D**):

- Promote Effective Communication and Coordination of Care
- Make Care Safer by Reducing Harm Caused in the Delivery of Care
- Promote Effective Prevention and Treatment of Chronic Diseases
- Strengthen Engagement in Care
- Make Care Affordable
- Promoting Communities of Healthy Living

The MAC Scorecard version 1.0 contains seven Adult Core Set measures and six Child Core Set measures (**Appendix E**). Of the 13 measures, eight are process measures; two are outcome measures; and one is a patient experience of care measure. Ten measures are assessed using administrative claims, six using electronic clinical data, and one using survey data. The composition of the MAC Scorecard aims to represent a diverse and balanced set of measures that address health and well-being across an individual's lifespan.

APPROACH

The National Quality Forum (NQF), in collaboration with the Center for Medicaid and CHIP Services (CMCS), launched the Medicaid and CHIP (MAC) Scorecard project in September 2018. NQF convened a Committee of Medicaid and measurement experts along with key stakeholders to explore which Medicaid- and CHIP-relevant measures can be used to support the MAC Scorecard's state health system performance pillar. MAC Scorecard Committee members were charged with considering existing measures for removal from the MAC Scorecard version 1.0 and evaluating relevant Medicaid and CHIP Adult and Child Core Set measures for potential addition to future versions.

The MAC Scorecard Committee largely comprises members drawn from the 2018 Medicaid Adult and Child Workgroups. The MAC Scorecard Committee has 38 members, including 15 organizational representatives, 19 subject matter experts, and four nonvoting federal liaisons. The Committee reflects the diversity of the Medicaid populations and has relevant interests and expertise in Medicaid and CHIP. It includes patient representatives, Medicaid providers, and state Medicaid directors (**Appendix A**).

For the purposes of this effort, NQF-endorsed measures are preferred because they have successfully undergone a consensus-based review process for importance—specifically evidence and scientific acceptability—amongst other rigorous criteria. The Committee's measure recommendations were further informed by NQF's Measure Selection Criteria (MSC) (**Appendix B**), a defined decision algorithm (**Appendix C**), the 2018 Adult and Child Core Sets, and the most recent available Core Set reporting data from states (FFY 2017).

The Committee reviewed the measures in the Child and Adult Core Sets as a source of measures to provide recommendations to strengthen the MAC Scorecard in support of CMCS' goals for the program. The MSC provide key considerations to guide measure selection decisions. The decision algorithm created by NQF is a summary profile of each measure under consideration. Both the MSC and the decision algorithm are intended to serve as a starting point for stakeholder deliberations and discussions.

In preparation for Committee deliberations, NQF staff compiled measure specifications of all Child and Adult Medicaid Core Set measures. Using the decision algorithm as a guide, Committee members submitted recommendations to NQF staff for addition or removal of measures from the MAC Scorecard. During the January 10-11, 2019 in-person meeting, the Committee discussed six measures recommended by individual members. All measures recommended for addition must address one or more of the State Health System Performance Pillar domains, be reported by 25 or more states, and fill a gap area on Scorecard version 1.0. This report summarizes the MAC Scorecard Committee's measure recommendations for MAC Scorecard version 2.0 as well as strategic considerations to strengthen future iterations of the Scorecard with an over-riding goal of proffering recommendations that can drive improvement in the Medicaid program's overall performance.

COMMITTEE REVIEW AND RECOMMENDATIONS

The MAC Scorecard Committee considered several measures during the in-person meeting and prioritized those that address critical areas in the Medicaid population. One such priority area included early childhood developmental screenings. The Committee identified these screenings as highly impactful for children and recognized the opportunity for improvement. In 2016, the median state percentage of children who received developmental screenings was just 36 percent. Moreover, screening rates varied greatly among states. Alaska reported that 1.6 percent of children received developmental screenings while 77.5 percent of children in Massachusetts received similar screenings.[10]

The Scorecard Committee also focused on the importance of monitoring immunization rates among children. According to figures from the Centers for Disease Control and Prevention (CDC), Medicaid beneficiaries consistently fall below the national average for recommended vaccines.[11] With respect to the adult population, the Scorecard Committee recognized the importance of selecting measures that address behavioral health (mental health and substance use disorders) for which Medicaid serves as the substantial payer of services.[12] Recent analysis from the Kaiser Family Foundation shows that in 2014—after the Affordable Care Act's (ACA) Medicaid expansion—Medicaid paid for 25 percent and 21 percent of the nation's mental health and substance use disorder expenditures, respectively. Moreover, that analysis demonstrated that nearly half of all Medicaid dollars go to behavioral health services because the program is disproportionately responsible for treating persons with the most severe forms of such illnesses.[6,13]

Despite the preference for NQF-endorsed measures, the Committee recognizes that not all measures on the Child and Adult Medicaid Core Sets or MAC Scorecard are endorsed. Currently, the Scorecard is populated by the Child and Adult Medicaid Core Sets measures. However, the Committee acknowledged that continuous monitoring of new measures in the development pipeline is necessary to ensure that process measures are replaced with more outcome-based measures, as they become available, for the success of future iterations of the Scorecard.

Measure-Specific Recommendations

The Committee considered the FFY 2018 Adult and Child Medicaid Core Sets when making recommendations for potential removal from or addition to the MAC Scorecard. During measure discussions, Committee members considered many factors, including whether measures address the diverse health needs of the Medicaid population and the most vulnerable among them, drive improvements in healthcare quality, and reduce or minimize reporting burden. Committee members considered measures for addition that directly address the usefulness of measure implementation and reporting. Given the recency of the Scorecard's creation, the Committee also considered the application of measures in the Scorecard and the consequences or implications of accountability.

The Committee recommended one measure for removal and four measures for addition. Below are the Committee's measure-specific recommendations. **Appendix E** provides details on the measures recommended for addition and the measure recommended for removal; in addition, it lists recommended measures and those that did not meet requirements for discussion during the in-person meeting. **Appendix F** lists other

individual recommendations for addition and removal that were discussed but did not pass the consensus threshold (>60 percent of voting members) to gain support or conditional support for addition to and/or removal from the Scorecard.

The MAC Scorecard Committee discussed six measures for potential removal, but ultimately recommended only one measure for removal from the MAC Scorecard: *Use of Multiple Concurrent Antipsychotics: Ages 1-17*. The Committee considered the following factors regarding measure removals:

- Consistently high levels of performance (e.g., >95 percent), indicating little opportunity for additional gains in quality (i.e., topped out measures)
- Changes 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
- Existence of superior measure(s) on the same topic have become available, and a substitution would be warranted

The Committee weighed in on the importance of maintaining the balance of measures within each of the domains addressed by the Scorecard (i.e., ensuring each domain is populated with an acceptable quality measure). They also acknowledged the importance of fostering stability of the composition of measures on the Scorecard from year to year, especially as the measure set evolves, thereby allowing for longitudinal data collection, managing burden, and supporting analysis of trends over time.

Public comments supported the Committee's decisions and recommendations. Public commenters unanimously supported the majority of measures recommended for addition to and/or removal from the MAC Scorecard. However, NQF 2940 *Use of Opioids at High Dosage in Persons Without Cancer* received comments both in support of and against the Committee's decision to retain the measure on the Scorecard. Additionally, general comments submitted reiterated the following gaps in the Scorecard for future consideration: experience of care, long-term services and supports, maternal and child health, mental health and substance use, and disparities measures. Commenters also called for outcome based rather than process or structural measures- on the state Scorecard.

Recommended for Removal

Use of Multiple Concurrent Antipsychotics: Ages 1-17 (Not NQF-endorsed)

This measure assesses the percentage of children and adolescents ages 1-17 who were treated with antipsychotic medications (i.e., "dopamine regulators") and who were apparently taking two or more different antipsychotic medications for at least 90 consecutive days during the measurement year. The Scorecard Committee agreed that the rationale given by the 2016 NQF Pediatric Standing Committee to not endorse this measure still holds true today. In 2016, the Pediatric Standing Committee voted to not endorse this measure due to concerns that the measure inappropriately discourages polypharmacy use which might be efficacious in rare instances. The latest performance results of the measure are reported at a median of 3 percent (lower scores represent better performance). Moreover, Committee members noted that this measure leaves little room for improvement. Committee members agreed that the overall goal for the Scorecard, and public reporting in general, is to drive performance improvement. The Committee also expressed concern that prescribing rates are proximal to an outcome and that measuring the desired outcome for this target population is a better indicator of quality of care. Therefore, the Committee recommended that this measure be removed from the Scorecard.

Considered but Not Recommended for Removal

As mentioned above, the Scorecard Committee discussed five additional measures for removal but ultimately did not recommend their removal. This section provides the rationale for not recommending the removal of the five measures.

