Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2018

FINAL REPORT
AUGUST 31, 2018

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I, Task Order HHSM-500-T0011.
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**EXECUTIVE SUMMARY**

Medicaid is the largest health insurance program in the United States, serving 76 million Americans in FY 2016. As the primary health insurance program for the nation’s low-income population, Medicaid covers many individuals with a high need for medical, healthcare, and support services. Since October 2013, Medicaid has experienced marked growth in adult enrollment, largely due to Medicaid expansion defined in the Affordable Care Act (ACA). Medicaid beneficiaries with complex care needs and multiple chronic conditions, including those who are dually eligible for Medicare and Medicaid, account for roughly 54 percent of total Medicaid expenditures, despite comprising just 5 percent of all Medicaid beneficiaries. In addition, Medicaid beneficiaries needing long-term services and supports, such as nursing home care and home and community-based services, more than doubled from FY 2012 to FY 2015, accounting for 20 percent of the total federal and state Medicaid spending. Understanding the diverse needs of the adult Medicaid population is imperative for improving health and the quality of care for these individuals.

Section 1139B of the Social Security Act (amended by Section 2701 of the ACA) mandates the Core Set for the assessment of care quality for adults enrolled in Medicaid. The Measure Applications Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF), provides guidance to the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs. Each year, through its Medicaid Adult Workgroup, MAP recommends measures that would enhance the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (the Adult Core Set). Guided by MAP’s Measure Selection Criteria, a defined decision algorithm, and feedback from several years of state implementation, this report includes MAP’s most recent recommendations to HHS for strengthening the Adult Core Set. The report also identifies for future consideration high-priority gaps where quality measures are needed and/or appropriate measures are lacking.

In 2018, MAP supports all but two of the current Adult Core Set measures for continued use and recommends eight measures for phased addition to the Adult Core Set.

- MAP recommends the removal of NQF #0476 PC-03 Antenatal Steroids. Multiple state representatives noted reporting challenges related to data collection for this measure. In addition, the Workgroup members reiterated that this hospital-level measure is currently reported to The Joint Commission and this duplicative reporting only adds to measurement burden for resource constrained Medicaid programs. For the same reasons noted in 2017, MAP recommended removal of this measure from the Adult Core Set to reduce duplication and burden of reporting at the state level while increasing bandwidth for reporting other measures.

- MAP recommends the removal of NQF #2082 HIV Viral Load Suppression from the Adult
Core Set. Multiple state representatives noted reporting challenges associated with NQF #2082 HIV Viral Load Suppression, including the measure's data source (i.e., electronic health records and paper medical records) and strict confidentiality laws associated with HIV and AIDS related clinical data.

MAP recommends that CMS consider up to eight measures for phased addition to the Adult Core Set (Exhibit ES1). The Workgroup is aware that additional federal and state resources are required for each new measure added. Therefore, the Workgroup members ranked the recommended measures based on their order of relative importance.

**Exhibit ES1. Measures Recommended for Phased Addition to the Adult Core Set**

<table>
<thead>
<tr>
<th>Rank</th>
<th>NQF Number and Measure Title</th>
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<tr>
<td>1</td>
<td>NQF #2967 CAHPS® Home and Community Based Services (HCBS) Measures</td>
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<td>2</td>
<td>NQF #2950 Use of Opioids from Multiple Providers in Persons Without Cancer</td>
</tr>
<tr>
<td>3</td>
<td>NQF #0712e Depression Utilization of the PHQ-9 Tool</td>
</tr>
<tr>
<td></td>
<td>NQF #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*</td>
</tr>
<tr>
<td>4</td>
<td>NQF #0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment</td>
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<tr>
<td>5</td>
<td>NQF #3175 Continuity of Pharmacotherapy for Opioid Use Disorder</td>
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<td>6</td>
<td>NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
</tr>
<tr>
<td></td>
<td>NQF #0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category</td>
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*Conditionally supported measure

The Workgroup recognizes that many priority areas for quality measurement and improvement lack fully developed metrics and documents these gap areas as future measurement needs for the measure developer community. In addition to the identified gaps, the Workgroup noted the need for population based cross-cutting measures to address the range of priority areas and needs among different states and their unique Medicaid populations.

