Measure Applications Partnership

Coordinating Committee Web Meeting

November 10, 2014

NATIONAL QUALITY FORUM

Meeting Agenda

- Welcome, Introductions and Review of Meeting Objectives
- MAP Process Improvements
- Overview of the Medicare Shared Savings Program
- MAP Pre-rulemaking Strategic Cross-Cutting Issues
- MAP Pre-rulemaking: Input on the Critical Program Objectives
- MAP Medicaid Child Task Force
- Opportunity for Public Comment
- Summary and Next Steps

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Coordinating Committee Membership

Committee Co-Chairs: George J. Isham, MD, MS
Elizabeth A. McGlynn, PhD, MPP

Organizational Members

AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Shaun O'Brien
American Board of Medical Specialties	Lois Margaret Nora, MD, JD, MBA
American College of Physicians	Amir Qaseem, MD, PhD, MHA
American College of Surgeons	Frank G. Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl A. Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla J. Weston, PhD, RN
America's Health Insurance Plans	Aparna Higgins, MA
Blue Cross and Blue Shield Association	Trent T. Haywood, MD, JD
Catalyst for Payment Reform	Shaudi Bazzaz, MPP, MPH
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip N. Kahn, III
Healthcare Financial Management Association	Richard Gundling, FHFMA, CMA
Healthcare Information and Management Systems Society	TBD
The Joint Commission	Mark R. Chassin, MD, FACP, MPP, MPH

Coordinating Committee Membership

Organizational Members continued…

LeadingAge	Cheryl Phillips. MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Steve Wojcik
National Committee for Quality Assurance	Margaret E. O'Kane, MHS
National Partnership for Women and Families	Alison Shippy
Pacific Business Group on Health	William E. Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher M. Dezii, RN, MBA, CPHQ

Subject Matter Experts

Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Marshall Chin, MD, MPH, FACP
Harold A. Pincus, MD
Carol Raphael, MPA

Federal Government Members

Agency for Healthcare Research and Quality (AHRQ)	Richard Kronick, PhD/Nancy J. Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MH, FACP
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Office of the National Coordinator for Health Information Technology (ONC)	Kevin Larsen, MD, FACP

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Background on MAP Process Improvement Efforts

- Based on feedback from MAP members, external stakeholders, NQF members, and staff, NQF undertook an intensive improvement effort on MAP.
- Our goal was to develop a streamlined and manageable process for MAP stakeholders and staff resulting in an improved product.

New for 2014-2015 Pre-rulemaking

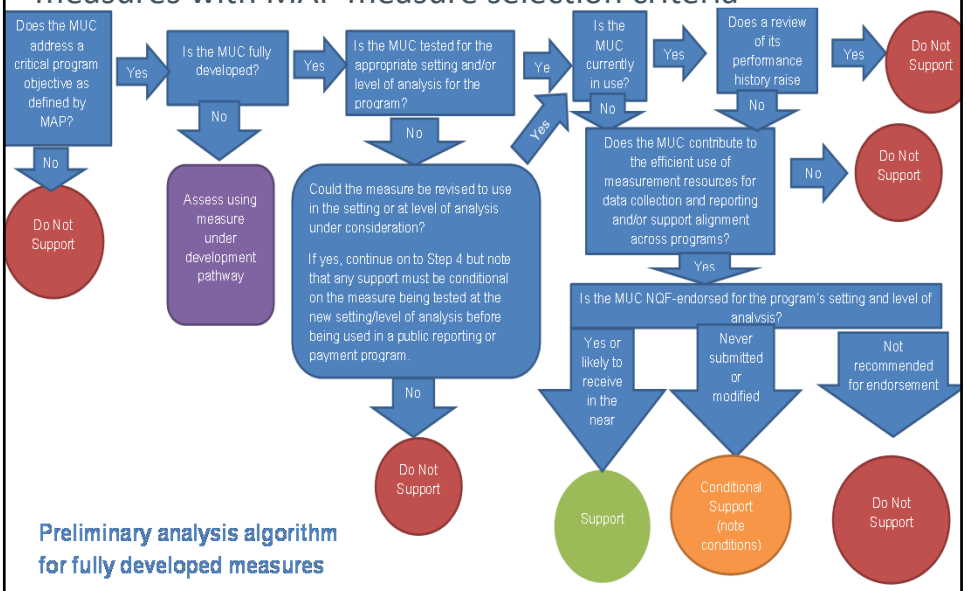
- Expanded opportunities to gather public feedback
- Easier access to information through focused products
- Centering decisions on critical program needs and objectives
- Better navigation and focused analysis in meeting materials
- More consistent and transparent deliberations process

Programmatic Approach to Decision-Making – *Preliminary Analysis Algorithm For Fully Developed Measures*

Standardized approach across all setting-specific programs:

- The measures under consideration will be divided into related groups for the purposes of discussion and voting
- Each measure under consideration will undergo a preliminary analysis by staff based on a standard decision algorithm applying the MAP measure selection criteria
- Discussion guide will note the result of the preliminary analysis and provide rationale to support how that conclusion was reached

New for 2014-2015 Pre-rulemaking: Preliminary analysis of measures with MAP measure selection criteria



Preliminary analysis algorithm for fully developed measures

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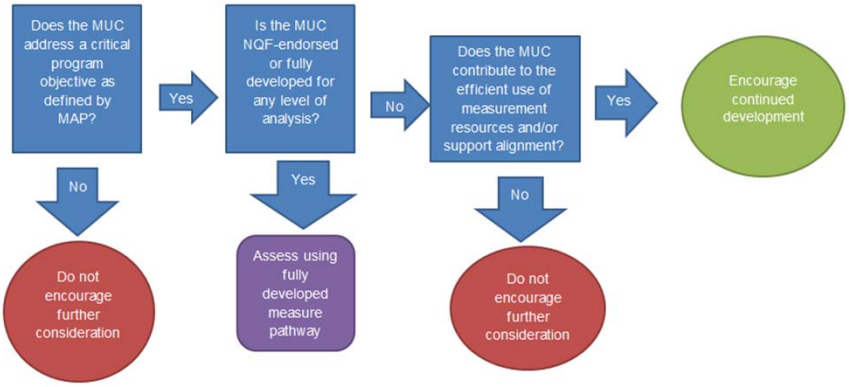
New for 2014-2015 Pre-rulemaking: Preliminary analysis of measures with MAP measure selection criteria



Preliminary analysis algorithm for measures in earlier stages of development

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New for 2014-2015 Pre-rulemaking:
Preliminary Analysis Algorithm For Fully Developed Measures

- Intended to identify and discuss programmatic strategic issues such as:
  - Are the current measures in the program helping to meet the program's overall objectives?
  - Are there ongoing measure implementation challenges or unintended consequences?
  - Are there opportunities to align measures across programs and across all settings?
- Will be more prospective, as opposed to reviewing measures already finalized in the program

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Medicare Shared Savings Program (MSSP)

- **Program Type:** Pay for Reporting and Pay for Performance
- **Incentive Structure:** Option for one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years).
- **Program Goal**: Facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in health care costs.

Medicare Shared Savings Program (MSSP)

Program Updates (Proposed PFS Rule for 2015):

- Quality improvement shown in 30 of 33 quality measures, such as:
  - Patients' ratings of clinicians' communication
  - Beneficiaries' rating of their doctor
  - Health promotion and education
  - Screening for tobacco use and cessation
  - Screening for high blood pressure.
- Controlling spending growth: 53 of 204 organizations slowed spending enough to receive bonus payments; one will face penalties after health spending accelerated.
- In 2013 alone, over 125,000 eligible professionals who were ACO providers or suppliers qualified for their incentive payments for reporting their quality of care through the Physician Quality Reporting System (PQRS).

Medicare Shared Savings Program (MSSP)

Critical Program Objectives

- Improve the overall health for a population of Medicare Fee-For-Service (FFS) beneficiaries
- Improve quality and health outcomes while lowering the rate of growth of healthcare spending
- Encourage coordination and shared accountability by including measures relevant to individuals with multiple chronic condition, measures in all settings that patients receive care (including ambulatory, acute, and post-acute settings), and measures that span across settings.
- Promote alignment across other quality measurement reporting programs.
- Include more high-value measures (with examples provided in previous MAP reports)

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MAP Pre-rulemaking Strategic Cross-Cutting Issues

In an effort to address cross-cutting issues in measurement across program settings:

- Measure Alignment
  - Data on current alignment of measures across federal programs
- Progress on filling critical gaps
  - Current challenges and potential strategies: quality vs. quantity
- Other potential topics

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MAP Pre-rulemaking Input on Critical Program Objectives

- Review setting-specific critical program objectives developed by MAP workgroups
  - Clinician
  - Hospital
  - PAC/LTC
- Build on cross-cutting input from the MAP Dual Eligible Beneficiaries Workgroup

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Medicaid Child Task Force Membership

Task Force Chair: Foster Gesten, MD, FACP

Organizational Members

Aetna	Sandra White, MD, MBA
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
American Nurses Association	Susan Lacey, RN, PhD, FAAN
American Academy of Pediatrics	Terry Adirim, MD, MPH, FAAP
America's Essential Hospitals	Beth Feldpush, DrPH
Children's Hospital Association	Andrea Benin, MD
Kaiser Permanente	Susan Fleischman, MD
March of Dimes	Cynthia Pellegrini
National Partnership for Women and Families	Carol Sakala, PhD, MSPH

Subject Matter Experts

Anne Cohen, MPH
Marc Leib, MD, JD

Federal Liaison (non-voting)

Marsha Smith, MD (CMS)

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Health Issues for Children in Medicaid/CHIP

Understanding the health-related needs of the population contributes to the selection of appropriate measures

- Primary care access and preventive care
  - Well-child
  - Developmental screenings
  - Preventive screenings
- Perinatal health and birth outcomes (also present in Adult Core Set)
- Management of acute and chronic conditions
  - Children with complex health needs
- Dental and oral health
- Behavioral health and mental disorders

CMS Goals for Child Core Set

CMS' Three-part goal for Child Core Set:

1. Increase number of states reporting Core Set measures
2. Increase number of measures reported by each state
3. Increase number of states using Core Set measures to drive quality improvement

Focus on incremental changes

- CMS and states continue to learning about current Child Core Set measures
- Take into account the state staff time and resources it takes to learn/incorporate a new measure

MAP can assist CMS in identifying ways to strengthen the Child Core Set:

- Which measures can be added to fill critical gap areas
- Ways to better reflect CMS's Measurement Quality Domains
- Ways to better align with other CMS/HHS programs
- *Which measures to retire (future reviews, not current)*

Current Medicaid Child Core Set Measures

NQF #	Measure Name	Measure Steward
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/Adolescents	NCQA
0033	Chlamydia Screening in Women	NCQA
0038	Childhood Immunization Status	NCQA
0108	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA
0139	Pediatric Central-line Associated Bloodstream Infections–Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CDC
0471	Cesarean Rate for Nulliparous Singleton Vertex (PC-02)	Joint Commission
0576	Follow-up After Hospitalization for Mental Illness	NCQA
1382	Live Births Weighing Less than 2,500 Grams	CDC
1391	Frequency of Ongoing Prenatal Care	NCQA
1392	Well-Child Visits in the First 15 Months of Life	NCQA

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Current Medicaid Child Core Set Measures

NQF #	Measure Name	Measure Steward
1407	Immunization Status for Adolescents	NCQA
1448	Developmental Screening in the First Three Years of Life	OHSU
1516	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA
1517	Timeliness of Prenatal Care	NCQA
1799	Medication Management for People with Asthma	NCQA
1959	Human Papillomavirus (HPV) Vaccine for Female Adolescents	NCQA
n/a	Ambulatory Care - Emergency Department (ED) Visits	NCQA
n/a	Adolescent Well-Care Visit	NCQA
n/a	Behavioral Health Risk Assessment (for Pregnant Women)	AMA-PCPI
n/a	Child and Adolescents' Access to Primary Care Practitioners	NCQA
n/a	Consumer Assessment of Healthcare Providers and Systems® CAHPS 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)	NCQA
n/a	Percentage of Eligibles That Received Preventive Dental Services	CMS
n/a	Percentage of Eligibles That Received Dental Treatment Services	CMS

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Overview of Medicaid Child Core Set FFY 2012 Reporting

- All states reported two or more of the Child Core Set measures
- Median of 14 measures reported
- 35 states reported at least 11 of the 22 core measures to CMS
  - Florida and Tennessee reported 22 of the core measures
  - Nebraska, South Dakota, and Wisconsin reported 2 measures
- The most frequently reported measures in the Child Core Set assess children's access to primary care, well-child visits, and dental services
- Quality improvement opportunities remain among frequently reported measures
- See draft report Appendix E for more detail

Key Themes From State Experiences: Implementation Challenges, Strategic Issues, and Measure Gap Areas

- Greater clarity is needed in the technical specifications provided by CMS
- States have limited capacity to report measures that require chart review
- Differences in reporting mechanisms across care settings and benefit structures (e.g., carve-outs) pose challenges when aggregating information at the state level
- Greater capacity for electronic data abstraction and measurement would facilitate participation in multiple programs
- More measures are needed on mental health topics
- Given the time necessary for measure up-take, changing measures on a yearly basis can create challenges

Forming MAP's Input on Strengthening the Child Core Set

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Gap Areas Discussed at Web Meeting with NQF-endorsed Measures

- ***Care Coordination(4)***
  - Home- and community-based care
  - Social services coordination
- Screening for abuse and neglect
- Injuries and trauma
- ***Mental health (5)***
  - Access to outpatient and ambulatory mental health services
  - ER use for behavioral health
- Overuse / medically unnecessary care
  - CT scans
- ***Inpatient measures (10)***
  - ***Readmissions (3)***
- Durable medical equipment
- Cost measures, specifically targeting children with chronic conditions

Task Force Recommendations

- MAP supports most measures already in the Core Set
  - 22 of 23 measures supported for continued use in the program
- Measures suggested for removal:
  - Percentage of Eligibles That Received Dental Treatment Services
  - Measure is not actionable for quality improvement because it is unclear whether and increase or decrease in the rate is desirable

Measures for Phased Addition: Prioritized Additions to Fill Gaps

Ranking	Measure Number and Title	Votes for Prioritization
1	NQF #2508 Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk	10
2	NQF #2548 Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS) *(conditional on endorsement)*	7
3	NQF #2509 Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk	5
4 (tie)	NQF #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment *(conditional on renewed endorsement)* NQF #0477 Under 1500g infant Not Delivered at Appropriate Level of Care	4
6	NQF #0480 PC-05 Exclusive Breast Milk Feeding	3

Strategic Issues for Further Consideration

- Feasibility of reporting and electronic data infrastructure
- Pipeline of measures in development
- Alignment of measures

- MAP is scheduled to review the Child Core Set in more detail during the spring/summer of 2015 to inform the next annual update to the program.