NQF 1517 Prenatal and Postpartum Care: Postpartum Care (Not NQF-endorsed)

This process measure assesses the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. In spring 2018, the American College of Obstetricians and Gynecologists (ACOG) released a new guideline recommending that all women have contact with their obstetric care providers within the first three weeks postpartum.[14] Committee members agreed that having a measure that does not align with the guidance issued to practitioners is problematic. The National Committee for Quality Assurance (NCQA) (the measure developer) is scheduled to revisit the postpartum care timing to align with guidelines. Any changes made to the measure would be implemented in the Healthcare Effectiveness and Information Set (HEDIS™) 2020. This is an access and availability of care measure which assesses whether a visit occurred according to guideline recommendations. Committee members noted that "ideal" improvements to the measure would yield data on access to care, effectiveness of care, maternal depression, and postpartum contraception. The Committee recommends that CMS maintain this measure as a placeholder while NCQA updates the measure to comport with ACOG's recent guidelines. Furthermore, maintaining this measure on the Scorecard, while waiting for a comprehensive measure to be developed, conveys the importance of maternal health for the Medicaid population.

NQF 1392 Well-Child Visit: First 15 Months

NQF 1392 assesses the percentage of children 15 months old who had well-child visits with a primary care physician during the measurement year. Although recommended for removal by one Committee member, the majority of the Committee supported this measure for continued use on the Scorecard. Committee members agreed that this measure applies to all children and therefore decided to keep it on the Scorecard. The Committee also highlighted that the variability among states indicates regional gaps in performance and further supports the Committee's preference for not removing the measure.

Adolescent Well-Child Visit: Ages 12 through 21 (Not NQF-endorsed)

This measure assesses the percentage of adolescents ages 12 to 21 who had a least one comprehensive well-care visit with a primary care practitioner or OB/GYN practitioner during the measurement year. The Committee noted that there remains a dearth of measures that target this age group specifically. The state Medicaid representatives on the Committee noted that this is a critical access to care measure that marks whether a well-care visit was accessed by a population that lacks screening and preventive care. Additionally, variability exists between the states, indicating a significant performance gap. Therefore, the Committee supported the continued use of this measure on the Scorecard.

NQF 2940 Use of Opioids at a High Dosage in Persons without Cancer

The Committee agreed that addressing the opioid crisis on the Scorecard is of high importance. Additionally, various government agencies are beginning to hold state Medicaid programs accountable for opioid use amongst beneficiaries. Given the current national opioid crisis in the U.S., the Scorecard Committee agreed to keep the measure on the Scorecard until a better outcome-based measure is available while signaling the significance of addressing this issue on the Scorecard. Committee members questioned whether a dosage of 120mg per day is an appropriate cutoff for this measure, and expressed that they would like to see more alignment with guidelines and/or evidence-based

dosage information. In response to this concern, the developer acknowledged that the measure dosage lacked a robust evidence-base, and they are now aligning the measure with CDC guidelines as one approach to address this concern. One state representative commented that NQF 2940 might mistakenly capture therapeutic use of narcotics for opioid use disorder (buprenorphine, methadone, etc.); however, the developer clarified that such medication-assisted treatment (MAT) for opioid use disorder is not a part of the numerator calculation for this measure. Another member noted that the measure is limited because it only addresses legal supply and does not address illegal distribution. Ultimately, the Committee noted that NQF 2940 is a suitable measure that captures the opioid crisis at multiple levels. A few Committee members noted that more measures are currently being developed in this space.

NQF 0018 Controlling High Blood Pressure, Ages 18 to 85

NQF 0018 is an outcome measure that assesses the percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year based on specified criteria. Although one Committee member recommended removal, the majority of the Committee agreed that the incidence and prevalence of high blood pressure in the Medicaid population is very high, and having an outcome measure that assesses blood pressure control is necessary. Therefore, maintaining this measure on the Scorecard highlights a gap area, mainly chronic care, and underscores an opportunity for improvement. Additionally, Committee members noted that the measure is already included in various accountability programs, and highlighted the value of aligning the MAC Scorecard measures with other federal programs.

Recommended for Phased Addition

The Scorecard Committee recommended that CMCS consider four measures for phased addition to the MAC Scorecard (Exhibit 1, below, and **Appendix E**). These measures passed the consensus threshold (≥60 percent of voting members) to gain the group's full support.

The Scorecard Committee recommended measures that they determined to address high-priority gap areas such as behavioral health and transitions of care/care coordination. The Committee also recommended measures to address the dearth of child measures on the Scorecard. The Committee targeted its efforts to align to these and other gap areas, but they also aimed for measure parsimony to minimize the data collection and reporting burdens that measurement can impose upon state health authorities. The Committee voted to include measures that focus on high-priority areas in Medicaid and CHIP programs, promote quality improvement efforts, and increase general accountability. The Committee unanimously agreed that the set should remain as small as possible and include measures that are relevant across the life span of the Medicaid population.

To help prioritize recommendations to CMCS, the Scorecard Committee rank ordered the measures they supported and recommended for addition, from most (1) to least important (3). The Committee's measure-specific recommendations for addition are described below.

EXHIBIT 1. MEASURES RECOMMENDED FOR PHASED ADDITION TO THE MAC SCORECARD

Rank*	NQF Number and Measure Title
1	1448 Developmental Screening in the First Three Years of Life
2	1768 Plan All-Cause Readmissions
3	0038 Childhood Immunization Status
	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

* 1 = most important, etc.

** The Adult Core Set and MAC Scorecard include the NCQA version of this measure, which is adapted from the CMS measure (NQF 1879).

NQF 1448 Developmental Screening in the First Three Years of Life (Not NQF-endorsed)

The Committee ranked this measure as having the highest priority of the four measures recommended to CMCS. NQF 1448 *Developmental Screening in the first Three Years of Life* assesses the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool. This measure lost NQF endorsement in 2017 because the developer withdrew it from NQF's measure maintenance process. Committee members' concerns were alleviated once the developer noted that even though funding to support maintenance through NQF's process is unavailable, the measure is being maintained, and CMS's contractor is updating the technical specifications on an annual basis. Committee members commented that this measure is of vital importance because of the downstream consequences of not capturing developmental delays in a timely manner. If kids are not screened for developmental, behavioral, and social delays, it is highly unlikely that they will receive early intervention. One member commented that kids with remediable developmental delays who are not screened and provided interventions require more resources as they progress into adolescence. Therefore, neglecting developmental delays early in life can result in costly morbidity later in life. Committee members noted operational challenges related to collecting and reporting this measure that cause burden for states. One Committee member noted that to effectively collect and report data at a population level, a state must retrieve data from medical records. This data has not been integrated into a standardized screen in electronic health records (EHRs). The Committee agreed that addition of this measure to the Scorecard could potentially have a large impact on the development of children.

NQF 1768 Plan All-Cause Readmissions

The Scorecard Committee believes that NQF 1768 is important for the Medicaid population because it promotes care coordination between acute care facilities and post-acute care settings. One Committee member commented that the measure aligns with many Medicaid requirements, such as assessing care needs prior to admission, transitions of care planning, readmission prevention planning, and discharge planning. Other Committee members noted that the measure helps to encourage both clinical and other health system-related (e.g., social supportive) resources to improve outcomes, and that it represents a good indicator for care coordination between physical and behavioral health.

NQF 0038 Childhood Immunization Status

The prioritization exercise ranked this measure as third for CMCS' consideration for addition to the Scorecard; this measure tied in ranking with *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*. The Scorecard Committee agreed that a measure that assesses the percentage of children who have been immunized is critical to ensure preventive care and to foster both child and population health. NQF 0038 assesses the percentage of children two years of age who had the following vaccines by their second birthday: four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus 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). The measure calculates a rate for each vaccine. The Committee acknowledged data source challenges, noting that immunization tracking systems vary by state, and that data are not as easily collected as when chart and claims reviews were the only information sources. Despite data source challenges, the Committee recommended the addition of this measure to the Scorecard because it addresses a gap area (screening and preventive care) and fulfills a national quality improvement need.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) (Not NQF-endorsed)

Tied for third place for CMCS' consideration for addition to the Scorecard, this measure assesses the percentage of beneficiaries age 19 to 64 with schizophrenia who were dispensed or remained on an antipsychotic medication for at least 80 percent of their treatment period during the measurement year. The Committee noted that this measure targets a high-cost, high-risk population. The Committee agreed that nonadherence is a huge problem in the treatment for schizophrenia and is linked to poor clinical outcomes, increased hospitalizations and emergency department visits, noncompliance with outpatient psychosocial treatment, violent behavior, higher risk for alcohol and other substance use dependence, and increased cognitive and functional impairment. In addition to the experiences that the state Medicaid representatives shared during the meeting, several Committee members commented that evidence-based studies have shown that adherence is strongly linked to improved outcomes in both mental and general physical health (e.g., adherence correlates with fewer hospitalizations for diabetes). Despite the fact that schizophrenia is a relatively rare condition, the Committee considered this measure particularly important because the disorder is chronic and severe relative to other illnesses. The Committee further noted that the high prevalence of serious mental illnesses in the adult Medicaid population justifies the addition of this behavioral health measure to the MAC Scorecard. A few members also noted that this population is a huge user of Long-Term Services and Supports (LTSS) services. Thus, the addition of this measure would indirectly promote the use of LTSS services to address some of the needs of this high morbidity and often neglected population.