Additionally, the Workgroup's strategic discussions included recommendations for improving Adult Core Set reporting at the state level. These discussions focused on maximizing data utility and lowering data collection burden. Both strategies focused on social risk factors, and how the collection of those data support stratification based on unique subpopulation needs. Access to social risk data will allow Medicaid agencies, providers, and payers to better address nonclinical community level factors that adversely affect health and healthcare outcomes.
INTRODUCTION AND PURPOSE

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF). MAP was created to provide input to the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. The work of the Medicaid Adult Workgroup is under the purview of MAP. As such, the Medicaid Adult Workgroup advises the MAP Coordinating Committee on changes and updates to the Adult Core Set. The MAP Coordinating Committee serves as the final ratifying body that oversees the recommendations for HHS. During the 2017-2018 review, the Medicaid Adult Workgroup evaluated measures in CMS’ 2018 Adult Core Set using state performance data from the federal fiscal year (FFY) 2016 reporting cycle to inform their deliberations. MAP-recommended changes, if instituted, would take effect for the 2019 Adult Core Set. Information and background on MAP is in Appendix A.

The purpose of the Workgroup is to help HHS strengthen the Adult Core Set of healthcare quality measures for adults enrolled in Medicaid as well as to identify high-priority measure gap areas. The Workgroup consists of organizational representatives, subject matter experts, state Medicaid representatives, and federal government liaisons with relevant interests and expertise (Appendix B).

MAP’s recommendations for the current Core Set are based on MAP’s Measure Selection Criteria (MSC) (Appendix C), a defined decision algorithm (Appendix D), and the most recent available measure reporting data from states. Additionally, MAP considers the voluntary nature of quality reporting when making measure recommendations. The Centers for Medicare & Medicaid Services (CMS) provided materials to inform the Workgroup’s review and recommendations, including summaries of the FFY 2016 measures reported by states and detailed analyses of state performance on 16 publicly reported measures.

This report summarizes the Workgroup’s measure-specific recommendations to fill high-priority gap areas (Appendix I) and highlights states’ feedback on collecting and reporting measures as presented to the Workgroup during the May 9-10, 2018 in-person meeting deliberations. In addition, the report outlines the strategic issues and opportunities for increasing state reporting identified by the Workgroup.

This report captures the Medicaid Adult Committee’s sixth set of annual recommendations on the Adult Core Set. The annual review process allows for a better understanding of Medicaid’s evolution as a program and states’ shifting priorities over time based on measures in use. HHS considers the Workgroup’s discussions and recommendations, including the state perspectives, as guidance to inform the statutorily required annual updates to the Adult Core Set.
BACKGROUND ON MEDICAID AND THE ADULT CORE SET

Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals. Medicaid is financed through a federal-state partnership, in which each state designs and operates its own program while following federal guidelines. In the 51 states reporting February 2018 data, 73,966,190 individuals were enrolled in the Medicaid and the Children's Health Insurance Program (CHIP); specifically, 67,562,271 individuals were enrolled in Medicaid, and 6,403,919 individuals were enrolled in CHIP.5

Medicaid covers a broad range of services to meet the diverse needs of its beneficiaries; therefore, performance measurement is critical for quantifying and addressing the program’s performance across states in a standardized manner. States have the flexibility to determine the amount, duration, and scope of services within broad federal standards.6 States are required to cover certain “mandatory” services through the Medicaid program, (e.g., hospital care, laboratory services, and physician/nurse midwife/certified nurse practitioner services).7 Many states also cover additional services that federal law designates as optional for adults based on the unique needs of their enrollees. These optional services include prescription drugs, dental care, home and community based services (HCBS), and hospice services. Additionally, Medicaid also covers a broad spectrum of long-term care benefits not provided by Medicare or private payers8 and has become the most significant source of financing for nursing home care.

Medicaid Adult Core Set

In January 2012, the Center for Medicaid and CHIP Services (CMCS) released the initial Adult Core Set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid. From 2013, NQF’s MAP has provided input to strengthen the Core Set and help promote measure alignment and parsimony. HHS established the Adult Core Set to standardize the measurement of healthcare quality across state Medicaid programs.9 Section 1139B of the Social Security Act (amended by Section 2701 of the ACA) notes that the Adult Core Set shall be updated annually beginning in January 2014.10 State Medicaid agencies voluntarily collect, report, and use Core Set measures to drive quality improvements.

The Adult Core Set provides a snapshot of healthcare quality within Medicaid. It is not intended to be all-inclusive; rather, the intent of the Core Set is to provide key indicators of healthcare access and quality at the state level for the beneficiaries served by Medicaid. Prior to the implementation of the Adult Core Set, performance measurement varied greatly by state, making it difficult to glean an overall picture of quality nationwide. Currently, statute requires CMS to provide annual updates on behalf of the Secretary of HHS on the reporting of state-specific adult Medicaid quality information. CMS also issues reports to Congress on this subject every three years.