MAP Coordinating Committee Discussion

- Does the MAP Coordinating Committee approve the Task Force recommendations?

- Important dates:
  - November 14: Finished report due to HHS and made available to the public
  - Spring 2015: Annual review begins

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Upcoming MAP Pre-Rulemaking Meetings

October/November Strategic Web Meetings

- Clinician Workgroup - **October 3**
- Hospital Workgroup - **October 8**
- Dual Eligible Workgroup - **October 10**
- PAC/LTC Workgroup - **October 17**
- Coordinating Committee - **November 10**

January In-Person Meeting

- Coordinating Committee -**January 26-27**

December In-Person Workgroup Meetings

- Hospital Workgroup - **December 9-10**
- PAC/LTC Workgroup - **December 12**
- Clinician Workgroup - **December 15-16**

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Pre-rulemaking Timeline

Oct-Nov
Web meetings to identify program strategic issues

On or Before Dec 1
List of Measures Under Consideration released by HHS

Nov-Dec
Initial public commenting

Dec
In-person workgroup meetings to make decisions on measures under consideration

Dec-Jan
Public commenting on workgroup deliberations

Late Jan
MAP Coordinating Committee finalizes MAP input

Feb 1 to March 15
Pre-Rulemaking deliverables released

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Draft Program Summary

Medicare Shared Savings Program

Program Type

MSSP is a combination pay for reporting and pay for performance program.

Incentive Structure

Option for one-sided risk model (sharing of savings only for the first two years, and sharing of savings and losses in the third year) or a two-sided risk model (sharing of savings and losses for all three years).

Program Goals

"Facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in health care costs."

Program Update (2015 Physician Fee Schedule Proposed Rule)

For 2014, the MSSP program has 33 measures that may be submitted through a CMS web interface, currently the group practice reporting (GPRO) web interface, calculated by CMS from internal and claims data, and collected through a patient and caregiver experience of care survey.

The 2015 Physician Fee Schedule final rule includes the following changes:

- Modifying the measure set (added 8 measures, retired 8) to be more outcome-oriented and reduce the reporting burden on ACOs
- Modifying benchmarking approach for topped out measures in order to provide ACOs with consistent targets for improvement.
- Interest in aligning with physician programs (like Value-Based Payment Modifier)
- Sought input on:
    - Measures that might be used to assess the ACO's performance with respect to care coordination in post-acute care and other settings;
    - Specific caregiver experience of care measures that might be considered in future rulemaking;
    - Suggestions of new measures of the quality of care furnished to the frail elderly population; and
    - Measures/tools to assess changes in physical and mental health over time.

MAP's Suggested Critical Program Objectives

The following are proposed critical program objectives for MSSP:

- Improve the overall health for a population of Medicare Fee-For-Service (FFS) beneficiaries;
- Improve quality and health outcomes while lowering the rate of growth of healthcare spending;
- Encourage coordination and shared accountability by including measures relevant to individuals with multiple chronic condition, measures in all settings that patients receive care (including ambulatory, acute, and post-acute settings), and measures that span across settings;
- Promote alignment across other quality measurement reporting programs;
- Include more high-value measures such as:
    - Patient-reported outcome measures in the areas of depression remission, functional status, and smoking;
    - Patient-reported outcome measures for medically complex patients (e.g., chronically ill or those with multiple chronic conditions);
    - Measure of health risks with follow-up interventions;
    - Cost and resource use measures; and
    - Appropriate use measures.

Appendix A: Summary of previous MAP Pre-rulemaking 2014 Input (Report link)

MAP's previous assessment of the MSSP measure set found it to be comprehensive, addressing cross-cutting measurement priorities such as patient experience as well as high-impact conditions and key quality outcomes. Additionally, observing that the measure set places heavy emphasis on ambulatory care, MAP recommended that it could be enhanced with the addition of acute and post-acute care measures, and measures relevant to individuals with multiple chronic conditions.

MAP reviewed 15 measures under consideration during the 2013-2014 pre-rulemaking and supported the inclusion of five. Recommendation focused primarily around patient experience (CG-CAHPS, S-CAHPS), follow-up after hospitalization for mental illness, and chronic disease care/management (i.e., asthma).

MAP did not support the remaining measures under consideration as they address specific conditions, recommending instead that ACOs continue to gain experience with the finalized measure set before expanding to additional condition-specific measures. Accordingly, MAP did not support two osteoporosis measures intended to promote alignment with the Medicare Advantage 5-Star program. MAP supports future inclusion of these measures in MSSP once ACOs are able to overcome implementation issues with the currently finalized measure set.

Physician Quality Reporting System (PQRS)

Program Type:

PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

Incentive Structure:

In 2012-2014, EPs could receive an incentive payment equal to a percentage (2% in 2010, gradually decreasing to 0.5% in 2014) of the EP's estimated total allowed charges for covered Medicare Part B services under the Medicare Physician Fee Schedule. Beginning in 2015, EPs and group practices that do not satisfactorily report data on quality measures will receive a reduction (1.5% in 2015 and 2% in subsequent years) in payment.

Program Goals:

The goal of the PQRS program is to encourage widespread participation by EPs to report quality information. In 2012, only 36% of EPs satisfactorily submitted quality information to PQRS.

Program Update:

For 2014 the PQRS program has 282 measures that may be submitted through a variety of mechanisms: claims, qualified registry, EHRs and the group reporting web interface (GPRO).

The most recent 2012 PQRS participation report reported:

- Participation increased from 29% of EPs in 2011 to 36% of EPs in 2012.
- PQRS participation is highest among EPs who see the most Medicare patients.
- Emergency physicians (64%) and anesthesiology (57%) had the high participation rates among the specialties using the individual claims reporting mechanism.
- Internal medicine and family practice had the highest numbers of EPs participating via the registry mechanism.
- Family practice, internal medicine, nurse practitioner, and cardiology were also the top four specialties using the EHR reporting mechanism.

The final 2015 Physician Fee Schedule rule includes the following updates:

- Beginning in 2015, a downward payment adjustment of -2 percent will apply to EPs who do not satisfactorily report data on quality measures for covered professional services or satisfactorily participate in a qualified clinical data registry
- Identification of 19 cross-cutting measures that can be used by all EPs – based on the recommendation of a core set from the MAP.
- For the 12-month reporting period (2015) for the 2017 PQRS payment adjustment EPs reporting by claims, EHR or registry would report at least 9 measures, covering at least 3 of the National Quality Strategy domains.
    - For individual EPs reporting via EHR: if the EHR does not contain data for 9 measures, then report on all measures with Medicare patient data (aligns with Medicare EHR Incentive Program).
    - Qualified Clinical Data Registries (QCDRs) must report at least 2 outcome measures or 1 outcome and 1 other (resource use, patient experience with care,

efficiency/appropriate use or patient safety) measure; QCRDs may report up to 30 non-PQRS measures; QCRDs must public report measure results beginning in 2015 (except new measures that are not required to report in the first year)
    - Group practices of 100 or more EPs that report via PQRS must report CAHPS for PQRS GPRO
- Changes to the total number of PQRS measures:
    - Addition of 20 new individual measures and two measures groups to fill existing measure gaps;
    - Removal of 50 measures for a variety of reasons:
        - Measure steward will no longer maintain the measure
        - Performance rates consistently close to 100%, i.e., "topped out"
        - Measure does not add clinical value to PQRS
        - Measures a standard of care
        - Evidence and guideline change
        - Duplicative measures
    - The measures to be removed include 8 hypertension measures, 3 stroke measures, 4 back pain measures, , 4 inflammatory bowel disease measures, 3 emergency medicine measures

CMS has an ongoing Call for Measures to solicit new measures for possible inclusion in PQRS. Aside from NQF endorsement, submitters are asked to consider the following:

- Measures that are not duplicative of existing or proposed measures.
- Measures that are further along in development than a measure concept.
- CMS is not accepting claims-based-only reporting measures.
- Measures that are outcome-based rather than clinical process measures.
- Measures that address patient safety and adverse events.
- Measures that identify appropriate use of diagnosis and therapeutics.
- Measures that include the NQS domains of care coordination, communication, patient experience and patient-reported outcomes.
- Measures that address efficiency, cost and resource use.

Critical Program Objectives

- To encourage widespread participation many measures are needed for the variety of EPs specialties and sub-specialties.
- The measures chosen by EPs to submit for PQRS will be reported on Physician Compare and used to determine the Value Based Payment Modifier, therefore all PQRS measures will be used for accountability purposes.
- Include NQF-endorsed measures relevant to clinician reporting to encourage engagement Measures selected for the program that are not NQF-endorsed should be submitted for endorsement.
- For measures that are not endorsed, include measures under consideration that are fully specified and that:
    - Support alignment (e.g., measures used in other programs, registries)

    - Are outcome measures that are not already addressed by outcome measures included in the program
    - Are clinically relevant to specialties/subspecialties that do not currently have clinically relevant measures
- Include more high value measures, e.g., outcomes, patient-reported outcomes, composites, intermediate outcomes, process measures close to outcomes, cost and resource use measures, appropriate use measures, care coordination measures, patient safety, etc.

Value-Based Payment Modifier and Physician Feedback of Quality Resource and Use Reports (QRURs) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html

Program Type:

Physician Feedback of QRURs: Feedback of quality and cost data to eligible professionals provides comparative performance information to improve the quality and efficiency of medical care

Value Based Payment Modifier: Medicare payment adjustment based on cost and quality data.

Incentive Structure:

The Physician Value Based Payment Modifier is being phased in over the three years 2015-2017:

CY 2015: Physicians in group practices of 100 or more eligible professionals (EPs) who submit claims to Medicare will be subject to the value modifier in 2015, based on their performance in calendar year 2013.

CY 2016: In order to avoid an automatic negative two percent ("-2.0%") Value Modifier payment adjustment in CY 2016, Eligible Professionals (EPs) in groups of 10 or more must participate in and satisfy the Physician Quality Reporting System (PQRS) requirements as a group or as individuals in CY 2014.

CY 2017: All physicians who participate in Fee-For-Service Medicare will be affected by the value modifier starting in 2017. An estimated 900,000 physicians will be affected.

CY 2018: The VM will apply to non-physician eligible professionals in groups subject to the VM and to non-physician eligible professionals who are solo practitioners.

Program Goals:

- Physician feedback of the QRURs provides preview information about quality and cost performance rates for the Value Modifier.
- Payment adjustment of Medicare Fee-for-service reimbursement based on performance on quality and cost measures thereby moving toward physician reimbursement that rewards *value* rather than volume.

Program Update:

- For 2015 and 2016, the Value Modifier does not apply to groups of physicians in which any of the group practice's physicians participate in the Medicare Shared Savings Program, Pioneer ACOs, or the Comprehensive Primary Care Initiative.
- After 2015, quality-tiering is the methodology used to evaluate a group's performance on cost and quality measures for the Value Modifier.
- The 2015 PFS Proposed Rule proposes increasing the amount of payment at risk under the Value Modifier from 2% in CY2016 to 4% in CY 2017. The Value Modifier payment adjustment is in addition to any payment adjustment for PQRS participation.
- Alignment of federal programs - the measures chosen by EPs to submit for PQRS are reported on Physician Compare and used to determine the Value Based Payment Modifier.

- Cost and quality measures are used to determine the payment modifier. Measures are collected for one year to establish national benchmarks prior to use in determining the payment modifier.

Critical Program Objectives

- NQF-endorsed measures are strongly preferred for pay-for-performance programs; measures that are not NQF-endorsed should be submitted for endorsement or removed.
- Include measures that have been reported in a national program for at least one year (e.g.,PQRS) and ideally can be linked with particular cost or resource use measures to capture value.
- Focus on outcomes, composites, process measures that are proximal to outcomes, appropriate care (e.g., overuse), and care coordination measures (measures included in the MAP Families of Measures generally reflect these characteristics).
- Monitor for unintended consequences to vulnerable populations (e.g., through stratification).

Physician Compare Initiative

Program Type:

Physician Compare is the federal website that reports information on physicians and other clinicians. The purpose of the web site is public reporting of information and quality measures that are meaningful to patients.

Incentive Structure:

There is no incentive specific to public reporting. The information reported on the web site is derived from other programs that have various incentives.

Program Goals:

- Providing consumers with quality of care information that will help them make informed decisions about their health care.
- Encourage clinicians to improve the quality of care they provide to their patients and create incentives to maximize performance.

Program Update:

The website was launched on December 30, 2010 by reporting provider information for participants in Physician Quality Reporting System (PQRS). Reporting of performance measure results is progressing in phases. Performance measure reporting for groups and ACOs began in 2014. In 2015, reporting will began for individual professionals for the cardiovascular group of measures in support of the Million Hearts campaign.

By statute, the following types of measures are required to be included for public reporting:

- PQRS measures
- Patient health outcomes and functional status of patients
- Continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use
- Efficiency
- Patient experience and patient, caregiver, and family engagement
- Safety, effectiveness, and timeliness of care

The final 2015 Physician Fee Schedule rule notes that beginning in 2015 all PQRS measures and all QCDR measures will be available for public reporting. Measures that are new to PQRS or a QCDR will not be publicly reported in the first year. Measures of specific interest to consumers and beneficiaries will be posted on the clinician's webpage. Other PQRS measures will be available in a downloadable format. Measures from QCDRs will be held to the same qualifications as PQRS measures, i.e., a minimum sample size of 20 and successful testing for reliability and validity.

For data collected in 2015, for publication on Physician Compare in 2016:

- PQRS, PQRS GPRO, EHR and Million Hearts: include an indicator of satisfactory participation
- PQRS GPRO and ACO GPRO: all PQRS GPRO measures for groups of 2 or more; all measures reported by ACOs with minimum sample size of 20.
- CAHPS for PQRS for all groups of 2 or more and CAHPS for ACOs for all measures that meet sample size
- PQRS: All PQRS measures for individual EPs collected through registry, EHR or claims.
- QCRD data: All individual EP-level 2015 QCDR data.