Considered But Not Recommended for Addition

The Scorecard Committee's rationales for not recommending the following measures are described below.

NQF 0105 Antidepressant Medication Management

A consensus was not achieved to add NQF 0105. Members commented that there are several options for treating depression, and medication is only one modality of treatment. Moreover, as a matter of patient choice, Medicaid beneficiaries may choose to switch to other modalities after medication has been initiated, making this measure difficult to interpret. Additionally, members agreed that adding *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* would add greater value to the Scorecard compared to NQF 0105, especially since medication adherence for schizophrenia is the "gold standard" of care. The heterogeneity of response and modalities of treatment makes this measure a poor candidate for the Scorecard.

NQF 0139 Pediatric Central Line-Associated Bloodstream

This measure assesses the standardized infection ratio (SIR) and adjusted ranking metric (ARM) of healthcare-associated, central line-associated bloodstream infections (CLABSI) calculated among patients in inpatient care locations. Data for this measure are obtained from CDC National Healthcare Safety Network. The Committee unanimously agreed to not recommend the addition of this measure to the Scorecard. While the Committee appreciated the value of this measure for a small subset of hospitalized patients, they ultimately decided it is more appropriate for hospital-based quality improvement efforts rather than state performance efforts related to the Medicaid and CHIP populations.

LEVERAGING MAC SCORECARD MEASURES TO IMPROVE HEALTH SYSTEM PERFORMANCE

The MAC Scorecard Committee deliberated on ways of leveraging data and measure reporting to drive health system-level change in care quality and health outcomes. The discussion primarily focused on the novelty and scope of the Scorecard as well as potential ways to develop and maximize the utility of the Scorecard as a flexible tool for state-level quality improvement.

MAC Scorecard: System Performance Evolution

Given the newness of the Scorecard, snapshots of actual use of this tool rely on data collected through other quality improvement efforts such as measures used in the Medicaid Adult and Child Core Sets. However, Medicaid Core Set data are based on voluntary state reporting, whereas the MAC Scorecard will likely evolve into a mandatory public reporting tool. Accordingly, the Committee spent much time discussing the complementary and competitive boundaries between both efforts, with an over-riding goal of harmonizing them towards local and national Medicaid program optimization.

The Committee discussion included broad considerations such as the power of measurement as a change-inducing, quality improvement lever along with practical issues such as Scorecard gaps and size. CMS representatives noted that the current iteration of the Scorecard is an evolving tool undergoing continual change and modification, and the Committee discussed the Scorecard's impact on utility in light of this circumstance.

Public commenters echoed Committee discussions and highlighted the need to finalize and communicate near and long-term accountability definitions and implementation plans with regards to the Scorecard. They also emphasized the need for alignment to specified prevention and treatment goals and parsimony by emphasizing fewer, more cross-cutting high-impact measures that address the lifespan of Medicaid and CHIP beneficiaries. Goals of alignment and parsimony led the Committee to suggest recurrent evaluations of how measures are selected and implemented.

Issues related to system performance evolution were further discussed with key informants, individuals who represented Medicaid Medical Directors on the Committee, and the Committee at large. However, the Committee did not put forth formal decisions and recommendations during these conversations. Instead, the Committee highlighted the need to consider expanding and/or changing the measure selection criteria, thereby increasing the potential measure pool and allowing states to address their unique population needs. Additionally, the Committee expanded on the accountability discussions and suggested that accountability for the Scorecard should go beyond current legal obligations such as the *Americans with Disabilities Act* and focus on two sets of measures: fundamental measures required of all states, and a pick list of flexible measures to be adapted differentially by states. The latter set would allow states to address their unique population needs while the former fundamental set will allow for comparison across states. Finally, the Committee suggested that accountability should be shared by providers, health plans, and states, since they share a substantial fiduciary and direct role in accounting for the care and management of Medicaid beneficiaries.

Regulatory Enforcement

The Committee acknowledged that systems-level change in performance is precipitated through fundamental considerations that cross

the spectrum of care delivery within Medicaid from primary to tertiary prevention and treatment efforts. One such lever discussed for change management was regulatory requirements that mandate data collection, thereby allowing for comparative analysis both within and across states. Regulatory requirements also were cited as promoters of continuous data collection which then allows for trend analysis as a catalyst for continuous quality improvement.

Based on the discussion, the Committee members agreed that mandatory measurement and public reporting are useful as a mechanism of change within and across states as well as across health plans in defined geographic areas. For example, future mandatory measurement of the Child Core Set and behavioral health measures from both Adult and Child Core Sets will not only promote data collection, but also will facilitate comparative analysis. As states start to report on measures in the Scorecard, data collected over time will reflect the evolution of public reporting as well as highlight trends in quality improvement in real time. The Committee also advised CMCS to improve the utility of the Scorecard by curating measures focusing on gap areas such as LTSS, primary care services, and outcome measures. The Committee also highlighted the need to incorporate measures into the scorecard with attention to the burden of collecting data for multiple measures, focusing on outcomes, as well as incentivizing quality improvement efforts beyond data collection.

The Committee noted that the goal of any Scorecard should transcend measurement science by explicitly coupling it to quality improvement activities. Therefore, quality improvement efforts need to identify issues related to quality and develop solutions to problems. Together, these two activities will help promote improvement in care quality. However, Committee members noted that the Scorecard measures are value-focused by design and thereby function as quality indicators of related care delivery components such as providers, plans, and communities.

The Committee suggested that CMS consider incentivizing measurement with financial assistance and or payment penalties to advance beyond data collection and reporting. Medicaid Directors who have successfully used financial incentives as a vehicle for improving Medicaid care quality put forth this suggestion. Care quality can improve either by using specific focus efforts such as individual measures or by using a set of measures and/or broadly tracking disease/condition-based endpoints. CMS representatives acknowledged that aligning federal reporting programs is one of their priorities along with investigating ways to increase quality improvement efforts related to the Scorecard. Furthermore, CMS noted that public reporting is only one piece of the quality improvement effort and that the Scorecard has two other pillars that are not in the purview of this Committee.

Leveraging Data for Change

The Committee agreed that the success of the MAC Scorecard lies in the ability of measures to capture representative samples at the appropriate level of analysis (e.g., provider, managed care organization, clinic) and care setting (e.g., inpatient, outpatient, ED, specialty clinic). Committee members argued that while data for the Scorecard are typically coalesced by state action/mandate, the greatest opportunity for improving the quality of healthcare delivery is likely at the provider and health plan level. The Committee acknowledged that data collection for quality measurement is resource-intensive and potentially quite burdensome. However, when paired with quality improvement efforts, such data can serve as a powerful tool in improving overall care quality, including enhancement in delivery efficiency. The group also emphasized that given the number of reporting requirements at the state level, some of which are duplicative and overlapping, alignment of federal reporting programs will enable reporting and quality improvement without an accompanying increase in burden at the state level.

Future Direction for the MAC Scorecard

The Committee also sought to provide perspectives and recommendations for future iterations of the Scorecard. The Committee suggested that CMS approach the Scorecard evolution in two phases by compartmentalizing efforts and creating goals for the short and the long term. In the short term, they suggested a focus on finalizing and optimizing the current Scorecard version with updates. Additionally, CMS was advised that subsequent versions of the Scorecard should address the Committee's broader recommendations as well as other stakeholder input provided over time. The Committee suggested that the Scorecard's role in quality should be rooted in processes such as curating an appropriate mix of measures for optimal results. At the same time, usability of the Scorecard at the state level should be enhanced via continual review. The evolutionary ideal is to use actual Scorecard results to review trends and ultimately to reshape the Scorecard such that it optimizes use (e.g., feedback to consumers) and usability (i.e., discernable changes in quality). To facilitate such a review in the most comprehensive way practical, the Committee suggested that CMS should encourage broad annual feedback from experts and stakeholders based on the regular release of summarized (but fully transparent) data.

CONCLUSION

Medicaid and CHIP cover 73 million lives, at an annual cost of approximately $600 billion. In order to drive improvements in healthcare outcomes for roughly one-quarter of the United States population, including a majority of the nation's most medically and socially vulnerable citizens, CMCS released a multifaceted measure set: the MAC Scorecard. NQF convened the MAC Scorecard Committee to evaluate the MAC Scorecard version 1.0 and provide measure recommendations for addition and removal. The Committee's recommendations were informed by NQF's Measure Selection Criteria (MSC) (**Appendix B**), a defined decision algorithm (**Appendix C**), the 2018 Adult and Child Core Sets, and the most recently available Core Set reporting data from states (FFY 2017).