MAP’s 2017 review and input helped inform CMCS’s 2018 Adult Core Set update. Following MAP’s recommendation, CMCS added three measures: Concurrent Use of Opioids and Benzodiazepines, NQF #1800 Asthma Medication Ratio, and NQF #2903 Contraceptive Care—Most & Moderately Effective Methods. These additions expand the measurement of quality of care for three populations—adults with substance use disorders, adults with chronic health conditions, and reproductive age women, respectively. No measures were retired from the 2018 Core Set.

The 2018 Adult Core Set contains 33 measures relevant to adults ages 18 and older and can be found in Appendix E.

CMS’s goals for the Adult Core Set are to increase the number of: (1) states reporting the Core Set measures; (2) measures reported by each state; and (3) states using the Core Set measures to drive quality improvement. CMS uses the annual data submissions to capture a snapshot of quality across Medicaid and CHIP. The data are presented in publications such as chart packs and Performance on the Adult Core Set Measures.11
STATE EXPERIENCE COLLECTING AND REPORTING THE ADULT CORE SET

Presentations from invited states’ Medicaid program representatives precede all Medicaid Core Set measure-related discussions and deliberations regarding the addition and removal of measures. These representatives provide an overview of their state Medicaid program as well as an overview of their experience with collecting, reporting, and using either the Adult or the Child Core Set. Additionally, they highlight successful state-specific programs and care models. The Medicaid Adult and Child Core Set update process is based on real world experiential information solicited from the field, prior to finalizing recommendations for changes to the Core Sets. Ultimately, the goal is to use this experiential data to provide well-informed and targeted recommendations to inform the Core Set updates.

For the Adult Core Set, state Medicaid representatives from Pennsylvania and Minnesota presented an overview of their state Medicaid programs. Additionally, the representatives provided information related to Core Set use (i.e., value-based purchasing, quality improvement models, managed care contracting, behavioral health, social determinants of health, etc.), issues related to reporting and potential strategies for improving Core Set measure reporting rates.

Pennsylvania

The Pennsylvania Medicaid representative, David Kelley, MD, Chief Medical Officer, presented the state’s experience with the Adult Core Set. The Pennsylvania Medicaid program covers 2.8 million individuals, including 1.1 million children and 60,000 deliveries. Since Pennsylvania expanded its Medicaid program in 2015, the state has enrolled 700,000 newly eligible individuals.

Pennsylvania is a mandatory managed care state with behavioral health carve-outs, and reports on 21 Adult Core Set measures. For the past decade, Pennsylvania has actively engaged in pay-for-performance and value-based purchasing programs. More recently, the state developed a program that focuses on behavioral health measures while incentivizing physical and behavioral health plans to engage in collaborative care. This program, referred to as the Integrated Care Program, requires managed care plans to engage in three processes. First, managed care plans are required to identify and stratify patients with serious, persistent mental illness based on cost and/or need. Second, physical health and behavioral health plans are required to co-design a member care plan for Medicaid beneficiaries with complex care needs, high costs, or high psychosocial needs. Finally, managed care organizations (MCOs) are required to notify their counterpart behavioral health plans if high-need patients experience an inpatient stay, 90 percent of the time. For instance, a physical health plan must inform the patient’s behavioral health plan if they experience an inpatient stay. If an MCO fails to meet any of these three requirements, the MCO is ineligible to receive the incentive payment.

Pennsylvania’s Integrated Care Program demonstrates how states can leverage Core Set measures to develop an incentive program that promotes care coordination at the plan level. The number of individuals who initiated and engaged in treatment rose during the performance period; however, the number of individuals who adhered to treatment decreased. Dr. Kelley attributed these mixed results to the rise in beneficiaries as a result of Medicaid expansion. As the program evolves, the goal is to include both behavioral and physical health providers, which would facilitate care coordination across different care settings.