CMS has indicated an interest in MAP identifying those PQRS measure that are most meaningful to consumers.

Critical Program Objectives (include program objectives and strategic issues)

- Public reporting of PQRS measures for:
    - Physicians—medicine, osteopathy, podiatric medicine, optometry, oral surgery, dental medicine, chiropractic
    - Practitioners—physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional, audiologists
    - Therapists—physical therapist, occupational therapist, qualified speech-language therapist
    - Reporting of physicians in groups and ACOs is included.

- NQF-endorsed measures are preferred for public reporting programs over measures that are not endorsed or are in reserve status (i.e., topped out); measures that are not NQF-endorsed should be submitted for endorsement or removed.

- Include measures that focus on outcomes and are meaningful to consumers (i.e., have face validity) and purchasers.
- Focus on patient experience, patient-reported outcomes (e.g., functional status), care coordination, population health (e.g., risk assessment, prevention), and appropriate care measures.
- To generate a comprehensive picture of quality, measure results should be aggregated (e.g., composite measures), with drill-down capability for specific measure results
- Alignment of measures in federal programs.

Medicare and Medicaid EHR Incentive Programs

Program Type:

The Medicare and Medicaid Electronic Health Care Record (EHR) Incentive Programs provide incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Incentive Structure:

The incentive structure varies by program:

- Medicare: Up to $44,000 over 5 continuous years. The last year to begin the program is 2014. Penalties take effect in 2015 and in each year hereafter where EPs are eligible but do not participate.
- Medicaid: Up to $63,750 over 6 years. The last year to begin the program is in 2016. Payment adjustments do not apply to Medicaid.

Program Goals:

- Promote widespread adoption of certified EHR technology by providers.
- Incentivize "meaningful use" of EHRs by providers to:
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and family
  - Improve care coordination, and population and public health
  - Maintain privacy and security of patient health information

Program Update:

- The three main components of Meaningful Use:
  - The use of a certified EHR in a meaningful manner, such as e-prescribing;
  - The use of certified EHR technology for electronic exchange of health information to improve quality of healthcare; and
  - The use of certified EHR technology to submit clinical quality and other measures.
- Meaningful Use Stage 2:
  - The earliest providers will demonstrate Stage 2 of meaningful use is 2014.
  - For Stage 2 (2014 and beyond): Eligible Professionals must report on 9 total clinical quality measures that cover 3 of the National Quality Strategy Domains (selected from a set of 64 clinical quality measures).
  - CMS is not requiring the submission of a core set of electronic CQMs (eCQMs). Instead, CMS has identified two recommended core sets of eCQMs—one for adults and one for children—that focus on high-priority health conditions and best-practices for care delivery.
- The program has several options that align with other programs:
  - Report individual eligible professionals' eCQMs through PQRS Portal
  - Report group's eCQMs through PQRS Portal

        - Report group's eCQMs through Pioneer ACO participation or Comprehensive Primary Care Initiative participation.

- Measures under consideration for the current pre-rulemaking cycle are for Meaningful Use Stage 3. CMS has determined that the measures under consideration (MUC) for the EHR Incentive Programs are appropriately specified as "electronic Clinical Quality Measures (eCQMs)" or "eMeasures". While some testing may have been done, the eMeasures under consideration are being revised to meeting the mist recent standards and have not been used in the field. CMS agrees the eCQMs on the MUC list are "Measures Under Development".

Critical Program Objectives (include program objectives and strategic issues)

- Include endorsed measures that have eMeasure specifications available.
- Over time, as health IT becomes more effective and interoperable, focus on:
    - Measures that reflect efficiency in data collection and reporting through the use of health IT
    - Measures that leverage health IT capabilities (e.g., measures that require data from multiple settings/providers, patient-reported data, or connectivity across platforms to be fully operational)
    - Innovative measures made possible by the use of health IT
- Alignment with other federal programs, particularly PQRS.

Ambulatory Surgical Centers Quality Reporting Program

Program Type:
Pay for Reporting – Performance information is currently reported to the Centers for Medicare & Medicaid Services (CMS) but it is expected to be publicly available in the future.

Incentive Structure:
Ambulatory surgical centers (ACSs) that treat Medicare beneficiaries and fail to report data will receive a 2.0 percent reduction in their annual payment update. The program includes ASCs operating exclusively to provide surgical services to patients not requiring hospitalization.

Program Goals:

- Promote higher quality, more efficient care for Medicare beneficiaries.
- Establish a system for collecting and providing quality data to ASCs.
- Provide consumers with quality of care information that will help them make informed decisions about their health care.

Program Update:

- For fiscal year (FY) 2017, CMS proposed the following measure: OP-32 Facility Seven-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy
- CMS proposed criteria for determining when a measure is "topped-out". Two criteria were proposed: 1) statistically indistinguishable performance at the 75th and 90th percentiles, and 2) a truncated coefficient of variation less than or equal to 0.10.

Critical Program Objectives:

- Include measures that have high impact and are meaningful to patients.
- Align measures with CMS' various quality reporting programs, particularly the Hospital Outpatient Quality Reporting program, to facilitate comparisons across care settings, and to reduce burden for facilities that participate in these programs.
- Priority measure gap areas for the ASCQR program include surgical care quality, infection rates, follow-up after procedures, complications including anesthesia related complications, cost, and patient and family engagement measures including an ASC-specific CAHPS module and patient-reported outcome measures.

Hospital-Acquired Condition (HAC) Reduction Program

Draft Program Summary

Program Type:

Pay-for-Performance and Public Reporting. HAC scores will be reported on the Hospital Compare website beginning December 2014.

Incentive Structure:

- The 25% of hospitals that have the highest rates of HACs (as determined by the measures in the program) will have their Medicare payments reduced by 1%.
- The measures in the program are classified into two domains: Domain 1 includes the Patient Safety Indicator (PSI) 90 measure, a composite of eight administrative claims based measures and Domain 2 includes infection measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network (CDC NHSN). Each domain will be weighted to determine the total score.
- In the FY 2014 IPPS/LTCH PPS rule, measures for FY 2015, FY 2016 and FY 2017 HAC Reduction Program were finalized.
    - FY 2015: PSI 90 (domain 1) and CDC NHSN's Central-line Association Bloodstream Infection (CLABSI and CAUTI measures (domain 2).
    - FY 2016: CDC NHSN surgical site infection measure (infections following abdominal hysterectomy and colon procedures) will be added to domain 2
    - FY 2017: CDC NHSN MRSA and C. difficile measures will be added to domain 2.
- The weight that each domain contributes to the total HAC score has been finalized for FY 2015 and FY 2016.
    - FY 2015: Domain 1 is 35% and Domain 2 is 65% of the Total HAC Score.
    - FY 2016: Domain 1 will be 25% and Domain 2 will be 75% of the Total HAC score.

Program Goals:

- Heighten awareness of HACs and eliminate the incidence of HACs that could be reasonably prevented by applying evidence-based clinical guidelines.
- Provide motivation to reduce the incidence of HACs, improve patient outcomes, and reduce the cost of care.
- Support a broader public health imperative by helping to raise awareness and action by prompting a national discussion on this important quality problem.
- Drive improvement for the care of Medicare beneficiaries, but also privately insured and Medicaid patients, through spill over benefits of improved care processes within hospitals.

Program Update:

- No new measures were added in the FY 2015 IPPS/LTCH PPS rule to allow hospitals time to gain experience with the measures that were finalized in the FY 2014 IPPS/LTCH PPS rule.
- PSI-90 is currently undergoing review by NQF. AHRQ is considering the addition of three additional measures for the composite, PSI #9 Perioperative Hemorrhage or Hematoma Rate, PSI #10 Postoperative Physiologic and Metabolic Derangement Rate, and PSI #11 Postoperative Respiratory Failure Rate. CMS believes this change to be significant and will propose the change in the rulemaking process prior to requiring reporting of the revised measure.
- The CDC NHSN CLABSI and CAUTI measures also recently underwent NQF review. These measures were recommended for continued endorsement.

Critical Program Objectives:

- Focus on reducing the major drivers of patient harm.
- Overlap in measures between the HAC Reduction Program and the Hospital Value-Based Purchasing Program can help to focus attention on critical safety issues.
- In its 2013-14 round of pre-rulemaking, MAP noted a number of gaps for this program: PSI-5 to address foreign bodies retained after surgery, and development of measures to address wrong site/wrong side surgery and sepsis beyond post-operative infections.

Hospital Value-Based Purchasing Program

Draft Program Summary

Program Type:
Pay for Performance

Incentive Structure:
Medicare bases a portion of hospital reimbursement on performance through the Hospital Value-Based Purchasing Program (VBP). Medicare withholds its regular hospital reimbursements from all hospitals paid under its inpatient prospective payment system (IPPS) to fund a pool of VBP incentive payments. The amount withheld from reimbursements increases over time:

- FY 2015: 1.5%
- FY 2016: 1.75%
- FY 2017 and future fiscal years: 2%

Hospitals are scored based on their performance on each measure within the program relative to other hospitals as well as on how their performance on each measure has improved over time. The higher of these scores on each measure is used in determining incentive payments.
Measures selected for the VBP program must be included in IQR and reported on the Hospital Compare website for at least 1 year prior to use in the VBP program.

Program Goals:

- Improve healthcare quality by realigning hospitals' financial incentives.
- Provide incentive payments to hospitals that meet or exceed performance standards.

Program Update:

- For the FY 2017 Measure Set:
    - Six measures were removed from the FY 2017 program measure set because they were topped out.
    - Three additional measures were added to the program measure set: NQF#0469 PC-01 Elective Delivery Prior to 39 Weeks Gestation, NQF #1716 Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia, and NQF #1717 Clostridium difficile (C. difficile) Infection
- For the FY 2019 Measure Set:
    - NQF #1550 Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) was added to the program measure set.

Critical Program Objectives:

- Include measures where there is a need and opportunity for improvement.
- Emphasize areas of critical importance for high performance and quality improvement, and ideally, link clinical quality and cost measures to capture value.
- NQF-endorsed measures are strongly preferred.
- Keep the program measure set parsimonious to avoid diluting the payment incentives.
- MAP identified a number of gap areas that should be addressed within the VBP program measure set, including medication errors, mental and behavioral health, emergency department throughput, a hospital's culture of safety, and patient and family engagement.

Hospital Readmission Reduction Program

Draft Program Summary

Program Type:
Pay for Performance and Public Reporting – Payments are based on information publicly reported on the Hospital Compare website.

Incentive Structure:
Diagnosis-related group (DRG) payment rates will be reduced based on a hospital's ratio of actual to expected readmissions. The maximum payment reduction is 2 percent, and will increase to 3% beginning October 2014.

Program Goals:

- Reduce readmissions in acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), which is approximately 4000 hospitals in the U.S.
- Provide consumers with quality of care information that will help them make informed decisions about their health care. Hospitals' readmissions information, including their risk-adjusted readmission rates, is available on the Hospital Compare website.

Program Update:

- The Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following Coronary Artery Bypass Graft (CABG) Surgery was added to the program measure set for implementation in FY 2017.
- The planned readmission algorithm for the acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, and total hip arthroplasty/ total knee arthroplasty measures was updated.

Critical Program Objectives:

- Reduce the number of admissions to an acute care hospital following discharge from the same or another acute care hospital.
- Engage patients and their families as partners in care.
- Improve patient care and reduce overall healthcare costs.
- Exclude planned readmissions from the measures in the program.
- Encourage hospitals to take a leadership role in improving care beyond their walls through care coordination across providers since the causes of readmissions are complex and multifactorial.
- Improve care transitions by decreasing readmission rates through optimizing processes under the hospital's control. For example, improving communication of important inpatient information to those who will be taking care of the patient post-discharge.
- Acknowledge that factors affecting readmissions are complex, and may include environmental, community-level, and patient-level factors, including socio-demographic factors.
- Recognize that multiple entities across the health care system, including hospitals, post-acute care facilities, skilled nursing facilities, and others, all have a responsibility to ensure high quality care transitions to reduce unplanned readmissions to acute care hospitals.

Inpatient Psychiatric Facilities Quality Reporting Program

Draft Program Summary

Program Type:

Pay for Reporting – Information will be reported on the Hospital Compare website.

Incentive Structure:

- Inpatient psychiatric hospitals or psychiatric units that do not report data on the required measures will receive a 2 percent reduction in their annual federal payment update.
- The IPFQR Program applies to freestanding psychiatric hospitals, government-operated psychiatric hospitals, and distinct psychiatric units of acute care hospitals and critical access hospitals. This program does not apply to children's hospitals, which are paid under a different system.

Program Goals:

- Provide consumers with quality information to help inform their decisions about their healthcare options.
- Improve the quality of inpatient psychiatric care by ensuring providers are aware of and reporting on best practices.
- Establish a system for collecting and providing quality data for inpatient psychiatric hospitals or psychiatric units.

Program Update:

- For FY 2016:
    - Two structural measures regarding routine assessment of patient experience of care and use of an electronic health records were added to the program measure set for FY 2016.
- For FY 2017:
    - NQF #1654 Tobacco Use Treatment Provided or Offered (TOB-2) and Tobacco Use Treatment (TOB-2a) was added to the program measure set for FY 2017.
    - Two influenza measures, NQF #0431 Influenza Vaccination Coverage Among Healthcare Personnel and #1659 Influenza Immunization) were added to the program measure set.

Critical Program Objectives (include program objectives and strategic issues)

- Ensure measures in the program are meaningful to patients.
- Align the reporting requirements in CMS' various quality reporting programs, particularly the Hospital Outpatient Quality Reporting program, to allow consumers to compare across facility types and to reduce burden for facilities that participate in these programs.
- Improve person-centered psychiatric care, such as assessing patient and family/caregiver experience and engagement and establishing relationships with community resources, are priority measure gap areas.
- Measure gaps in the IPFQR program include step down care, behavioral health assessments and care in the ED, readmissions, identification and management of general medical conditions, partial hospitalization or day programs, and a psychiatric care module for CAHPS.

Inpatient Quality Reporting Program (IQR)

Draft Program Summary

Program Type:
Pay-for-Reporting and Public Reporting. A subset of the measures in the program are publicly reported on the Hospital Compare web site.

Incentive Structure:
Hospitals that do not report data on the required measures will receive a 2 percent reduction in their annual Medicare payment update.