The Committee reiterated the need for prioritization of utility, parsimony, and appropriate curation of the measures in the Scorecard as necessary steps in maximizing health system change through data collection and analysis. The Committee also discussed gap areas and high need areas as part of the broader discussion related to the evolution and growth of the Scorecard.

The MAC Scorecard Committee recommended that CMCS consider the phased addition of the following four measures (in order of priority): NQF 1448 *Developmental Screening in the First Three Years of Life,* NQF 1768 *Plan All-Cause Readmissions,* NQF 0038 *Childhood Immunization Status,* and *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD).* Phased addition entails introducing measures one by one to spread out implementation challenges. In an effort to thoughtfully curate the current Scorecard as well as promote alignment and parsimony, the Committee recommended that CMCS consider the removal of the following measure: *Use of Multiple Concurrent Antipsychotics: Ages 1-17*.

Based on the recent development of the Scorecard, the Committee suggested that CMS focus on maintaining and evolving an appropriate set of measures which are useful and flexible within and between states (i.e., those that encourage national goals, but leave room for locally tailored quality improvement as well). CMS was advised to use the Scorecard to trigger regulatory levers such as value-based payments that facilitate substantive quality improvement efforts, beyond just data collection. Committee members emphasized the need to undertake efforts that enhance the utility and functionality of the Scorecard such as short-term and long-term changes, alignment across federal programs, and prevention and therapeutic goals, as well as accountability targets that explicitly list who is responsible for which metrics along with the consequences of meeting (or failing to meet) benchmarks on those indicators.

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APPENDIX A:
Roster for the MAC Scorecard Committee and NQF Staff

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APPENDIX B:
MAP Measure Selection Criteria

The Measure Selection Criteria (MSC) are intended to assist the Committee with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they provide general guidance on measure selection decisions and complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address health system improvement priorities, 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 actively promotes key healthcare improvement priorities, such as those highlighted in CMS' "Meaningful Measures" Framework

Demonstrated by a program measure set that promotes improvement in key national healthcare priorities such as CMS' Meaningful Measures Framework.

Other potential considerations include addressing emerging public health concerns and ensuring the set addresses key improvement priorities for all providers.

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

Demonstrated by a program measure set that is "fit for purpose" for the particular program

Subcriterion 3.1 Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)

Subcriterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Subcriterion 3.3 Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

Subcriterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program

Subcriterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

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

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

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

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

Subcriterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

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

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

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

Subcriterion 5.2 Measure set addresses shared 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

APPENDIX C:
Medicaid Preliminary Analysis Algorithm

NQF staff provided a preliminary analysis of all measures under consideration using the Preliminary Analysis Algorithm derived from the Measure Applications Partnership (MAP) Measure Selection Criteria to support the Committee's review of potential measures. The table below summarizes the preliminary analysis criteria applied.

Assessment	Definition
The measure addresses a critical quality objective not adequately addressed by the measures in the program set.	• The measure addresses key healthcare improvement priorities such as CMS' Meaningful Measures Framework; 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/consumers and providers, and/or addresses a high-impact area or health condition.
The measure is evidence-based and is either strongly linked to outcomes or is an outcome measure.	• 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.
The measure addresses a quality challenge.	• 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.
The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.	• 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
The measure can be feasibly reported.	• 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 is applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)	• 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.
If a measure is in current use, no negative unintended issues to the patient have been identified.	• Feedback from implementers or end users has not identified any negative unintended consequences to patients (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and • Feedback is supported by empirical evidence.

APPENDIX D:
Characteristics of the Current MAC Scorecard

The MAC Scorecard measures fall under six domains (predominantly the *Promote Effective Prevention and Treatment of Chronic Diseases* domain) (Exhibit D1). Measures are not exclusive to each domain and can span across more than one domain.

On the current MAC Scorecard, there are seven measures taken from the Adult Core Set and six measures taken from the Child Core Set. Adult Core Set measures comprise the *Promote Effective Communication and Coordination of Care*, *Strengthen Engagement in Care*, and *Make Care Affordable* domains. Three Adult Core Set measures are housed within the *Promote Effective Prevention and Treatment of Chronic Diseases* domain. A Child Core Set measure comprises the *Make Care Safer by Reducing Harm Caused in the Delivery of Care* domain. Five Child Core Set measures fall within the *Promote Effective Prevention and Treatment of Chronic Diseases* domain.

EXHIBIT D1. MEASURES IN THE MAC SCORECARD BY DOMAIN

APPENDIX E:
Current MAC Scorecard and Recommendations for Addition and Removal

There are 13 measures included in the MAC Scorecard. Exhibit E1 below outlines the MAC Scorecard measure set, including measures' current NQF endorsement status, FFY 2017 state reporting rates, and the MAC Scorecard Committee's recommendation. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's Quality Positioning System. Exhibit E2 lists the four measures recommended for addition to the next iteration of the MAC Scorecard. Exhibit E3 includes measures recommended by individual Scorecard Committee members that did not meet minimum requirements for discussion during the in-person meeting. Exhibit E4 lists the measure that the Committee recommended for removal from the MAC Scorecard.

EXHIBIT E1. MAC SCORECARD SET OF MEASURES WITH FFY 2017 REPORTING DATA

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2017	MAC Scorecard Committee Recommendation
0004 Endorsed **Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment** *Measure Steward: National Committee for Quality Assurance (NCQA)*	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis • Engagement of AOD treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	30 states reported in FFY 2017	Supported remaining on Scorecard
0018 Endorsed **Controlling High Blood Pressure: Ages 18-85** *Measure Steward: National Committee for Quality Assurance (NCQA)*	The percentage of patients 19 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year	25 states reported in FFY 2017	Supported remaining on Scorecard
0272 Endorsed **Diabetes Short-Term Complications Admission Rate (PQI 01)** *Measure Steward: National Committee for Quality Assurance (NCQA)*	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions	27 states reported in FFY 2017	Supported remaining on Scorecard

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2017	MAC Scorecard Committee Recommendation
0576 Endorsed **Follow-Up After Hospitalization for Mental Illness (FUH)** *Measure Steward: National Committee for Quality Assurance (NCQA)*	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 a follow-up visit with a mental health practitioner. Two rates are reported: • 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	41 states reported in FFY 2017	Supported remaining on Scorecard
1392 Endorsed **Well-Child Visits in the First 15 Months of Life** *Measure Steward: National Committee for Quality Assurance (NCQA)*	The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life	49 states reported in FFY 2017	Supported remaining on Scorecard
1407 Endorsed **Immunizations for Adolescents** *Measure Steward: National Committee for Quality Assurance (NCQA)*	The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diptheria toxoids and acellular pertussis vaccine (Tdap) or tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday	44 states reported in FFY 2017	Supported remaining on Scorecard
1516 Endorsed **Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life** *Measure Steward: National Committee for Quality Assurance (NCQA)*	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year	49 states reported in FFY 2017	Supported remaining on Scorecard

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2017	MAC Scorecard Committee Recommendation
1517 Endorsement Removed **Prenatal & Postpartum Care (PPC)** *Measure Steward: National Committee for Quality Assurance (NCQA)*	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: • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received prenatal care visit as a member 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	38 states reported in FFY 2017	Supported remaining on Scorecard
2940 Endorsed **Use of Opioids at High Dosage in Persons Without Cancer** *Measure Steward: Pharmacy Quality Alliance*	The proportion of (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) per day for 90 consecutive days or longer	23 states reported in FFY 2017	Supported remaining on Scorecard
Not NQF-endorsed **Adolescent Well-Care Visits** *Measure Steward: National Committee for Quality Assurance (NCQA)*	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.	49 states reported in FFY 2017	Supported remaining on Scorecard
Not NQF-endorsed **Percentage of Eligibles Who Received Preventive Dental Services** *Measure Steward: Centers for Medicare & Medicaid Services (CMS)*	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	51 states reported in FFY 2017	Supported remaining on Scorecard

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2017	MAC Scorecard Committee Recommendation
Not NQF-endorsed **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)** *Measure Steward: National Committee for Quality Assurance (NCQA)*	This measure provides information on parents' experiences with their child's health care and gives a general indication of how well the health care meets their expectations. Results summarize children's experiences through ratings, composites, and individual question summary rates. Four global rating questions reflect overall satisfaction: • Rating of All Health Care • Rating of Personal Doctor • Rating of Specialist Seen Most Often • Rating of Health Plan Five composite scores summarize responses in key areas: • Customer Service • Getting Care Quickly • Getting Needed Care • How Well Doctors Communicate • Shared Decision Making Item-specific question summary rates are reported for the rating questions and each composite question. Question summary rates are also reported individually for two items summarizing the following concepts: • Health Promotion and Education • Coordination of Care	40 states reported in FFY 2017	Supported remaining on Scorecard
Not NQF-endorsed **Use of Multiple Concurrent Antipsychotics: Ages 1-17** *Measure Steward: National Committee for Quality Assurance (NCQA)*	Percentage of children and adolescents ages 1 to 17 who were treated with antipsychotic medications and who were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.	35 states reported in FFY 2017	Recommended for removal from Scorecard