Program Goals:

- Provide an incentive for hospitals to publicly report quality information about their services
- Provide consumers information about hospital quality so they can make informed choices about their care.

Program Update:

- For FY 2017, CMS has finalized a total of 63 measures for the program measure set.
    - 11 new measures were added for FY 2017.
        - These measures address coronary artery bypass graft (CABG) surgery readmissions and mortality, pneumonia and heart failure episode of care payments, severe sepsis and septic shock management, newborn screening for hearing, exclusive breast feeding, child asthma home management plan of care, and healthy term newborns.
        - Two measures were readopted as voluntary electronic clinical quality measures to support alignment with the Medicare EHR Incentive Program for Eligible Hospitals and Critical Access Hospitals. These measures are NQF #0142 AMI-2 Aspirin Prescribed at Discharge and NQF #0639 AMI-10 Statin Prescribed at Discharge.
    - 19 measures were removed for FY 2017. These measures were removed because they were topped out. However, to continue aligning the IQR and Medicare EHR Incentive Program, 10 measures will be retained on a voluntary basis to allow hospitals an opportunity to test the accuracy of the electronic health record reporting systems.

Critical Program Objectives:

- Choose high impact measures that will improve both quality and efficiency of care and are meaningful to consumers.
- Move towards more outcome measures rather than structure or process measures.
- Align reporting requirements with other clinical programs where appropriate to reduce the burden on providers and support efficient use of measurement resources.
- Engage patients and families as partners in their care.
- Expand the program to include measures that allow rural and other small hospitals to participate.
- In the 2013-14 pre-rulemaking process, MAP recommended the rapid filling of the following fairly extensive gap list for this program: pediatrics, maternal/child health, cancer, behavioral health, affordability/cost, care transitions, patient education, palliative and end of life care, medication reconciliation, a culture of safety, pressure ulcer prevention, and adverse drug events. MAP suggested that HHS could look to existing measures in the PPS-Exempt Cancer Hospital Quality Reporting Program, the Inpatient Psychiatric Facility Quality Reporting Program, and Hospice Quality Reporting Programs to begin to fill these gaps.

Medicare and Medicaid EHR Incentive Program for Hospitals and Critical Access Hospitals (CAHs)

Program Type:
Pay for Reporting. The Medicare and Medicaid EHR Incentive Programs provide incentives to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Incentive Structure:
For the Medicare Incentive Program (hospitals), incentive payments began in 2011 and are comprised of an Initial Amount, Medicare Share, and Transition Factor. The CAH EHR Incentive payment is based on a formula for Allowable Costs and the Medicare Share. The Medicaid Incentive program includes an Overall EHR Amount and Medicaid Share. Medicare payment penalties will take effect in 2015 for providers who are eligible but do not participate. Payment penalties do not apply to Medicaid.

For Stage 1, eligible facilities must report on all 15 total clinical quality measures. For Stage 2 (2014 and beyond) eligible facilities must report on 16 clinical quality measures that cover 3 of the National Quality Strategy domains. Measures are selected from a set of 29 clinical quality measures that includes the 15 measures from Stage 1.

Program Goals:
- Promote widespread adoption of certified EHR technology by providers.
- Incentivize "meaningful use" of EHRs by hospitals to:
    - Improve quality, safety, efficiency, and reduce health disparities
    - Engage patients and family
    - Improve care coordination, and population and public health
    - Maintain privacy and security of patient health information

Program Update:
- The three main components of Meaningful Use:
    - The use of a certified EHR in a meaningful manner, such as e-prescribing;
    - The use of certified EHR technology for electronic exchange of health information to improve quality of healthcare; and
    - The use of certified EHR technology to submit clinical quality and other measures.
- For Stage 1 (2014):
    - Removal of clinical quality measures (CQMs) as a separate core objective for Stage 1 for eligible professionals, eligible hospitals, and CAHs. Reporting CQMs will still be required in order to achieve meaningful use.
    - For Stage 2 (2014):
    - The earliest Hospitals and Critical Access Hospitals will demonstrate Stage 2 of meaningful use is October 2014.
- For Stage 2 (2014 and beyond):
    - Eligible hospitals and CAHs must meet 16 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 19 core objectives.
    - New Core Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)

Critical Program Objectives:

- Preference should be given to NQF-endorsed quality measures.
- Select measures that represent the future of measurement (facilitating information exchange between institutions and longitudinal tracking of care, such as measures that monitor incremental changes in a patient's condition over time).
- Align the measure set with other hospital performance measurement programs.
- Ensure e-measures in the program are reliable and provide comparable results to paper-based measures.

Hospital Outpatient Quality Reporting Program

Draft Program Summary

Program Type:
Pay for Reporting – Information on measures is reported on the Hospital Compare website.

Incentive Structure:
Hospitals that do not report data on the required measures will receive a 2 percent reduction in their annual Medicare payment update.

Program Goals:

- Establish a system for collecting and providing quality data to hospitals providing outpatient services such as clinic visits, emergency department visits, and critical care services.
- Provide consumers with quality of care information that will help them make informed decisions about their health care.

Program Update:

- For FY 2017, CMS proposed the following measure: OP-32 Facility Seven-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy
- CMS proposed criteria for determining when a measure is ”topped-out”. Two criteria were proposed: 1) statistically indistinguishable performance at the 75th and 90th percentiles and 2) a truncated coefficient of variation less than or equal to 0.10.
- CMS proposed removal of the following measures:
    - OP-4 Aspirin on arrival
    - OP-6 Timing to Prophylactic Antibiotics
    - OP-7 Prophylactic Antibiotic Selection for Surgical Patients

Critical Program Objectives:

- Focus on measures that have high impact and support national priorities
- Align the OQR measures with ambulatory care measures
- Specific gap areas for the OQR program measure set include measures of emergency department (ED) overcrowding, wait times, and disparities in care—specifically, disproportionate use of EDs by vulnerable populations. Other gaps include measures of cost, patient-reported outcomes, patient and family engagement, follow-up after procedures, fostering important ties to community resources to enhance care coordination efforts, and an outpatient CAHPS module.

PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR)

Program Type:
Reporting: Information will be publicly reported beginning in 2014.

Incentive Structure:
There is currently no financial incentive for the 11 hospitals in this program to report quality measures. CMS plans to create an incentive structure in the future.

Program Goals:

- Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program.
- Encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices

Program Update:

- NQF #1822 External Beam Radiotherapy for Bone Metastases was added to the program beginning in October 2017. MAP supported this measure for the PCHQR program, noting that it helps to fill a gap in palliative care.
- CMS noted that future measure topics may include patient-centered care planning and care coordination, shared decision making, measures of quality of life outcomes, and measures of admissions for complications of cancer and treatment for cancer.
- CMS will make the results of NQF #220 Adjuvant Hormonal Therapy publicly available in 2015. The results of NQF #138 NHSN Catheter-Associated Urinary Tract Infections (CAUTI) Outcome Measure and NQF #139 NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome measure will be made available by 2017.

Critical Program Objectives:

- Include measures appropriate to cancer hospitals that reflect the highest priority services provided by these hospitals.
- Align measures with the Inpatient Quality Reporting Program and Outpatient Quality Reporting Program where appropriate and relevant.
- The measures should address gaps in cancer care quality. MAP has previously identified pain screening and management, patient and family/caregiver experience, patient-reported symptoms and outcomes, survival, shared decision making, cost, care coordination and psychosocial/supportive services as gap areas for this program

NATIONAL QUALITY FORUM

Draft Program Summary

End Stage Renal Disease Quality Incentive Program

Program Type:
Pay for Performance, Public Reporting

Incentive Structure:
Starting in 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score, which is the sum of the scores for established individual measures during a defined performance period. Payment reductions will be on a sliding scale, which could amount to a maximum of two percent per year.[1] Facility performance in the End Stage Renal Disease Quality Incentive Program (ESRD QIP) is publicly reported through three mechanisms: Performance Score Certificate, the Dialysis Facility Compare website, and ESRD QIP Dialysis Facility Performance Information.[2]

Program Goals:
Improve the quality of dialysis care and produce better outcomes for beneficiaries.[3]

Program Update:

- Proposed rule for End-Stage Renal Disease (ESRD) prospective payment system (PPS) for calendar year (CY) 2015:[4]
    - Proposed Measures for the PY 2017 ESRD QIP
        - Continue using measures finalized for the PY 2016 program measure set except one measure *Anemia Management: Hgb >12 Percentage of Medicare patients with a mean hemoglobin value greater than 12 g/dL' measure*, which CMS is proposing to remove because it is topped out.
        - Adopt the Standardized Readmission Ratio (SRR) clinical measure, which is currently under review by NQF (NQF#2496) and addresses care coordination.
    - Proposed Measures for the PY 2018 ESRD QIP
        - Continue using measures proposed for the PY 2017 program measure set with the exception of the ICH CAHPS reporting measure, which CMS is proposing to convert to a clinical measure, 0258 In-center hemodialysis CAHPS Survey.
        - Adopt three new measures which are based on NQF-Endorsed measures that MAP supported in 2014 (NQF #0420, NQF #0418, NQF #0431). CMS is proposing to adopt the following measures as a reporting measure until such time that they can collect the baseline data needed to score it as a clinical measure:
            - Pain Assessment and Follow-Up, a reporting measure.
            - Depression Screening and Follow-Up, a reporting measure
            - NHSN Healthcare Personnel Influenza Vaccination, a reporting measure
        - Adopt a new measure *Percentage of pediatric peritoneal dialysis patient-months with spKt/V greater than or equal to 1.8,* which was conditionally supported by MAP in 2014.

Critical Program Objectives (include program objectives and strategic issues)

Statutory Requirements

- Program measure set should include measures of anemia management that reflect labeling approved by the Food and Drug Administration (FDA), dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access. [5]

MAP Previous Recommendation

- Measure set expand beyond dialysis procedures to include nonclinical aspects of care such as care coordination, medication reconciliation, functional status, patient engagement, pain, falls, and measures covering comorbid conditions such as depression.[6]
- Explore whether the clinically focused measures could be combined in a composite measure for assessing optimal dialysis care. [7]

Future direction of the Program

- Outcome measures are preferred
- Inclusion of pediatric measures to assess the pediatric population that has been largely excluded from the existing measures
- Identify appropriate data elements and sources to support measures

[1] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/

[2] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP/Downloads/ESRD-QIP-FAQ.pdf

[3] Ibid

[4] https://www.federalregister.gov/articles/2014/07/11/2014-15840/medicare-program-end-stage-renal-disease-prospective-payment-system-quality-incentive-program-

[5]Final rule ESRD PY 2014. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

[6] http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx

[7] NQF. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

NATIONAL QUALITY FORUM

Draft Program Summary

Home Health Quality Reporting Program

Program Type:
Pay for Reporting, Public Reporting

Incentive Structure:
Medicare-certified[1] home health agencies (HHAs) are required to collect and submit the Outcome and Assessment Information Set (OASIS). The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.[2] Home health agencies meet their quality data reporting requirements through the submission of OASIS assessments and Home Health CAHPS. HHAs that do not submit data will receive a 2 percentage point reduction in their annual HH market basket percentage increase.[3] Subsets of the quality measures generated from OASIS are reported on the Home Health Compare website, which provides information about the quality of care provided by HHAs throughout the country.[4]

Program Goals:
As home health quality goals, CMS has adopted the mission of The Institute of Medicine (IOM) which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient centeredness, safety, and timeliness. [5]

Program Update:

- Updates listed in the CY 2015 Home Health Notice of Proposed Rulemaking:[6]
    - Specified the adoption of two claims based measures in the CY 2014 HH PPS final rule and the beginning date of CY 2014 for reporting. These claims based measures supported by MAP in the past pre-rulemaking cycle are: (1) Rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH
    - Set a date of October 2014 for removal of the episode stratified process measures in the CASPER reports
    - Proposed a new pay-for-reporting performance requirement for OASIS reporting. HHAs will need to achieve a goal of 90% submission of admission and discharge OASIS data in an incremental fashion over a 3 year period, with the goal of reaching 70% compliance rate in the first year and increasing by 10% for each subsequent year to reach the 90% compliance rate.
    - Will continue to require HHCAHPS

Critical Program Objectives (include program objectives and strategic issues)
Statutory Requirements

- Home health is a covered service under the Part A Medicare benefit. It consists of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is ordered by a physician.[7]

- Two categories of quality measures used in HH QRP are outcome measures and process measures. There are three types of outcome measures used including: [8]
    - Improvement measures (i.e., measures describing a patient's ability to get around, perform activities of daily living, and general health);
    - Measures of potentially avoidable events (i.e., markers for potential problems in care); and
    - Utilization of care measures (i.e., measures describing how often patients access other health care resources either while home health care is in progress or after home health care is completed).

- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs[9]:
    - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
    - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes
    - Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
    - Applicable PAC programs are defined as: 1)HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
    - Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
        - New quality measures will address, at a minimum, the following domains:
            - functional status and changes in function;
            - skin integrity and changes in skin integrity;
            - medication reconciliation;
            - incidence of major falls; and
            - accurately communicating health information and care preferences when a patient is transferred
        - Resource use measures will address the following:
            - efficiency measures to include total Medicare spending per beneficiary;
            - discharge to community; and
            - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
    - Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF,

and LTCH and January 1, 2018 for HHA ; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

MAP Previous Recommendation

- MAP noted that the large measure set reflects the heterogeneity of home health population; however, the measure set could be more parsimonious. [10]

Future Direction of the Program

- Conduct a thorough analysis of the measure set to identify priority gap areas, remove measures that are topped out, and improve the existing measures.

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[1] "Medicare-certified" means the home health agency is approved by Medicare and meets certain Federal health and safety requirements.

[2] Centers for Medicare and Medicaid Services. Background. June 2011. Available at http://www.cms.gov/OASIS/02_Background.asp#TopOfPage. Last accessed October 2014.

[3] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html. Last accessed October 2014.

[4] The Official U.S. Government Site for Medicare. Introduction. Available at http://www.medicare.gov/HomeHealthCompare/About/What-Is-HHC.html. Last accessed October 2014.