EXHIBIT E2. MEASURE RECOMMENDATIONS FOR ADDITION TO THE MAC SCORECARD

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2017	MAC Scorecard Committee Recommendation
0038 Endorsed **Childhood Immunization Status** *Measure Steward: National Committee for Quality Assurance (NCQA)*	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 haemophilus 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	44 states reported in FFY 2017	Recommended for addition to Scorecard
1448 Endorsement Removed **Developmental Screening in the First Three Years of Life** *Measure Steward: Oregon Health & Science University*	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	27 states reported in FFY 2017	Recommended for addition to Scorecard
1768 Endorsed **Plan All-Cause Readmissions** *Measure Steward: National Committee for Quality Assurance (NCQA)*	For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays* (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmissions *An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).	25 states reported in FFY 2017	Recommended for addition to Scorecard

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2017	MAC Scorecard Committee Recommendation
Not NQF-endorsed **Adherence to Antipsychotic Medications for Individuals with Schizophrenia** *Measure Steward: Centers for Medicare & Medicaid Services*	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months)	32 states reported in FFY 2017	Recommended for addition to Scorecard

EXHIBIT E3. MEASURE RECOMMENDATIONS FOR ADDITION TO MAC SCORECARD, NOT DISCUSSED

Measure #, NQF Status, Title, and Steward	Measure Description	MAC Scorecard Committee Recommendation
0027 Endorsed **Medical Assistance With Smoking and Tobacco Use Cessation** *Measure Steward: National Committee for Quality Assurance*	The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of patients 18 years of age and older who are current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of patients 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year	Remains a Core Set measure
0039 Endorsed **Flu Vaccinations for Adults Ages 18 and Older** *Measure Steward: National Committee for Quality Assurance*	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, and commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older	Remains a Core Set measure
0418/0418e Endorsed **Preventive Care and Screening: Screening for Depression and Follow-Up Plan** *Measure Steward: Centers for Medicare & Medicaid Services*	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Remains a Core Set measure
0471 Endorsed **PC-02 Cesarean Birth** *Measure Steward: The Joint Commission*	This measure assesses the rate of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Deliver, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding; Beginning 1/1/2019 PC-06 Unexpected Complications in Term Newborns will be added).	Remains a Core Set measure

Measure #, NQF Status, Title, and Steward	Measure Description	MAC Scorecard Committee Recommendation
1360 Endorsed **Audiological Evaluation no later than 3 months of age** *Measure Steward: Centers for Disease Control and Prevention*	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	Remains a Core Set measure
1800 Endorsed **Asthma Medication Ratio** *Measure Steward: National Committee for Quality Assurance (NCQA)*	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	Remains a Core Set measure
1932 Endorsed **Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications** *Measure Steward: National Committee for Quality Assurance (NCQA)*	The percentage of patients 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year	Remains a Core Set measure
2372 Endorsed **Breast Cancer Screening** *Measure Steward: National Committee for Quality Assurance (NCQA)*	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer	Remains a Core Set measure
2605 Endorsed **Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence** *Measure Steward: National Committee for Quality Assurance (NCQA)*	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge Four rates are reported: • The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge • The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge • The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge	Remains a Core Set measure

Measure #, NQF Status, Title, and Steward	Measure Description	MAC Scorecard Committee Recommendation
2607 Endorsed **Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1C) Poor Control (>9.0%)** *Measure Steward: National Committee for Quality Assurance (NCQA)*	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control >9.0%). This measure is endorsed by NQF and is stewarded by NCQA	Remains a Core Set measure
2801 Endorsed **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics** *Measure Steward: National Committee for Quality Assurance (NCQA)*	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	Remains a Core Set measure
2902 Endorsed **Contraceptive Care-Postpartum Women (Ages 15-20)*** *Measure Steward: U.S. Office of Population Affairs* *Child Core Set includes ages 15-20 only. Adult Core Set evaluates ages 21-44.	Among women ages 15 through 44 who had a live birth, the percentage that is provided: 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. 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.	Remains a Core Set measure

Measure #, NQF Status, Title, and Steward	Measure Description	MAC Scorecard Committee Recommendation
2903/2904 Endorsed **Contraceptive Care – Most and Moderately Effective Methods (Ages 15-20)*** *Measure Steward: U.S. Office of Population Affairs* *Child Core Set includes ages 15-20 only. Adult Core Set evaluates ages 21-44.	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) methods of contraception. 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.	Remains a Core Set measure

EXHIBIT E4. MEASURE RECOMMENDATION FOR REMOVAL FROM MAC SCORECARD 1.0

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2017	MAC Scorecard Committee Recommendation
Not NQF-endorsed **Use of Multiple Concurrent Antipsychotics: Ages 1-17** *Measure Steward: National Committee for Quality Assurance (NCQA)*	Percentage of children and adolescents ages 1 to 17 who were treated with antipsychotic medications and who were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.	35 states reported in FFY 2017	Recommended for removal from Scorecard

APPENDIX F:
Additional Measures Considered

The MAC Scorecard Committee considered several measures that did not pass the consensus threshold (≥60 percent of voting members) to gain support or conditional support for use in or removal from the MAC Scorecard. These and other measures could be reconsidered during a future review of the MAC Scorecard.

EXHIBIT F1. MEASURES CONSIDERED FOR ADDITION TO THE MAC SCORECARD—CONSENSUS NOT REACHED

Measure Number	Measure Title	Measure Steward
0105	Antidepressant Medication Management (AMM)	National Committee for Quality Assurance
0139	Central Line-Associated Bloodstream Infection (CLABSI)	Centers for Disease Control and Prevention

EXHIBIT F2. MEASURES CONSIDERED FOR REMOVAL FROM THE MAC SCORECARD—CONSENSUS NOT REACHED TO REMOVE

Measure Number	Measure Title	Measure Steward
0018	Controlling High Blood Pressure: Ages 18-85	National Committee for Quality Assurance
1392	Well-Child Visits: First 15 Months	National Committee for Quality Assurance
1517	Prenatal and Postpartum Care: Postpartum Care	National Committee for Quality Assurance
2940	Use of Opioids at High Dosage in Persons Without Cancer	Pharmacy Quality Alliance
N/A	Adolescent Well-Care Visits: Ages 12-21	National Committee for Quality Assurance

APPENDIX G:
Public Comments

General Comments

American Academy of Family Physicians

Sandy Pogones

The American Academy of Family Physicians (AAFP) thanks the NQF for this opportunity to comment on the Medicaid and CHIP (MAC) Scorecard. In general, the AAFP agrees with the recommendations contained in the report, with two exceptions, as discussed under Indivdual Measure Comments.

A continued frustration with use of public reporting, such as the scorecard, is the lack of consumer engagement in accessing this information. More effort needs to be directed at informing the public of performance measures and obaining public commitment and resources aimed at improving performance gaps. We agree with the Committee that "the goal should be not only to measure things, but also to fix them in an effort to improve quality."

American Occupational Therapy Association

Jeremy Furniss

The American Occupational Therapy Association (AOTA) appreciates the opportunity to comment on the MAC scorecard. We commend NQF for convening a multi-stakeholder group to review and make recommendations on the scorecard. We are happy to provide this feedback in collaboration with Joy Hammel, PhD, who was a part of the committee.

Childrens Hospital Association (CHA)

Sally Turbyville

Enhance Purpose of Scorecard**:** DRAFT report states, "The Scorecard is designed to increase the public's access to performance data for the Medicaid and CHIP programs including health outcomes experienced by enrollees." While true, encourage the addition of other stated uses. Specifically, incorporate Seema Verma "The Scorecard will be used to track and display progress being made throughout and across the Medicaid and CHIP programs so that others can learn from the successes of high performing states. By using meaningful data and fostering transparency, we will see the development of best practices that lead to positive health outcomes for our most vulnerable populations." (https://www.cms.gov/newsroom/press-releases/cms-unveils-scorecard-deliver-new-level-transparency-within-medicaid-and-chip-program).

Statements attributed to the Committee Unpack Committee agreed-upon statements from discussions. Committee discussions do not always include dissenting input. It is important not to classify or frame Committee Discussions as Committee Statement unless the Committee understood that was the desired end-point. As a committee member, I don't suggest striking these from the report, rather being careful about how discussions are framed.

As a committee member, I don't recall Committee Advise to CMS: "CMS was advised [by the Committee] to consider regulatory levers such as value-based payment to facilitate quality improvement efforts beyond just data collection." May have discussed, and some may have touched on regulatory levers, I don't recall when the Committee created and then provided this advice to CMS.

The Draft REPORT states, "The MAC Scorecard Committee recommended that CMCS consider the phased addition of the following four measures (in order of priority)..." It is important to acknowledge that it is in CMS' purview to decide whether or not (and how) these measure recommendations are implemented into the Scorecard. As a Committee member, I recollect that the Committee made no attempt to infringe upon this purview, but rather recommended the four measures and prioritized measures to support decisions CMS makes about phasing in measures.