[5] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html?redirect=/homehealthqualityinits/

[6] Proposed Home Health Rule CY 2015. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

[7] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html

[8] Ibid

[9] https://www.congress.gov/bill/113th-congress/senate-bill/2553

[10] NQF. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

NATIONAL QUALITY FORUM

Draft Program Summary

Hospice Quality Reporting Program

Program Type:
Pay for Reporting, Public Reporting

Incentive Structure:
Failure to submit required quality data, beginning in FY 2014 and for each year thereafter, shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year. [1] The data must be made publicly available, with Hospice Programs having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of hospice quality data. [2]

Program Goals:
Hospice care uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through the use of a broad spectrum of professional and other caregivers and volunteers. The goal of hospice care is to make the hospice patient as physically and emotionally comfortable as possible, with minimal disruption to normal activities, while remaining primarily in the home environment. [3]

Program Update:

- FY 2015 Hospice Final Rule:[4]
  - CMS finalized the Hospice Item Set (HIS) in last year's rule to meet the quality reporting requirements for hospices for the FY 2016 payment determination (data submission takes effect on or after July 1, 2014) and each subsequent year. HIS to be used by all hospices to collect and submit standardized data items about each patient admitted to hospice.
  - The CAHPS Hospice Survey has a Jan 1, 2015 implementation date. (Participation requirements for the survey begin January 1, 2015 for the FY 2017 annual payment update.)

Critical Program Objectives (include program objectives and strategic issues)

Statutory Requirements

- As of July 1, 2014, all Medicare-certified hospices are required to submit an HIS-Admission record and HIS-Discharge record for each patient admission to their hospice.[5]
  - The HIS is a patient-level data collection tool developed as part of the HQRP, which can be used to collect data to calculate 6 National Quality Forum-endorsed (NQF) Measures and 1 modified NQF Measure: [6]

1. NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
2. NQF #1634 Pain Screening
3. NQF #1637 Pain Assessment
4. NQF #1638 Dyspnea Treatment
5. NQF #1639 Dyspnea Screening
6. NQF #1641 Treatment Preferences
7. Modified NQF #1647 Beliefs/Values Addressed (if desired by the patient)

MAP Previous Recommendation

- Include measures addressing concepts such as goal attainment, patient engagement, care coordination, depression, caregiver's role, and timely referral to hospice. [7]

Future Direction of the Program

- Develop an outcome measure addressing pain.
- Select measures that address care coordination, communication, timeliness/responsiveness of care, and access to the healthcare team on a 24-hour basis.

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[1] CMS. Hospice Quality Reporting. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html

[2] Ibid

[3] https://www.federalregister.gov/articles/2014/08/22/2014-18506/medicare-program-fy-2015-hospice-wage-index-and-payment-rate-update-hospice-quality-reporting

[4] Ibid

[5] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html

[6] Ibid

[7] NQF. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

NATIONAL QUALITY FORUM

Draft Program Summary

Inpatient Rehabilitation Facilities Quality Reporting Program

Program Type:
Pay for Reporting, Public Reporting

Incentive Structure:
For fiscal year of 2014, and each year thereafter, Inpatient Rehabilitation Facility providers (IRFs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive annual payment updates. Failure to report quality data will result in a 2 percent reduction in the annual increase factor for discharges occurring during that fiscal year.[1] The data must be made publicly available, with IRF providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data.[2]

Program Goals:
Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge. [3]

Program Update:

- IRF Prospective Payment System for Federal Fiscal Year 2015 final rule:[4]
  - For the FY 2017 adjustments to the IRF PPS annual increase factor, in addition to retaining the previously finalized measures, CMS adopted two new quality measures:
    - Measure NQF#1717 NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (supported by MAP in the 2014 pre-rulemaking report)
    - Measure NQF #1716 NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (conditionally supported by MAP in the 2014 pre-rulemaking report)

Critical Program Objectives (include program objectives and strategic issues)

Statutory Requirements

- Measures should align with the National Quality Strategy (NQS), be relevant to the priorities of IRFs (such as patient safety, reducing adverse events, better coordination of care, and person- and family-centered care.[5]

- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs[6]:
  - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
  - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes

- Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
- Applicable PAC programs are defined as: 1)HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
- Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
    - New quality measures will address, at a minimum, the following domains:
        - functional status and changes in function;
        - skin integrity and changes in skin integrity;
        - medication reconciliation;
        - incidence of major falls; and
        - accurately communicating health information and care preferences when a patient is transferred
    - Resource use measures will address the following:
        - efficiency measures to include total Medicare spending per beneficiary;
        - discharge to community; and
        - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
- Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA ; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

MAP Previous Recommendation

- Program measure set is too limited and could be enhanced by addressing core measure concepts not currently addressed in the set such as care coordination, functional status, and medication reconciliation and the safety issues that have high incidence in IRFs, such as MRSA, falls, CAUTI, and C. difficile.[7]

[1] CMS.gov. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

[2] Ibid

[3] https://www.federalregister.gov/articles/2011/08/05/2011-19516/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal

[4] https://www.federalregister.gov/articles/2014/08/06/2014-18447/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal

[5] https://www.federalregister.gov/articles/2011/08/05/2011-19516/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal

[6] https://www.congress.gov/bill/113th-congress/senate-bill/2553

[7] NQF. MAP 2014 Recommendations on Measures for More Than 20 Federal Programs. http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx

NATIONAL QUALITY FORUM

Draft Program Summary

Long-Term Care Hospitals Quality Reporting Program

Program Type:
Pay for Reporting, Public Reporting

Incentive Structure:
For fiscal year 2014, and each year thereafter, Long-Term Care Hospital providers (LTCHs) must submit data on quality measures to the Centers for Medicare & Medicaid Services (CMS) to receive full annual payment updates; failure to report quality data will result in a 2 percent reduction in the annual payment update.[1] The data must be made publicly available, with LTCH providers having an opportunity to review the data prior to its release. No date has been specified to begin public reporting of quality data. [2]

Program Goals:
Furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).[3]

Program Update:

- Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System FY 2015 Final Rule: [4]
  - For the FY 2018 payment determination and subsequent years, in addition to retaining the previously finalized measures, CMS adopted three new quality measures:
    - Percent of LTCH patients with an admission and discharge functional assessment and a care plan that addresses function (conditionally supported by MAP in the 2014 pre-rulemaking report)
    - Functional Outcome Measure: change in mobility among patients requiring ventilator support (conditionally supported by MAP in the 2014 pre-rulemaking report)
    - Ventilator-Associated Event (supported by MAP in the 2014 pre-rulemaking report)

Critical Program Objectives (include program objectives and strategic issues)

Statutory Requirements

- Measures should align with the National Quality Strategy (NQS), promote enhanced quality with regard to the priorities most relevant to LTCHs (such as patient safety, better coordination of care, and person- and family-centered care).[5]
- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs[6]:
  - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
  - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes

- Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
- Applicable PAC programs are defined as: 1)HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program
- Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
    - New quality measures will address, at a minimum, the following domains:
        - functional status and changes in function;
        - skin integrity and changes in skin integrity;
        - medication reconciliation;
        - incidence of major falls; and
        - accurately communicating health information and care preferences when a patient is transferred
    - Resource use measures will address the following:
        - efficiency measures to include total Medicare spending per beneficiary;
        - discharge to community; and
        - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
- Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA ; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

MAP Previous Recommendation

- Functional status assessment should cover a broad range of mobility issues, such as position changes, locomotion, poor mobility, picking up objects, and chair-to-bed transfers. [7]
- Increased attention should be given to pain, agitation, and delirium among the ventilated population, as these factors are the biggest impediments to mobility. [8]
- Add measures to address cost, cognitive status assessment (e.g., dementia identification), medication management (e.g., use of antipsychotic medications), and advance directives. [9]

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[1] CMS.gov. LTCH Quality Reporting.http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html?redirect=/LTCH-Quality-Reporting/

[2] Ibid

[3] FY 2012 IPPS/LTCH PPS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

[4] https://www.federalregister.gov/articles/2014/08/22/2014-18545/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

[5] FY 2012 IPPS/LTCH PPS final rule. The Office of the Federal Register. http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

[6] https://www.congress.gov/bill/113th-congress/senate-bill/2553

[7] NQF. MAP 2014 Recommendations on Measures for More Than 20 Federal Programs. http://www.qualityforum.org/Publications/2014/01/MAP_Pre-Rulemaking_Report__2014_Recommendations_on_Measures_for_More_than_20_Federal_Programs.aspx

[8] Ibid

[9] NQF. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

NATIONAL QUALITY FORUM

Draft Program Summary

Nursing Home Quality Initiative

Program Type:
Public Reporting

Incentive Structure:

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. Part of this requirement includes completing the Minimum Data Set (MDS), a clinical assessment of all residents in Medicare- or Medicaid-certified nursing facilities. Quality measures are reported on the Nursing Home Compare website using a Five-Star Quality Rating System, which assigns each nursing home a rating of 1 to 5 stars, with 5 representing highest standard of quality, and 1 representing the lowest.[1]

Program Goals:

The overall goal of NHQI is to improve the quality of care in nursing homes using CMS' informational tools. The objective of these informational tools is to share quality information with consumers, health care providers, intermediaries and other key stakeholders to help them make informed decisions about nursing home care (e.g., Nursing Home Compare, Nursing Home Checklist).[2]

Program Update:

None

Critical Program Objectives (include program objectives and strategic issues):

Statutory Requirements

- The Improving Medicare Post-Acute Care Transformation Act of 2014, a.k.a "IMPACT ACT of 2014" provisions for PAC programs[3]:
    - Require post-acute care (PAC) providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures
    - Require the data to be interoperable to allow for its exchange among PAC and other providers to give them access to longitudinal information so as to facilitate coordinated care and improve Medicare beneficiary outcomes
    - Modify PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers
    - Applicable PAC programs are defined as: 1)HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program

- Establishes a new "SNF Quality Reporting Program" at the start of FY 2019 and directs the Secretary to reduce by 2% the update to the market basket percentage for skilled nursing facilities which do not report assessment and quality data under this program.
- Specifies requirements for the creation and reporting of new quality measures which will be implemented in a staggered time frame by PAC providers.
  - New quality measures will address, at a minimum, the following domains:
    - functional status and changes in function;
    - skin integrity and changes in skin integrity;
    - medication reconciliation;
    - incidence of major falls; and
    - accurately communicating health information and care preferences when a patient is transferred
  - Resource use measures will address the following:
    - efficiency measures to include total Medicare spending per beneficiary;
    - discharge to community; and
    - risk adjusted hospitalization rates of potentially preventable admissions and readmissions.
- Directs the Secretary to: (1) provide confidential feedback reports to PAC providers on their performance with respect to required measures by October 1, 2017 for SNF, IRF, and LTCH and January 1, 2018 for HHA; and (2) arrange for public reporting of PAC provider performance on quality, resource use, and other measures by October 1, 2018 for SNF, IRF, and LTCH and January 1, 2019 for HHA.

- The Protecting Access to Medicare Act of 2014 (PAMA)[4]:
  - Directs the Secretary to establish a skilled nursing facility value-based purchasing (SNF VBP) program under which value-based incentive payments are made in a fiscal year to skilled nursing facilities, beginning in fiscal year 2019.
  - Readmission measure - Not later than October 1, 2015, the Secretary shall specify a skilled nursing facility all-cause all-condition hospital readmission measure (or any successor to such a measure).
  - Resource use measure – Not later than October 1, 2016, the Secretary shall specify a measure to reflect an all-condition risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities.
  - Directs the Secretary to: (1) provide confidential feedback reports to SNFs on their performance with respect to above measures, beginning October 1, 2016 and every quarter thereafter; and (2) establish procedures for making available to the public by posting on the Nursing Home Compare Medicare website (or a successor website) information on the performance of SNF with respect to the above measures beginning not later than October 1, 2017.

MAP Previous Recommendation

- Determine whether (1) there are opportunities to combine the long-stay and short-stay measures using risk adjustment and/or stratification to account for patient variations and (2)

any of the measures could be applied to other PAC/LTC programs to align measures across settings. [5]

- Add measures that assess discharge to the community and the quality of transition planning. [6]
- Include Nursing Home-CAHPS measures in the program to address patient experience. [7]

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[1] Centers for Medicare and Medicaid Services. Five-Star Quality Rating System. Available at https://www.cms.gov/CertificationandComplianc/13_FSQRS.asp#TopOfPage. Last accessed October 2011.

[2] Health Policy Monitor. Nursing Home Quality Initiatives. Available at http://hpm.org/en/Surveys/CMWF_New_York_-_USA/02/Nursing_Home_Quality_Initiatives.html. Last accessed September 2014

[3] https://www.congress.gov/bill/113th-congress/senate-bill/2553

[4] https://www.govtrack.us/congress/bills/113/hr4302/text

[5] NQF. MAP Pre-Rulemaking Report: 2013 Recommendations on Measures Under Consideration by HHS. http://www.qualityforum.org/Publications/2013/02/MAP_Pre-Rulemaking_Report_-_February_2013.aspx

[6] Ibid

[7] NQF. Pre-Rulemaking Report: Input on Measures Under Consideration by HHS for 2012 Rulemaking. http://www.qualityforum.org/Publications/2012/02/MAP_Pre-Rulemaking_Report__Input_on_Measures_Under_Consideration_by_HHS_for_2012_Rulemaking.aspx

NATIONAL QUALITY FORUM

Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2014

EXPEDITED REVIEW, DRAFT REPORT FOR PUBLIC COMMENT

October 27, 2014

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

Contents

Introduction and Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF). MAP provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs (Appendix A). MAP has also been charged with providing input on the use of performance measures to assess and improve the quality of care delivered to children who are enrolled in Medicaid and the Children's Health Insurance Program (CHIP).

The MAP Medicaid Child Task Force advises the MAP Coordinating Committee on recommendations to HHS for strengthening and revising measures in the Core Set of Health Care Quality Measures for Children Enrolled in Medicaid and CHIP (Medicaid Child Core Set), with a focus on addressing high-priority measure gaps. The task force consists of MAP members from the MAP Coordinating Committee and MAP workgroups (Appendix B).

MAP's input on the Medicaid Child Core Set begins with an expedited review, described in this report, scheduled to be completed by November 14, 2014. MAP will also conduct a second, more in-depth review scheduled to be completed in August 2015. Because a comprehensive retirement review was recently completed by the Agency for Healthcare Research and Quality (AHRQ), the focus for MAP's expedited review was to recommend measures to fill critical gap areas. In tandem with the MAP Measure Selection Criteria (MSC) (Appendix C), MAP considered states' experiences implementing the Child Core Set in making its recommendations. HHS will use MAP's findings to inform an update of the Medicaid Child Core Set required by statute to occur by January 2015. NQF will continue to convene the Medicaid Child Task Force and MAP Coordinating Committee to provide additional review and recommendations in 2015 for the January 2016 update.