Regardless of CMS decisions of the timing of their implementation in the Scorecard, CHA strongly recommends that the Childhood Immunization Measure is implemented immediately. Immunizations are a critical part of high-quality care and ensuring the best health outcomes for all children and their well-being.

Community Catalyst

Kyle Stock

Thank you for the opportunity to provide input on the draft report on Strengthening the Medicaid and CHIP (MAC) Scorecard. Community Catalyst is a national non-profit advocacy organization that works to ensure that all individuals and communities can influence the local, state and national decisions that affect their health.

However, we are concerned about the Scorecard's lack of quality measures that holistically reflect patient outcomes and experience. We note that there are gaps in the Scorecard's measures particularly related to long-term services and supports (LTSS), substance use disorders and mental illness. Because Medicaid is the largest payer of long-term care in the country, we believe that the omission of any LTSS-focused measure is a substantial deficiency. LTSS scorecard measures should focus on home and community based services (HCBS), which comprise the majority of Medicaid LTSS spending and which consumers prefer. As we have noted in our past comments to the National Quality Forum, the most important HCBS quality indicators focus on quality of life and extent of engagement in community activities. Also important are those measures that focus on consumer choice, experience and satisfaction with services and supports, as well as beneficiary sense of control, autonomy and self-determination. For the scorecard, we encourage the Committee to adopt the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home & Community Based Services Survey, which has been endorsed by the National Quality Forum. We also urge the Committee to consider including elements of the National Core Indicators – Aging and Disability, and National Core Indicators - Intellectual and Developmental Disabilities in the Scorecard.

Community Catalyst is also concerned that no outcomes measures are included for mental health or substance use disorders, despite the stated prioritization of such outcomes measures. Data from the National Survey of Children's Health shows that young children living in lower-income households had higher prevalence of mental, behavioral, or developmental disorders. Data also shows a significant prevalence of substance use disorders and mental illness among people with Medicaid coverage. This makes it particularly important to measure Medicaid's success in providing behavioral health care. Community Catalyst urges the Committee to consider the CAHPS Experience of Care and Health Outcomes (ECHO) Survey for behavioral health, which includes several critical outcome questions, and the Substance Abuse and Mental Health Services Administration National Outcomes Measures, which are currently being used by the New York Medicaid program. These measures track improvements in critical life activities, including education, employment and stable housing. These are the types of measures that are truly meaningful to consumers.

National Partnership for Women & Families

Carol Sakala

The National Partnership for Women & Families applauds the MAC Scorecard project as a response to Medicaid and CHIP program responsibility "for delivering high-quality healthcare to a significant portion of Americans" and applauds the project aim of increasing "the public's access to performance data for the Medicaid and CHIP programs." The clear volume-to-value trajectory of our health care system requires rigorous mechanisms for accountability. As Medicaid and CHIP are responsible for the health care of 73 million individuals and a tremendous expenditure of taxpayer dollars, it is essential to shape the Scorecard into a highly effective, impactful tool for meaningful information, accountability and oversight.

The domain approach to a basket of Scorecard measures has value but by itself does not foster adequate responsibility for core Medicaid and CHIP populations. As the Medicaid Child Core Set is one of two feeder measure sets at present, children's health issues are well represented in the evolving set of Scorecard measures. However, the Scorecard lacks meaningful oversight regarding other large, crucial, vulnerable populations for which Medicaid has responsibility. For example, although there are several Contraceptive Care measures in the Core Sets, the current Scorecard composition offers nothing in the way of wellness, primary care and prevention for women of reproductive age. As the National Partnership discusses under "Measure-specific comments," the Scorecard is woefully inadequate

for accountable maternal and newborn health care. Another key Medicaid population that is not well addressed is people requiring long-term services and supports.

A major limitation of Scorecard methodology is requiring that its measures be drawn from Core Set measures reported by 25 or more states. The eligible measures are thus disproportionately easy-to-collect measures that use claims data (and tend to be less meaningful than other data sources) and have been in the core sets for multiple years. Newer measures of value and measures that may be more meaningful than those derived from claims data are generally excluded from consideration, thus weakening this effort and arbitrarily limiting its impact. Notably, before learning of the 25-state restriction, Scorecard Committee members nominated 11 priority measures for addition to the Scorecard that were not considered as they are reported by fewer than 25 states. This restriction precludes inclusion of measures that are foundational for core Medicaid populations, such as Cesarean Birth and Contraceptive Care—Postpartum for childbearing women and newborns, and multiple Contraceptive Care measures for women of reproductive age. The National Partnership strongly encourage a methodology that enables CMS to include the strongest measures in and beyond the Core Sets with greatest opportunity for improvability.

RMAConsulting

Rhonda Anderson

The draft is very well done and captures the discussion we had in our face to face meeting.

Measure-Specific Comments

American Academy of Family Physicians

Sandy Pogones

Measure 1393 - The AAFP agrees this measure is important. Performance rates may depend at least partially on variations in coverage and co-pays among states. Emphasis needs to be placed on determining the root cause(s) of variation and low performance so improvements can be made.

Measure 2940 - The AAFP opposes this measure in general and recommends removal of this measure from the Scorecard for the following reasons: 1) Patients do not understand MME; 2) There is a lack of agreement in the scientific community on specific dosage threshold levels and different measures recommend different levels (i.e., no measure alignment); 3) The >120 mg MME cut-off level is somewhat arbitrary and may single out pre-existing patients that are stable at or above this level based on functional and other assessments. There are different conversion factors used than what is listed in the measure for methadone and hydromorphone. 4) None of the CDC recommendations on which the measure is based, reached the level of high quality evidence. Due to the poor evidence base, the recommendations are generally consensus and therefore are "good practice points" rather than category A recommendations. 5) The methodology included inconsistent inclusion and exclusions; 6) Measures that address specific milliequivalents are inconsistent among many payers and the AAFP anticipates unintended consequences (patients being stopped abruptly, physicians refusal to accept OUD patients). 7) use of MME in quality measures is too prescriptive, difficult to locate in the EHR, and inadvisable for use in performance measures. Dosage requirements need to be tailored to individuals; 8) Expert speakers at the 2019 CMS Quality Conference Speakers Master Class on Opioid Use stated that efforts focused on reducing all patients to [specific MMEs] are misguided." They encouraged focus instead on quarterly pain and functional assessment, counseling on the risks and benefits of opioids, urine drug testing, and counseling/prescription for naloxone.

While the AAFP does not disagree with the need to monitor levels of opioid use, the lack of scientific agreement on specific dosage thresholds leaves us unconvinced that the evidence is strong enough to support a specific MME level for use in performance measurement at this time. Other quality measures for opioid use may be more effective and more feasible to collect. Feeding information to physicians in real time to bring awareness of high use levels of opioid use is necessary and a critical need that must be addressed prior to implementing a dosage-based performance measure.

SAA-AD - The AAFP recommends removing this

measure. As stated, the measure applies to a very small portion of the population and is not appropriate for inclusion as a publicly reported measure. The scorecard should focus on more impactful measures.

American Occupational Therapy Association

Jeremy Furniss

AOTA strongly supports the recommended addition of the measure NQF 1448 Developmental Screening in the First Three Years of Life. We strongly agree with the rationale expressed in the draft report including that it "is of vital importance because of the downstream consequences of not capturing developmental delays in a timely manner." AOTA also supports the addition of measure 1768 Plan All-Cause Readmissions for the reasons stated in the report, especially in light of the need for discharge and transition planning as part of patient-centered care.

Childrens Hospital Association (CHA)

Sally Turbyville

CHA strongly recommends that the Childhood Immunization Measure is implemented immediately. Immunizations are a critical part of high-quality care and ensuring the best health outcomes for all children and their well-being.

Community Catalyst

Kyle Stock

Community Catalyst appreciates the work being done to improve health outcomes and increase public transparency of Medicaid and CHIP performance data. We support the addition of the following measures recommended by the Committee: Developmental Screening in the First Three Years of Life and Childhood Immunization Status. We also support the Committee's recommendation to retain the following measures: Prenatal and Postpartum Care: Postpartum Care; Well-Child Visit: First 15 Months; Adolescent Well-Child Visit: Ages 12 through 21.

GlaxoSmithKline

Tilithia McBride

NQF # 1768: Plan All-Cause Readmissions measure – the measure owner/steward, NCQA, is modifying the measure in Healthcare Effectiveness Data and Information Set (HEDIS), its measurement set. The measure assesses the percentage of hospital discharges resulting in unplanned readmissions within 30 days of discharge. The noted changes to be made by NCQA include:

Adding observation stays as hospital discharges and readmissions in the denominator and the numerator; and

Removing individuals with high frequency hospitalizations.

NCQA has stated removing individuals with high frequency hospitalizations from the measure calculation allows the readmissions rates not to be skewed by this population. GSK is concerned with the removal of any patient population from the measure, as this may unintentionally remove patients with chronic conditions in need of hospital readmission prevention programs, care coordination for discharged patients and post-discharge home medication reconciliation assistance or medication therapy management (MTM). Upon further research, we've noted that NCQA defines frequent hospitalizations as "Medicare and Medicaid members with four or more index hospital stays during the measurement year and commercial members with three or more index hospital stays during the measurement year."[1]

While GSK supports the goal of ensuring that the data underlying performance measurement can capture meaningful changes in quality performance, we are concerned that the proposed changes to the measure may inadvertently exclude patients with chronic conditions, such as chronic obstructive pulmonary disease (COPD), who could benefit from appropriate care management programs and potentially improve patients' quality of life and reducing hospitalization rates. Before making this change, additional assessments should be undertaken to better understand which patient populations are being removed from the measure with the proposed changes. In addition, further study should be done to understand how keeping the Plan All-Cause Readmission measure as-is (i.e., allowing individuals with high frequency hospitalizations to remain in the measure) skew readmission rates. NCQA should also detail the diagnoses to be removed from the measure, as using quantity to define outliers may capture patients in need of greater care coordination

and management.

[1] National Committee for Quality Assurance. "HEDIS®1 2019 Volume 2: Technical Update."2018. Accessible at: https://www.ncqa.org/wp-content/uploads/2018/10/HEDIS-2019-Volume-2-Technical-Update.pdf. Accessed December 20, 2018.

Health Watch USA

Kevin Kavanagh

Health Watch USA feels that measurement of opioid usage in the Medicaid population is of utmost importance. Opioid usage is currently the number one U.S. public health problem and most of those addicted to these medications started with prescription opioids.

We recommend that this measure be modified to report the number of Medicaid participants on opioids for chronic pain, regardless of the dosage given. The current measure may give the impression that opioids should be a mainstream treatment for chronic pain. Opioids have been shown to have only minor effectiveness in chronic pain and evidence indicates they are no better than non-opioid alternatives but carry much higher risks. A recent Meta-analysis concluded:

"In this meta-analysis of RCTs of patients with chronic noncancer pain, evidence from high-quality studies showed that opioid use was associated with statistically significant but small improvements in pain and physical functioning, and increased risk of vomiting compared with placebo. Comparisons of opioids with nonopioid alternatives suggested that the benefit for pain and functioning may be similar, although the evidence was from studies of only low to moderate quality."

1) Busse JW, et al. Opioids for Chronic Noncancer Pain. A Systematic Review and Meta-analysis. JAMA, Dec 18, 2018 Vol 320, Number 23 2448

https://jamanetwork.com/journals/jama/article-abstract/2718795

A number of states have filed lawsuits, e.g., Massachusetts attorney general, and have instigated investigations regarding opioid indications and the lack of efficacy in the treatment of chronic pain.

1) Armstrong D. Document: Facing blame for seeding the opioid crisis, Purdue explored its next profit opportunity-treating addiction. STAT Jan. 30, 2019.

https://www.statnews.com/2019/01/30/purdue-pharma-oxycontin-maker-explored-addiction-treatment/

2) Willmsen C, Bebinger M. Lawsuit Details How The Sackler Family Allegedly Built An OxyContin Fortune. NPR. Feb 1, 2019. https://www.npr.org/sections/health-shots/2019/02/01/690556552/lawsuit-details-how-the-sackler-family-allegedly-built-an-oxycontin-fortune

Numerous news investigations are also centering on this indication and how these drugs were approved by the FDA without submitted evidence. The most prominent was broadcasted by 60 mins.

https://www.cbsnews.com/news/the-opioid-epidemic-who-is-to-blame-60-minutes/

Those currently receiving opioids for chronic pain may well have to be managed with opioids due to tolerance and lower pain thresholds. However, rarely should a new patient with chronic pain be started on these dangerous drugs.

Thus, tracking of overall usage is imperative but the arbitrary cut off of >120 mg MME tends to not only mitigate the problem but may give the impression that lower dosages of opioids are the treatment of choice for chronic pain.

National Partnership for Women & Families

Carol Sakala

(First of two measure-specific comments from National Partnership for Women & Families.)

The Scorecard Committee considered recommending removal of Prenatal and Postpartum Care: Postpartum Care (formerly NQF 1517) from the Scorecard. This measure lost NQF endorsement, including because expert consensus level of evidence no longer meets NQF standards. The Committee recognized that this measure of the mere fact of a visit is weak and provides no information about the visit's content, outcomes, experiences or resource use. The fact of a visit at the end of this prolonged, consequential, costly episode is completely inadequate as the sole measure to provide any accountability for the 43% of pregnancies and births covered by Medicaid. The National Partnership for Women & Families finds this inadequacy especially

troubling in light of the nation's ongoing maternal health crisis with rising maternal mortality and severe maternal morbidity, persistent egregious racial disparities and Medicaid's disproportionate responsibility for vulnerable childbearing women and newborns.

Two specification-related matters further limit the value of this measure and the current sole maternal-newborn Scorecard measure. First, the measure disincents appropriate early visits (e.g., for wound care, breastfeeding support, maternal mood concerns) by not counting office visits during the first three weeks postpartum. Second, the use of claims data to calculate this measure greatly overestimates the proportion of women with no postpartum visit, as many billing codes do not specifically document a postpartum visit. Whereas surveys of childbearing women estimate about one woman in ten has no postpartum visit, the measure produces estimates many-fold higher, figures that are not interpretable given the invalid data source. The Committee recognized these shortcomings and supported retention of this measure as a placeholder to signify the importance of the population of childbearing women and newborns and with the expectation that better measures will be added for this population.

National Partnership for Women & Families

Carol Sakala

(Second of two measure-specific comments from National Partnership for Women & Families.)

We alert Scorecard personnel that the National Committee for Quality Assurance has proposed a re-specified version of the postpartum measure in response to recent more robust postpartum care guidelines from the American College of Obstetricians and Gynecologists. A comment period recently closed, and next steps for this measure within HEDIS are unknown. However, likely changes to the underlying measure are a future matter for the Medicaid Core Sets and the Scorecard.

The National Partnership strongly encourages future inclusion in the Scorecard of more robust measures for this population, including Cesarean Birth, Contraceptive Care-Postpartum and two endorsed Joint Commission Core Set measures that are not presently in the Medicaid Core Sets: Exclusive Breast Milk Feeding and Unexpected Complications of Term Newborns. Especially in the context of the maternal health crisis, the Scorecard is an important opportunity and responsibility to ramp up accountability for the various stakeholders that impact maternal-newborn care.

PQA Alliance

Lisa Hines

As the developer/steward of NQF 2940 Use of Opioids at a High Dosage in Persons without Cancer, we reviewed the draft MAC Scorecard report. We would greatly appreciate the opportunity to make some clarifications related to the notes of the discussion regarding the measure (excerpted below).

NQF 2940 Use of Opioids at a High Dosage in Persons without Cancer The Committee agreed that addressing the opioid crisis on the Scorecard is of high importance. Additionally, various government agencies are beginning to hold state Medicaid programs accountable for opioid use amongst beneficiaries. Given the current national opioid crisis in the U.S., the Scorecard Committee agreed to keep the measure on the Scorecard until a better outcome-based measure is available while signaling the significance of addressing this issue on the Scorecard. Committee members questioned whether a dosage of 120mg per day is an appropriate cutoff for this measure, and expressed that they would like to see more alignment with guidelines and/or evidence-based dosage information. In response to this concern, the developer acknowledged that the measure dosage lacked a robust evidence-base, and they are now aligning the measure with CDC guidelines as one approach to address this concern. One state representative commented that NQF 2940 might mistakenly capture therapeutic use of narcotics for opioid use disorder (buprenorphine, methadone, etc.); however, the developer clarified that such medication assisted treatment (MAT) for opioid use disorder is not a part of the numerator calculation for this measure. Another member noted that the measure is limited because it only addresses legal supply and does not address illegal distribution. Ultimately, the Committee noted that NQF 2940 is a suitable measure that captures the opioid crisis at multiple levels. A few Committee members noted that more measures are currently being developed in this space.

1. The measure's dosage threshold is represented in the NQF document as 120 mg per day; however, it should be >120 Morphine Milligram Equivalents (MME)/day. We realize this is a recap of committee discussion but would like the measure to be accurately represented to avoid confusion.
2. The measure is evidence-based, so the highlighted statement above that the measure dosage lacked a robust evidence-base is not accurate. The measure was developed prior to the publication of the CDC guidelines, so the evidence, guidelines, and standards that existed in 2015 supported the >120 MME/day threshold. PQA updated the 2019 measure specifications to ≥90 MME/day to align with the recommendations in the CDC guideline.
3. Opioids that are indicated for medication assisted treatment (MAT) are not part of the measure (denominator or numerator).