Background on Medicaid and the Child Core Set

Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals. CHIP provides coverage to children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. Both Medicaid and CHIP are financed through federal-state partnerships; each state designs and operates its own programs within federal guidelines.[1]

Medicaid and CHIP Benefits for Children

Together, Medicaid and CHIP cover more than 43 million children, which is more than 1 in every 3,[2] and about 40 percent of all births.[3] The federal government sets minimum guidelines for Medicaid eligibility, but states can choose to expand coverage beyond the minimum threshold. Most states have elected to provide Medicaid to children with family incomes above the minimum of 100 percent of the Federal Poverty Level (FPL);[4] the FPL is determined by family size, and is $19,790 for a family of three in 2014.[5] As of April 2014, 29 states (including DC) covered children in families with income up to at least 250 percent FPL under Medicaid or CHIP. 19 of these states covered children with income up to at least 300 percent FPL.[6]

States establish and administer their own Medicaid programs but are required to cover certain mandatory benefits, and can choose to provide other optional benefits. All children enrolled in Medicaid are entitled to the comprehensive set of health care services known as Early, Periodic Screening, Diagnosis and Treatment (EPSDT). This benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The preventive focus of EPSDT helps to ensure that health problems, including behavioral health issues, are identified and treated early, before problems become more complex and their treatment more costly.[7] Although pharmacy coverage is an optional benefit under federal Medicaid law, all States currently provide coverage for outpatient prescription drugs to all categorically eligible individuals and most other enrollees within their Medicaid programs.[8]

CHIP also ensures a comprehensive set of benefits for children, but states have flexibility to design the benefit package depending on how the CHIP program is set up. States can design their CHIP program in one of three ways: as an expansion of the Medicaid program, as a separate Child Health Insurance Program, or as a combination of the two approaches. If it is a Medicaid Expansion CHIP program, it will provide the standard Medicaid benefit package, including EPSDT. Separate CHIP programs can provide either Benchmark coverage or Benchmark-equivalent coverage.[9]

Health Issues for Children in Medicaid and CHIP

Understanding the health-related needs of children in Medicaid and CHIP contributes to the selection of appropriate measures across the continuum of child health. Data from the National Health Interview Survey (NHIS) in 2012 found that 83 percent of U.S. children under age 18 had excellent or very good health.[10] While most children are healthy, an important sub-group to consider is children with complex health needs. Approximately two-thirds of all children with complex health needs are covered by Medicaid, accounting for about about 6 percent of the total number of children on Medicaid. However, this 6 percent of enrollees incur nearly 40 percent of costs.[11]

In 2010, children constituted one-fifth of the approximately 130 million visits to hospital-affiliated emergency departments (EDs) in the United States. The vast majority—96 percent—of ED visits resulted in the child being treated and released from the ED rather than being admitted to a hospital for further care. An analysis of Healthcare Cost and Utilization Project (HCUP) data found that two-thirds of ED visits for infants younger than one year were billed to Medicaid. Medicaid was also the largest primary expected payer for ED visits among children aged 1-4 and 5-9 years. Injuries and poisoning and respiratory disorders were the most common reasons for all ED visits, followed by nervous system disorders and infectious and parasitic diseases. When the data are broken out by age, injuries and poisoning were the most common reasons for ED visits for older children, while respiratory disorders were the most common reasons for ED visits for younger children. Among ED visits that result in the child being admitted to a hospital for further, dehydration and respiratory conditions, especially asthma, were common reasons. Additionally, mood disorders and conduct or disruptive behavioral disorders were frequent reasons for ED visits resulting in admission among older children.[12]

Health expenditures provide another lens on children's health issues. According to MEPS data, $117.6 billion was spent for the medical care and treatment of children in 2011. The five most costly medical

conditions in terms of total direct medical spending were mental disorders, asthma, trauma-related disorders, acute bronchitis and upper respiratory infections, and otitis media, as defined by the Clinical Classification System (CCS). Of the five most costly conditions for children, mental disorders affected the fewest children but had the highest average expense per child; nearly half of the $13.8 billion spent on mental disorders in 2011 was covered by Medicaid. About 41.5 percent of mental health expenditures on children were for prescription medications.[13]

While poor birth outcomes lead to high average expenditures per infant, they do not occur as frequently as other high-impact conditions, and so do not appear in the list of top five most costly medical conditions. If examining average expenditures per case, the three most costly conditions are infant respiratory distress syndrome, premature birth/low birth weight, and cardiac and circulatory birth defects, all of which are regarded as poor birth outcomes. Moreover, more than half of hospital stays related to short gestation, low birth weight, or inadequate fetal growth were covered by Medicaid.[14]

Dental caries are the most common chronic disease in children in United States,[15] and, if left untreated, can lead to problems in eating, speaking, learning, and lower quality of life.[16] Six percent of children had an unmet dental need because their families could not afford dental care.[17] The percentage of children ages 2 to 18 who receive dental benefits from Medicaid increased from 20.5 percent in 2000, to 36.8 percent in 2011.[18]

Medicaid Child Core Set

With such a large share of children relying on Medicaid and CHIP for comprehensive health services, the quality of these services is paramount. Performance measurement provides the health system with information it needs to monitor quality and undertake improvement activities when deficits are identified.

The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) provided for the development of a core set of healthcare quality measures for children enrolled in Medicaid and CHIP. The Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) jointly charged a group of experts with creating this core set of measures in 2009.[19] The initial core set of 24 measures contained within the set are relevant to children ages 0-18 as well as pregnant women in order to encompass both pre-natal and post-partum quality of care issues.

CMS' three-part goal for the Child Core Set is to increase the number of states reporting Core Set measures, increase the number of measures reported by each state, and increase the number of states using Core Set measures to drive quality improvement. CHIPRA also required CMS to update the initial core set annually. The 2013 Child Core Set revision added three measures and retired one measure, for a total of 26 measures.[20] For the 2014 update, CMS focused only on measures for retirement. In December 2013, CMS released the 2014 Child Core Set, which retired three measures and brought the total to 23 measures.[21]

Characteristics of the Medicaid Child Core Set

The 2014 Child Core Set contains 23 measures (Appendix D) that are concentrated in the National Quality Strategy priority area of Healthy Living and Well-Being (Exhibit 1).

Exhibit 1. National Quality Strategy

National Quality Strategy Priority	Number of Measures in the Child Core Set (n = 23)
Patient Safety	1
Person- and Family-Centered Experience of Care	1
Effective Communication and Care Coordination	3
Prevention and Treatment of Chronic Disease	0
Healthy Living and Well-Being	16
Affordability	2

Viewed as an array of measure types, the set contains no structural measures, 19 process measures, 4 outcome measures, and 1 experience of care measure. Additionally, the Child Core Set is well-aligned with other quality and reporting initiatives: seven of the measures are used in one or more federal programs, including the Medicaid Adult Core Set and the Health Insurance Marketplace Quality Rating System Measure Set.[22,23] Representing the diverse health needs of the child Medicaid and CHIP population, the Child Core Set measures span many clinical topic areas (Exhibit 2).

Exhibit 2. Clinical Areas Covered by Measures in the Medicaid Child Core Set

Clinical Topics	Number of Measures in the Child Core Set (n = 23)
Access to Care	1
Acute Care and Chronic Conditions (e.g., Asthma, Overweight/Obesity)	3
Behavioral Health	3
Consumer Experience	1
Oral Health	2
Perinatal Care	6
Preventive Care and Screening	7

State Experience Collecting and Reporting the Core Set

MAP values implementation and impact information about measures and uses this feedback to inform its decisionmaking. MAP received feedback on the implementation of the Child Core Set from presentations from states that participated in reporting and from the 2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP. This report states that in 2012, all states reported on at least two measures, with a median of 14 measures per state. Appendix E provides more details. CMS now has four years of experience with this voluntary reporting program and providing technical assistance and analytic support for states. These valuable inputs informed MAP's measure-specific and strategic recommendations for the Medicaid Child Core Set to achieve CMS' three-part goal.

Presentations from two states highlighted that the Child Core Set measures are being used as an important tool to drive improvements on priority issues. The panelists identified implementation and measure-specific challenges to reporting the Medicaid Child Core set, including:

- Greater clarity is needed in the technical specifications, especially around definitions.
- Measures that require chart review pose significant data collection burdens. Not only can they be resource-intensive, but also there may be legal and or technical barriers for the state to review medical records from hospitals and health systems.
- The differences in reporting mechanisms across care settings and benefit structures also pose challenges. States that have "carve-outs" for mental health services experience challenges in gathering data on follow-up care and other details.
- States and their contracted health plans and providers are involved in multiple quality reporting initiatives, such as the Meaningful Use incentives and accreditation for managed care organizations. Greater alignment of measures among these programs would improve the efficiency of participation.

The presenters also provided feedback on strategic issues and measure gap areas:

- Greater capacity for electronic data abstraction and measurement would reduce some of the effort associated with data collection and quality reporting for multiple programs. It would also allow for quality improvement activities that are incorporated into the EHR clinical workflow.
- More measures are needed on mental health topics, such the complex care issues of children in the foster care system, medication use and overuse, and adolescent suicide.

There are various potential reasons states have for reporting relatively few of the Child Core Set measures, including data access and technical capacity. Additionally, states may be using other measures to address local needs and not sharing those results with CMS.

MAP Review of the Medicaid Child Core Set

The focus for MAP's expedited review was to identify opportunities to strengthen the Child Core Set by recommending measures to fill critical gap areas. Prior to MAP's opportunity to provide input on the Child Core Set, the Subcommittee of the National Advisory Council on Healthcare Research and Quality (SNAC) convened by the Agency for Healthcare Research and Quality (AHRQ) reviewed the measures to determine which should be retired from the set.[24] CMS acted on the SNAC's 2013 recommendations and removed three measures from the set in its January 2014 update: pharyngitis testing, annual HbA1c testing, and the asthma ED measure. The removal of these measures created capacity for a small number of new measures to be added in the next annual update, scheduled to occur by January 2015.

High Priority Gaps

During a September 2014 web meeting, MAP identified numerous gaps in measures in the current Child Core Set. These were reviewed and refined at the October in-person meeting and include:

- Care coordination
    - Home- and community-based care

    - Social services coordination
- Screening for abuse and neglect
- Injuries and trauma
- Mental health
    - Access to outpatient and ambulatory mental health services
    - ED use for behavioral health
- Overuse/medically unnecessary care
    - Appropriate use of CT scans
- Inpatient measures
- Durable medical equipment
- Cost measures
    - Targeting people with chronic needs
    - Enrollees' out-of-pocket spending

Although the current version of the Medicaid Child Core Set includes measures pertaining to some of these topics, MAP did not perceive them as comprehensive. For example, two measures in the Child Core Set relate to mental health, but others are available and in development that could be considered for future addition to the set.

Based on the prioritization of gap areas, MAP reviewed available NQF-endorsed measures for potential addition to the measure set. MAP's Measure Selection Criteria (Appendix C) dictate that NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective. NQF-endorsed® measures have undergone a rigorous multi-stakeholder evaluation to ensure they address aspects of care that are important and feasible to measure, provide consistent and credible information, and can be used for quality improvement and decision-making.

MAP also took note of a large number of measures in various stages of development under the auspices of the AHRQ-CMS Pediatric Quality Measures Program (PQMP).[25] Seven CHIPRA Pediatric Healthcare Quality Measures Program Centers of Excellence (COEs) have received cooperative agreement grants to support measure development activities. When complete, these measures will be publicly available for use and will help address the relative lack of measures designed for use with the pediatric population. A large volume of measures on care coordination, behavioral health, and inpatient care are scheduled to be completed by February 2015 and NQF anticipates receiving many of them for endorsement review. MAP will review these new measures in more detail as part of the 2015 process.

Measure-Specific Recommendations

MAP supported all but one of the measures in the current Child Core Set for continued use in the program. Maintaining stability in the measure set will allow states to continue to gain experience reporting the measures, potentially increasing the number of individual measures they are able to submit to CMS on an annual basis. State participants identified some feasibility concerns related to the current measures, but detailed exploration of those challenges will be better addressed during MAP's planned 2015 review. MAP's measure-specific recommendations are described below, with details on the individual measures provided in Appendix D.

Measures for Removal from the Child Core Set

MAP recommends removal of the measure Percentage of Eligibles That Received Dental Treatment Services. CMS and other stakeholders described that the measure is not an effective tool for quality improvement because it is unclear if an increase or decrease in the rate is desirable. For example, a higher number of Medicaid enrollees receiving dental treatment could indicate the positive outcome of improved access to care or the negative outcome of more individuals needing treatment for caries or other poor oral health outcomes. The information collected is not actionable by states or CMS. The measure is not NQF-endorsed.

Measures for Phased Addition to the Child Core Set

MAP recommends that CMS consider up to six measures for phased addition to the Child Core Set. These measures received the approval of 60 percent or more of voting MAP Task Force members. Their use would strengthen the measure set by promoting the measurement of a variety of high-priority quality issues, including oral health, beneficiary experience, and maternity care. However, MAP is aware that additional federal and state resources are required for each new measure. Past revisions to the measure set have not altered more than three measures at a time, indicating that the immediate addition of all measures supported by MAP is highly unlikely. MAP rank-ordered the measures it supports for inclusion in the Child Core Set to provide CMS with a clear sense of priority among the potential measures. CMS may need flexibility to add the measures gradually and only if they are found to be feasible to implement at the state level.

Exhibit 5: Ranking of Measures Supported for Addition to the Child Core Set

Ranking	Measure Number and Title	Votes for Prioritization
1	NQF #2508 Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk	10
2	NQF #2548 Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS)	7
3	NQF #2509 Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk	5
4 (tie)	NQF #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment NQF #0477 Under 1500g infant Not Delivered at Appropriate Level of Care	4
6	NQF #0480 PC-05 Exclusive Breast Milk Feeding	3

MAP awards particular emphasis to the first three measures. NQF #2508 Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk is intended as a replacement for the dental treatment measure recommended for removal. It is clearly linked to improved outcomes and will more accurately capture the quality of care delivered than the original utilization-oriented measure. The use of this measure will also allow CMS to respond to a legislative mandate to measure the use of dental sealants in this age group. Measure #2509 is similar but evaluates the application of sealants to the second set of

molars, which develop at a later age. MAP members discussed whether the use of both measures is necessary, noting that children of all ages need to benefit from these services but also that use of one measure is likely to drive broader changes in practice.