RMAConsulting

Rhonda Anderson

In the meeting we removed the pregnancy measure. I would recommend that a measure around prenatal and post natal care be considered in the future since so many pregnant women are in the Medicaid programs and don't have timely prenatal care.

Strategic Issues

American Academy of Family Physicians

Sandy Pogones

The AAFP agrees that the burden of documentation must be addressed, and with the Committee's suggestion that financial assistance be given to clinicians for collecting data. Documenting data in an electronic-prescribed format does not currently align with workflow of physicians and is an added task to their work. Alternatively, data should be obtained from claims or other databases (such as geospatial applications) and/or clinical data extracted from electronic health record with no burden on the part of physicians. We understand the technology to do so is not currently widely available, but physicians should not be expected to fill current technology gaps by expending their own time, effort, and resources for quality measurement and reporting, with little, if any, return on investment.

The AAFP disagrees with the statement, "It is important to note that data for the Scorecard are collected at the state level, but the greatest opportunity for improving the quality of healthcare delivery is at the provider and health plan level" (page 14). Numerous studies have demonstrated that health is determined primarily by factors outside the healthcare system, with healthcare influencing only 20% or less of health outcomes. Our focus on performance of healthcare providers is out-of-balance with root causes of poor health. Holding states and federal programs accountable for addressing social determinants of health would have a much greater impact than our continued focus on the minutiae of healthcare. The Pareto Principle would tell us to focus efforts and resources there. Potential measures that may better indicate value for inclusion in a scorecard may include primary care spend (i.e., a higher spend on primary care has been demonstrated to improve health and lower costs); health of the community (food desserts, public access to transportation, tobacco use) financial barriers to access, drivers of high cost (e.g., pharmaceutical, hospital/ED, waste, duplication), coordination, and patient engagement.

American College of Nurse-Midwives

Diana Jolles

Thank you for your attention to measure alignment, parsimony and impact.

In reading the report- I continue to be struck by how there are too many measures, with far too little mandatory reporting.

It seems wise to focus on cross cutting, high impact population health measures-

Things that are EASY to fix, are subject to unwarranted variation in care (e.g. geographic variations, institutional, state level, etc.)

For example- exclusive breastfeeding is a high impact measure, with known systems level variations, clear corrective actions can be taken to improve performance. Improved performance influences life course health- of both mother and baby-

I am surprised to see this omitted.

American Occupational Therapy Association

Jeremy Furniss

While we understand that for the scorecard to be effective, parsimony is necessary, AOTA encourages NQF to consider the addition of person satisfaction or experience of care measure and a measure of function or functional independence. We believe that understanding the experience of the person receiving services is critically important. Reporting feedback to providers in this area signals that person centered care is a priority. A publically reported measure of function ("patient" reported or otherwise) can be an important overall outcome measure.

AOTA is a strong advocate for understanding, measuring, and reporting function and the person's experience of care. As the report notes, publically reported measures are not used as frequently or to the extent as would be ideal. We believe that including meaningful and simple to understand measures of function and experience can be a driver for more widescale adoption by consumers.

Finally, we believe that NQF should examine and consider measures related to long-term care utilization (e.g., number of people in long term care or other institutional settings compared to the number who are living in the community with waiver/ community living supports).

Childrens Hospital Association (CHA)

Sally Turbyville

CHA encourages CMS to finalize and communicate the mid- and long-term accountability scheme (continued public reporting, financial incentives or penalties for Medicaid State Agencies…) for the Scorecard. Will financial incentives or penalties be attached to state Scorecard performance? If so, starting in what year? And how will the state health system performance pillar be used in that type of scheme?

CHA encourages CMS to have an active role in establishing and supporting the learning environment. Strategies should include within and across states (as suggested by the CMS Administrator) and providers. It is important that the learning environment includes actionable information for the states and providers of care.

The Draft report states: "It is important to note that data for the Scorecard are collected at the state level, but the greatest opportunity for improving the quality of healthcare delivery is at the provider and health plan level." This statement may be interpreted as very narrow in scope that discounts the ongoing efforts of states and Medicaid agencies. States and the Medicaid agencies are important innovators and influencers that do and can enable multidisciplinary initiatives to address social risk factors associated with health outcomes.

The draft report states, "However, Medicaid Core Set data are based on voluntary state reporting, whereas the MAC Scorecard will likely evolve into a mandatory public reporting tool. This disconnect in actual use of the measures as well as the opportunity to flourish based on past reporting experiences directed the discussion by the MAC Scorecard Committee." As a member of the committee, it is not clear to me what the implications are of this statement. For example, the Scorecard is already publicly reported and reportedly (by CMS at the meeting) will only draw on information already reported to CMS by the states (like what is reported on Core Sets); thus, I am unsure of the implication of the statement that the Scorecard will likely become a mandatory public reporting tool.

Community Catalyst

Kyle Stock

We encourage the prioritization of patient experience measures, patient-reported outcome measures and patient goals-directed measures. We also support quality measurement that elicits information on health disparities. Data should be disaggregated and stratified by race, ethnicity, primary language, gender identity, sexual orientation, and disability status to measure progress on reducing disparities.

Community Catalyst would also like to note that quality measurement work is less successful when consumers and communities are not involved, or when they have been involved superficially. When consumers and communities notice that the process is not working well for them, they are less likely to support implementation and use of quality measures. In our experience, consumer engagement in all stages of quality measurement can address these concerns,

but success depends on both measurement leaders and consumer advocates. For additional information and detailed recommendations, see our report (available here: https://www.communitycatalyst.org/resources/publications/document/Resource-for-Advocates-on-Quality-Measurement-Recommendations-Final.pdf).

GlaxoSmithKline

Tilithia McBride

GSK appreciates the opportunity to provide comments on the future direction of the Medicaid and CHIP (MAC) Scorecard Project, specifically on the current criteria used for measure selection. The Scorecard is designed to increase the public's access to performance data for the Medicaid and CHIP programs including health outcomes experienced by enrollees.[1] We encourage a change the methodology of only recommending the public reporting of measures from the Adult Medicaid Core set that have been reported by 25 or more states. Under this approach, states may continue to deprioritize vulnerable populations, such as those with human immunodeficiency virus (HIV) and fail to demonstrate the quality of care provided to all Medicaid beneficiaries.

State governments are important partners in preventing and combating HIV. Medicaid has played a critical role in HIV care since the epidemic began, and it is the second largest source of coverage for people living with HIV.[2]

GSK encourages the use of HIV quality measures to drive the advancement of high-quality care through adherence to clinical guidelines, improvements in care coordination and care transitions, patient engagement, and a focus on achieving outcomes. Specifically, we support the adoption of NQF #2082 HIV Viral Load Suppression measure for public reporting on the Medicaid and CHIP (MAC) Scorecard. The implementation of this outcome measure across state quality programs will help realize HHS' plan of Ending the HIV Epidemic: A Plan for America in the next 10 years.[3] Additionally, viral load suppression is the gold standard in HIV treatment and means that the virus has been reduced to an undetectable level in the body with standard tests.[4] The primary advantage of implementing outcome measures generally, and the viral load suppression measure, specifically, is that they directly measure what patients care about—namely, whether their interaction with the health care system improved their health or led to an adverse event.

[1] CMS. Medicaid & CHIP Scorecard website. https://www.medicaid.gov/state-overviews/scorecard/index.html. Accessed March 2019.

[2] Kaiser Family Foundation. State Health Facts. Medicaid and HIV. https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.

[3] Department of Health and Human Services. 2019. "Ending the HIV Epidemic: A Plan for America." Accessible at: https://www.hhs.gov/sites/default/files/ending-the-hiv-epidemic-fact-sheet.pdf.

[4] National Institutes of Health (NIH) "Ten things to Know about HIV Suppression" https://www.niaid.nih.gov/news-events/10-things-know-about-hiv-suppression.

National Partnership for Women & Families

Carol Sakala

The Scorecard report states that the Scorecard composition aims for a "balanced set of measures that address health and well-being across an individual's life span." To do this, the National Partnership for Women & Families recommends an assessment of Scorecard measures created by arraying the current domains and measures within them by the larger core Medicaid and CHIP subpopulations to display in grid format the measures that fall within the various domains and promote quality care for the core populations. At minimum, across the life span, these populations include: children, women of reproductive age, childbearing women and newborns, and individuals requiring long-term services and supports.

Taking stock of the Scorecard measures in this way will identify crucial and unacceptable gaps given the responsibilities of the Medicaid and CHIP programs. To address these gaps, we encourage adjusting the criteria for eligible Scorecard measures to be able to promote accountability and value-based care for core subpopulationss as part of the fiduciary responsibility of the Center for Medicaid and CHIP Services for the health care of one-quarter of the population and a disproportionately vulnerable population. This would

also address the CMCS fiduciary responsibility for the wise expenditure of a large proportion of taxpayer dollars. The National Partnership strongly encourages wiser spending on high-value care versus reducing access to care, an approach that can improve rather than threaten health outcomes. The Scorecard can play a crucial role in such a strategy.

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