MAP also prioritized the new CAHPS® tool focused on evaluating the family's experience of care when a child is hospitalized. The use of this measure would help to address two gaps that were noted in the measure set; specifically, inpatient measures and patient experience. Hospitals may be using a variety of local, proprietary tools to gauge pediatric patient/family experience at the present time. Broad adoption of a survey that is in the CAHPS family will enhance comparability across sites and across populations. The survey contains a field to capture the payer of care, so MAP concluded that it would be feasible for survey administrators to subset those that apply to Medicaid for the purposes of reporting.

MAP also supported the remaining measures because they addressed important gaps in the current measure set. Specifically, MAP determined that suicide risk screening among children and adolescents with depression was an important intervention for one of the most common behavioral health diagnoses in this population. Participants also flagged the issue of rising rates of antipsychotic use as a prime opportunity for quality improvement, especially among children in the foster care system insured by Medicaid. One measure of antipsychotic use in young children was considered by the group but did not reach the consensus threshold necessary to gain MAP's support. Because several measures are nearly complete but have not yet been reviewed by NQF for endorsement, MAP plans to re-evaluate the measures on this topic during its next review.

Use of measures #0477 and #0480 would strengthen the presence of perinatal care issues in the Child Core Set. While delivery of a low birthweight infant at a facility not well-equipped to handle complex cases is not always avoidable, MAP members agreed that there is much room for improvement on this indicator. It represents an opportunity for women experiencing high-risk pregnancy to receive counseling about the appropriate site of delivery and for regional medical systems to coordinate and communicate about their NICU capabilities. Similarly, breast milk feeding is associated with a variety of positive downstream health outcomes for both mothers and babies, including lowering risk of asthma, allergies, obesity, and certain infections.[26]

Two of the above measures received MAP's conditional support for inclusion because they are currently undergoing review for NQF endorsement. NQF #2548 Child HCAHPS and NQF #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment have both been recommended for endorsement by standing committees.

Strategic Issues

During MAP's review of measures in the Child Core Set, members discussed numerous cross-cutting and strategic issues. While not specific to the use of particular measures, these observations can guide ongoing implementation of the measurement program and inform future iterations of the set.

Feasibility of Reporting and Electronic Data Infrastructure

Several important factors underpin the feasibility of reporting state-level data on quality measures. MAP discussed the impact of the lack of Medicaid data infrastructure and limited resources available to invest in analytics. States have varied, but generally limited, capacity to collect clinical quality information

electronically as eMeasures at this time. Although MAP discussed the possibility of adding more eMeasures to the Child Core Set, most participants felt that uptake of those measures would be quite low in the near term. However, the group called for continued development of eMeasures that are appropriate for use in the Medicaid population, understanding that is the future direction of the quality measurement enterprise. Finally, feasibility of measure implementation can be diminished when measures designed to be used in facilities and/or health plans are retrofitted for state-level reporting. CMS needs to provide clear technical guidance for states to ensure uniformity in data collection and reporting.

Pipeline of Measures in Development

A major strategic consideration for the future direction of the Child Core Set is the large volume of measures undergoing developing and testing in Pediatric Centers of Excellence under the PQMP. As previously described, dozens of measures pertaining to important issue areas will become available for MAP's consideration over the course of the next year. Knowing that other measures were on the horizon influenced MAP's decision-making related to behavioral health and care coordination measures, in particular. The majority of participants wanted to defer action on supporting measures in these topic areas until more information on the new measures could be made available for MAP's review. Some, but not all, of the new measures are expected to be submitted to NQF for endorsement review. Submission to NQF was encouraged but not a grant requirement.

Some measures created by the PQMP grantees are already included in the Child Core Set. For example, the measure of behavioral health risk screening for pregnant women was developed as part of the PQMP. Conscious that the current grant support is scheduled to end in 2015, MAP recognized the need for additional long-term planning for measure development to ensure that work on high-priority pediatric care measures continues to be pursued.

Alignment of Measures

When making recommendations about measures for the Child Core Set, MAP considered the relationship between the selected measures and those contained in the Adult Core Set. Though the two measurement programs are separate, both CMS and States regard them as working together to provide an overall picture of quality within Medicaid and CHIP. Additionally, MAP's 2014 review of the Adult Core Set noted this inter-relationship. Alignment of measures across the programs is especially apparent when considering the quality of the continuum of the prenatal, maternity, and postnatal care of mothers and infants. There is a large presence of perinatal measures in the Child Core Set and three others are contained in the Adult Core Set (i.e., elective delivery, antenatal steroids, and postpartum care rate). This accurately reflects the longstanding importance of Medicaid in providing health coverage to low-income women and babies. MAP discussed the need to further explore health outcomes of the mother/child dyad, specifically how a mother's health and healthcare affects that of her child or children.

Alignment is important on other planes as well. MAP discussed the synergies that arise when measures are shared across the physician-level EHR Incentive Program, better known as Meaningful Use, and the National Committee for Quality Assurance's (NCQA) HEDIS® measure set for health plans. Overlap with HEDIS is especially helpful for states with a significant presence of managed care in their Medicaid

delivery systems because the collection of common measures can satisfy multiple program reporting requirements.

Conclusion

Medicaid is the largest health insurance program in the United States and, together with CHIP, provides for coverage for more than a third of the nation's children. [27] States' participation in reporting measures in the Medicaid Child Core Set greatly contributes to understanding how successful Medicaid programs are in delivering high-quality care to their enrollees. MAP's recommendations are intended to strengthen the measure set and support the three-part goal of CMS for increasing the scope of participation in the program.

MAP requests that CMS remove a measure of the utilization of dental treatment services because it is not actionable for quality improvement purposes. MAP supports the addition of up to six measures to the measure set, including two measures that better address oral health care. In general, the measures recommended for addition address healthcare services and clinical conditions that have significant impact on low-income families and long-term health outcomes.

This expedited review was completed over a period of ten weeks to assist CMS in meeting a statutory deadline, limiting its scope and ability to thoroughly explore states' experiences reporting the current measures and the status of numerous measures still undergoing development and testing. MAP will conduct a more in-depth review of the Medicaid Child Core Set in 2015 to inform the next annual update of the measure set.

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Appendix A: MAP Background

Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment, and other programs. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[1]

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

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

MAP's objectives are to:

1. **Improve outcomes in high-leverage areas for patients and their families**. MAP encourages the use of the best available measures that are high-impact, relevant, and actionable. MAP has adopted a person-centered approach to measure selection, promoting broader use of patient-reported outcomes, experience, and shared decisionmaking.
2. **Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy based on value**. MAP promotes the use of measures that are aligned across programs and between public and private sectors to provide a comprehensive picture of quality for all parts of the healthcare system.
3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden**. MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology to improve patient care, and providing knowledge and tools to healthcare providers and professionals to

help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare. Foundational to the success of all of these efforts is a robust quality enterprise that includes:

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

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

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

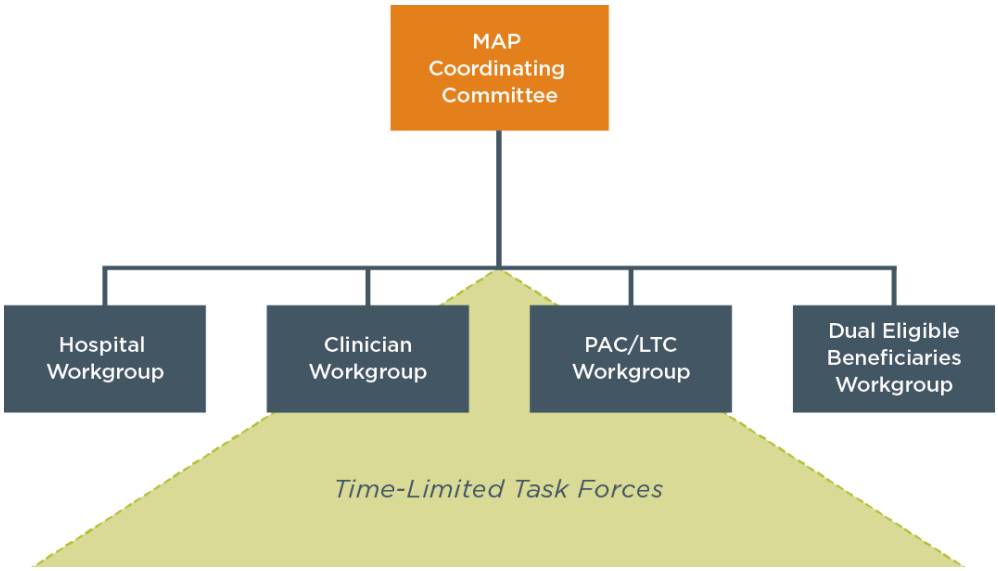
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for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

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

Structure

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

Figure A1. MAP Structure



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

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see MAP 2014 Pre-Rulemaking Report).

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall to inform MAP's pre-rulemaking input. To date MAP has issued a series of reports that:

- Developed the **MAP Strategic Plan** to establish MAP's goal and objectives. This process identified strategies and tactics that will enhance MAP's input.
- Identified **Families of Measures**—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities—to facilitate coordination of measurement efforts.
- Provided input on **program considerations and specific measures** for federal programs that are not included in MAP's annual pre-rulemaking review, including the Medicaid Adult Core Set and the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces.
- Developed **coordination strategies** intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives.

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Appendix B: Rosters for the MAP Medicaid Child Task Force and MAP Coordinating Committee

Roster for the MAP Medicaid Child Task Force

CHAIR (VOTING)
Foster Gesten, MD, FACP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
Aetna	Sandra White, MD, MBA
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
American Academy of Pediatrics	Terry Adirim, MD, MPH, FAAP
American Nurses Association	Susan Lacey, RN, PhD, FAAN
America's Essential Hospital's	Beth Feldpush, DrPH
Children's Hospital Association	Andrea Benin, MD
Kaiser Permanente	Susan Fleischman, MD
March of Dimes	Cynthia Pellegrini
National Partnership for Women and Families	Carol Sakala, PhD, MSPH

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Disability	Anne Cohen, MPH
State Medicaid	Marc Leib, MD, JD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Centers for Medicare & Medicaid Services (CMS)	Marsha Smith, MD, PhD, FAAP

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

Roster for the MAP Coordinating Committee

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

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
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Healthcare Financial Management Association	Richard Gundling, FHFMA, CMA
Healthcare Information and Management Systems Society	Representative TBD
The Joint Commission	Mark R. Chassin, MD, FACP, MPP, MPH
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Appendix C: MAP Measure Selection Criteria

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

Criteria

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

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

Subcriterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need

Subcriterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs

Subcriterion 1.3 Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

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

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

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

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

Subcriterion 2.3 Affordable care

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

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

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

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

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

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

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

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

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

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

Subcriterion 4.2 Public reporting 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 decisionmaking, such as for care and service planning and establishing advance directives

Subcriterion 5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

Subcriterion 7.2 Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

Appendix D: Medicaid Child Core Set and MAP Recommendations

In February 2011, HHS published the initial core set of quality measures for children enrolled in Medicaid and CHIP. The authorizing legislation also requires HHS to publish annual changes to the Child Core Set beginning in January 2013. Table D1 below lists the measures included in the current version of the Child Core Set along with their current NQF endorsement number and status. States voluntarily collect the Medicaid Child Core Set measures using the 2014 Technical Specifications and Resource Manual. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's Quality Positioning System. Table D2 lists the measures supported by MAP for potential addition to the Child Core Set.

Table D1: Current Medicaid Child Core Set

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0024 Endorsed Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) Measure Steward: National Committee for Quality Assurance	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: • Body mass index (BMI) percentile documentation • Counseling for nutrition • Counseling for physical activity	27 states reported FY 2012 Alignment: Meaningful Use (EHR Incentive Program) - Eligible Professionals (MU-EP), Physician Feedback, Physician Quality Reporting System (PQRS), Health Insurance Exchange–Quality Rating System (HIX-QRS)	Support continued use of this measure in the program. No significant implementation issues identified at this time.
0033 Endorsed Chlamydia Screening in Women (CHL) Measure Steward: National Committee for Quality Assurance	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	35 states reported FY 2012 Alignment: Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (Medicaid Adult Core Set), MU-EP, PQRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0038 Endorsed Childhood Immunization Status (CIS) Measure Steward: National Committee for Quality Assurance	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B(HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	34 states reported FY 2012 Alignment: MU-EP, PQRS, HRSA program(s), HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
0108 Endorsed Follow-Up Care for Children Prescribed ADHD Medication (ADD) Measure Steward: National Committee for Quality Assurance	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. • Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. • Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	29 states reported FY 2012 Alignment: MU-EP, PQRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0139 Endorsed National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure Measure Steward: Centers for Disease Control and Prevention	Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • other inpatient locations. (Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.	40 states reported FY 2012 Alignment: Hospital Acquired Condition Reduction Program, Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, Long-term Care Hospital Quality Reporting, PPS-Exempt Cancer Hospital Quality Reporting	Support continued use of this measure in the program. No significant implementation issues identified at this time.
0471 Endorsed PC-02 Cesarean Section Measure Steward: Joint Commission	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	12 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0576 Endorsed Follow-Up After Hospitalization for Mental Illness (FUH) Measure Steward: National Committee for Quality Assurance	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: - 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.	27 states reported FY 2012 Alignment: Dual Eligibles Core Quality Measures - Capitated Demonstrations and Managed Fee For Service Demonstrations, Medicaid Adult Core Set, Inpatient Psychiatric Hospital Quality Reporting, Medicare Part C Plan Rating, HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1382 Endorsed Percentage of low birthweight births Measure Steward: Centers for Disease Control and Prevention	The percentage of births with birth weight <2,500 grams	15 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1391 Endorsed Frequency of Ongoing Prenatal Care (FPC) Measure Steward: National Committee for Quality Assurance	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: •<21 percent of expected visits •21 percent–40 percent of expected visits •41 percent–60 percent of expected visits •61 percent–80 percent of expected visits •> or =81 percent of expected visits	25 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
1392 Endorsed Well-Child Visits in the First 15 Months of Life (W15) Measure Steward: National Committee for Quality Assurance	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported: •No well-child visits •One well-child visit •Two well-child visits •Three well-child visits •Four well-child visits •Five well-child visits •Six or more well-child visits	43 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1407 Endorsed Immunizations for Adolescents (IMA) Measure Steward: National Committee for Quality Assurance	The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.	32 states reported FY 2012 Alignment: HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1448 Endorsed 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.	12 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1516 Endorsed Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) Measure Steward: National Committee for Quality Assurance	Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	46 states reported FY 2012 Alignment: HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
1517 Endorsed Prenatal & Postpartum Care (PPC)* Measure Steward: National Committee for Quality Assurance *Medicaid Child Core Set includes "Timeliness of Prenatal Care" rate only. "Postpartum Care" rate is evaluated in Medicaid Adult Core Set.	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 a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	31 states reported FY 2012 Alignment: Medicaid Adult Core Set, HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1799 Endorsed Medication Management for People with Asthma (MMA) Measure Steward: National Committee for Quality Assurance	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.	0 states reported FY 2012 (New)	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1959 Endorsed Human Papillomavirus Vaccine for Female Adolescents (HPV) Measure Steward: National Committee for Quality Assurance	Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	0 states reported FY 2012 (New)	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
N/A Not Endorsed Maternity Care: Behavioral Health Risk Assessment Measure Steward: AMA-PCPI/NCQA/ACOG	Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: screening for depression, alcohol use, tobacco use, drug use, and intimate partner violence screening	0 states reported FY 2012 (New)	Support continued use of this measure in the program. No significant implementation issues identified at this time.
N/A Not Endorsed Percentage of Eligible Children Who Received Dental Treatment Services Measure Steward: 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 dental treatment services.	51 states reported FY 2012	Recommend the removal of this measure from the program. Measure is not actionable for quality improvement because it is unclear whether an increase in the number of children receiving dental treatment is a positive outcome (e.g., access is improved) or a negative outcome (e.g., more children require treatment because of poor oral health).
N/A Not Endorsed Children and Adolescents' Access to Primary Care Practitioners Measure Steward: NCQA	The percentage of children 12 months –19 years of age who had a visit with a primary care practitioner. Four separate percentages are reported: Children 12 through 24 months and children 25 months through 6 years who had a visit with a primary care practitioner during the measurement year; Children 7 through 11 years and adolescents 12 through 19 years who had a visit with a primary care practitioner during the measurement year or the year prior to the measurement year.	43 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
N/A Not Endorsed Adolescent Well-Care Visits Measure Steward: 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.	43 states reported FY 2012 Alignment: HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
N/A Not Endorsed Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0, Child Version Measure Steward: NCQA	This measure provides information on parents' experience with their child's health care for population of children with chronic conditions. Results include same ratings, composites, and individual question summary rates as reported for the CAHPS Health Plan Survey 4.0H, Child Version. Three CCC composites summarize satisfaction with basic components of care essential treatment, management and support of children with chronic conditions. 1. Access to Specialized Services; 2. Family Centered Care: Personal Doctor Who Knows Child; 3. Coordination of Care for CCC. Question summary rates also reported individually for summarizing the following two concepts: 1. Access to Prescription Medicines; 2. Family Centered Care: Getting Needed Information. Five composite scores summarize responses in key areas: 1. Customer Service; 2. Getting Care Quickly: 3. Getting Needed Care: 4. How Well Doctors Communicate; 5. Shared Decision Making.	27 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
N/A Not Endorsed Percentage of Eligible Children Who Received Preventive Dental Services Measure Steward: 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 FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
N/A Not Endorsed Ambulatory Care: Emergency Department Visits Measure Steward: NCQA	The rate of emergency department visits per 1,000 member months among children up to age 19.	28 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Table D2: Measures Supported by MAP for Addition to the Medicaid Child Core Set

Measure Number & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
2508 Endorsed Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk Measure Steward: American Dental Association on behalf of the Dental Quality Alliance	Percentage of enrolled children in the age category of 6-9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year.		Support addition of this measure to the program. Potential replacement for measure of dental treatment services recommended for removal.
2548 Undergoing Endorsement Review Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS) Measure Steward: Center for Quality Improvement and Patient Safety -Agency for Healthcare Research and Quality	The Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS) is a standardized survey instrument that asks parents and guardians (henceforth referred to as parents) of children under 18 years old to report on their and their child's experiences with inpatient hospital care.		Support addition of this measure to the program. Addresses gaps in inpatient measures and beneficiary experience of care.
2509 Endorsed Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk Measure Steward: American Dental Association on behalf of the Dental Quality Alliance	Percentage of enrolled children in the age category of 10-14 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent second molar tooth within the reporting year.		Support addition of this measure to the program. Potential replacement for measure of dental treatment services recommended for removal.
1365 Endorsed Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	Meaningful Use (EHR Incentive Program) - Eligible Professionals; Physician Quality Reporting System (PQRS)	Support addition of this measure to the program. Addresses gap in behavioral health.

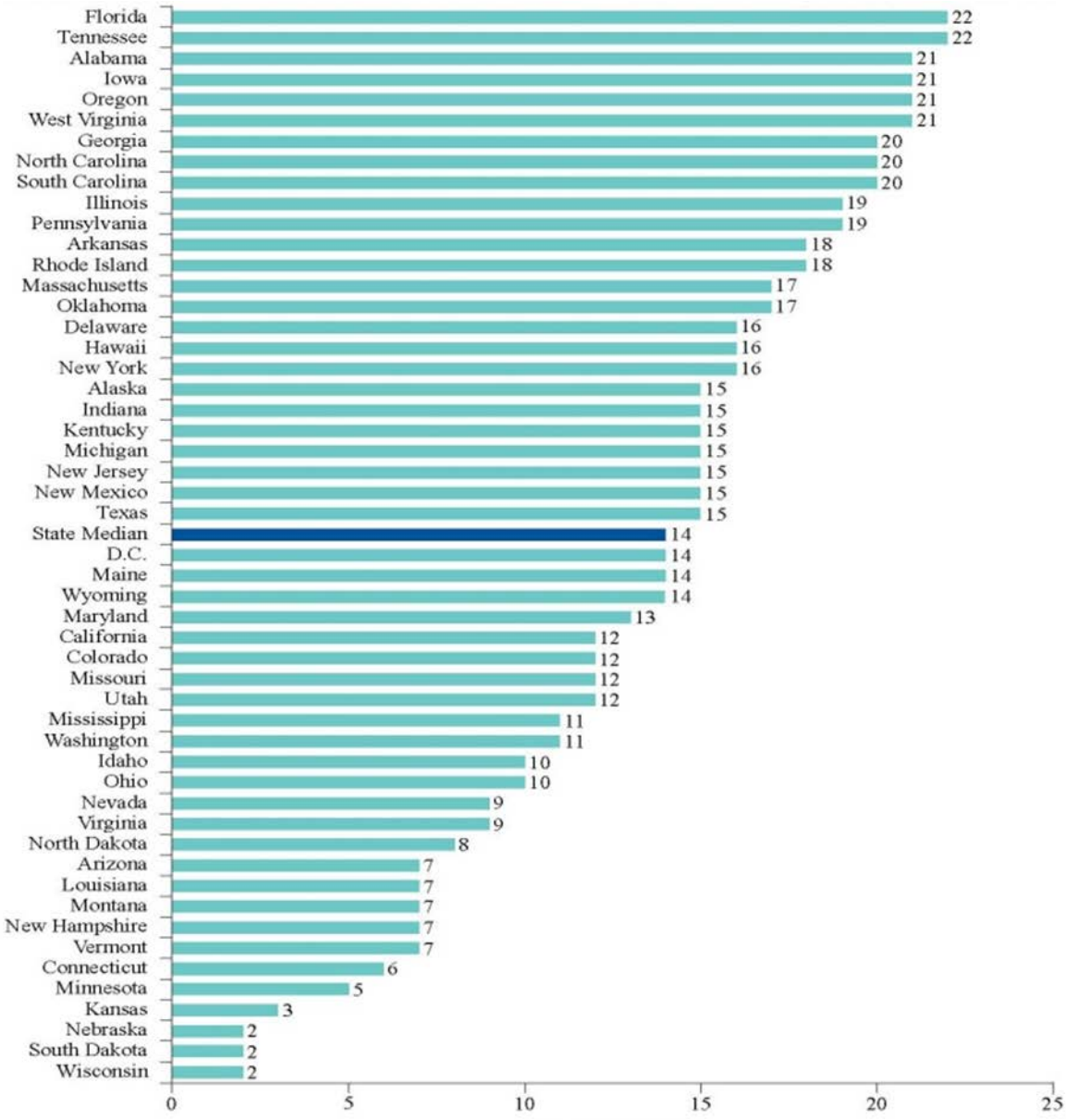
0477 Endorsed Under 1500g infant Not Delivered at Appropriate Level of Care Measure Steward: California Maternal Quality Care Collaborative	The number per 1,000 livebirths of <1500g infants delivered at hospitals not appropriate for that size infant.		Support addition of this measure to the program. Enhances perinatal measures and would improve regional care coordination for high-risk pregnancies.
0480 Endorsed PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice Measure Steward: The Joint Commission	PC-05 assesses the number of newborns exclusively fed breast milk during the newborn´s entire hospitalization and a second rate, PC-05a which is a subset of the first, which includes only those newborns whose mothers chose to exclusively feed breast milk. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns).	Meaningful Use (EHR Incentive Program) - Hospitals, CAHs	Support addition of this measure to the program. Enhances perinatal measures and is associated with positive health outcomes for mother and child.

Appendix E: State Implementation and Participation in Reporting Measures

CMS now has four years of experience with this voluntary reporting program and providing technical assistance and analytic support for states. In 2012, CMS began calculating the two dental measures, Percentage of Eligible Children Who Received Dental Treatment Services and Percentage of Eligible Children Who Received Preventive Dental Services, using data reported by states on Form CMS-416. Thus, all states report on at least two measures (Exhibit E1). Thirty-five states reported at least 11 of the 22 core measures to CMS, with a median of 14. Notably, Florida and Tennessee reported 22 of the core measures while Nebraska, South Dakota, and Wisconsin reported 2 measures. [1]

Exhibit E1. Number of Medicaid/CHIP Child Core Set Measures Reported by States in FY 2012

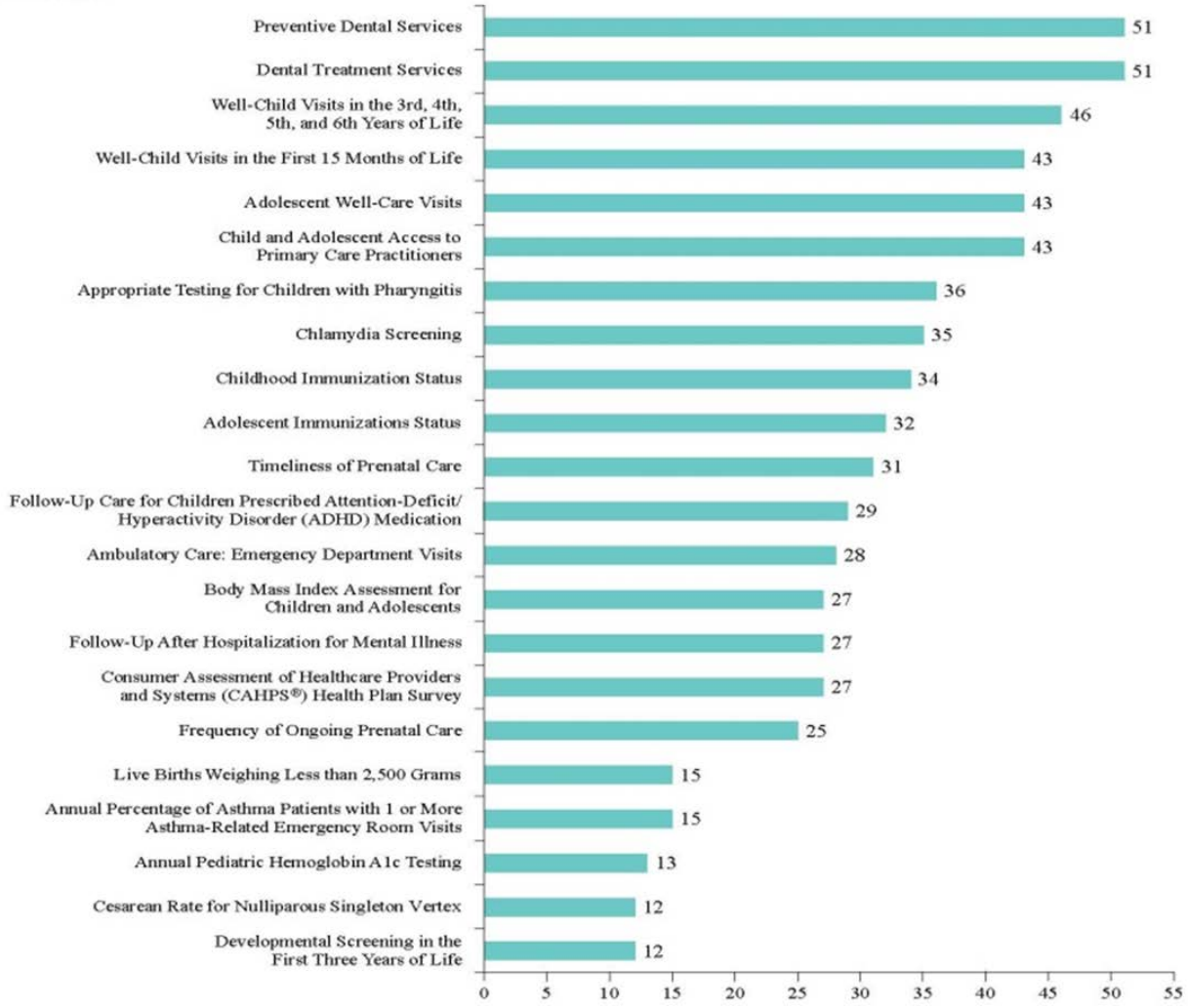
(Source: *2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP*)



As shown in Exhibit E2, The most frequently reported measures in FY2012 assess dental services, well-child visits, and access to care.[2]

Exhibit E2. Number of States Reporting Measures in Medicaid/CHIP Child Core Set in FY 2012

(Source: *2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP*)



[1] HHS. 2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf. Last accessed September 2014.

[2] HHS. 2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf. Last accessed September 2014.