Dr. Kelley also highlighted Pennsylvania’s work related to opioid use disorders (OUD). In the last
year, Pennsylvania required managed care plans to develop prior authorization requirements based on Centers for Disease Control and Prevention (CDC) guidelines for chronic pain prescribing by primary care physicians. Additionally, Pennsylvania worked in partnership with the University of Pittsburgh to conduct predictive modeling to pinpoint beneficiaries at high risk of an overdose event. Subsequently, the state shared this model with all the plans and required them to perform interventions accordingly. The state has also conducted data analyses on opioid measures to identify patients and providers who require focused outreach to either effectively tailor treatment or modify prescribing habits, respectively. Data have shown that patients with OUD frequent the inpatient emergency department at higher rates than their counterparts without OUD. Beneficiaries with OUD also used behavioral health services at higher rates, and the majority had an established relationship with a primary care provider.

Dr. Kelley highlighted several key measurement priorities that the Workgroup should consider when suggesting edits and revisions to the Core Set. First, Core Set stability is critical in keeping MCOs focused on priority measures. Second, population-based measures with national benchmarks serve as useful tools to gauge performance across states, regardless of NQF endorsement status. Finally, Pennsylvania views reporting burden, such as technical specifications of measures, which require chart audits, as one of the principal reasons for excluding a Core Set measure from its portfolio.

Minnesota

The Minnesota Medicaid representative, Jeff Schiff, MD, MBA, Medical Director from the Minnesota Department of Human Services, presented to the combined Medicaid Adult and Child Workgroups. He focused on Minnesota’s experiences examining social determinants of health (SDOH), as well as two initiatives on care integration. The presentation focused on healthcare’s accountability paradox where the onus of measuring, tracking, and improvement falls both within and outside the healthcare system. The integrated care presentation focused on ways to analyze and harness the information present in data already collected, focusing mainly on SDOH factors, and applying the findings in the development of integrated care models and initiatives.

Minnesota (MN) Medicaid covers on average 1.1 million low-income individuals on a monthly basis, of whom 65 percent are families with children, 17 percent are older adults and people with disabilities, and 18 percent are nondisabled adults without children. In treating these individuals, the state focuses on addressing SDOH and seeks ways to address them within the healthcare system. In doing so, the state has identified two categories of social risk factors, modifiable and non-modifiable, which are listed below.

**Modifiable Social Determinants**

- Family functioning:
  - Mental illness
  - Substance use disorder
  - Child abuse and other adverse childhood experiences (ACEs) (measured by Child Protection involvement)

- Family economics:
  - Homelessness
  - Food insecurity
  - Deep poverty

**Non-modifiable Social Determinants**

- Culture
- Gender
- Gay, Lesbian, Bi-sexual, Transgender, Questioning (GLBTQ) status

To develop the SDOH list presented above, Minnesota looked at social determinants in the national literature with the goal of identifying those that affect health outcomes.
SDOH literature finds that only 10 to 20 percent of health outcomes directly correlate to actual healthcare services. Consequently, most of the health outcomes noted in the Minnesota study resulted from environmental factors that affect health and well-being. In addition, analysts in Minnesota mined Medicaid data and found that the presence of social determinants—such as deep poverty, parental substance abuse disorder, homelessness, and child protective services (CPS) involvement—strongly predicted poor health outcomes, even when controlling for demographics, geography, and other social risk factors. For example, study data showed that children experiencing homelessness have a significantly higher rate of asthma compared to the baseline population of all children on Medical Assistance.14

Ultimately, these SDOH factors increase the prevalence of health risks for the Medicaid population which in turn affects the cost of Medicaid programs. Additionally, a lack of public health support systems exacerbates the prevalence of health risks due to a lack of focus on prevention and community supports. Dr. Schiff noted a pronounced disconnect between the clinical Medicaid care delivery system and the public health system at large. He noted that this disconnect results in insufficient or poorly coordinated community based programs, educational resources, and outreach efforts, leading to adverse events such as unplanned pregnancies and premature births. Therefore, any effort to address SDOH needs to account for the importance of coordination and connections between both clinical care and public health systems.

The discussion of the disconnect between clinical care under Medicaid and the larger public health system highlighted the inadequate focus on surveillance along with insufficient services related to primary and secondary prevention. These inadequacies, coupled with an overemphasis on tertiary care, result in an exacerbation of SDOH factors that fall outside the purview of clinical care. SDOH factors—by virtue of their pervasiveness beyond the clinical realm—can only be addressed by public programs and by community organizations and resources. As a result, a lack of these services leads to poor health outcomes, which is both indicative of SDOH and community factors along with failures of the social service and healthcare delivery system. These failures increase population vulnerability and social risk. Delivering equitable and cost effective care has become an important priority for the health system. As a result, healthcare organizations are adopting a public health approach and increasingly working on issues, such as availability of food and access to community-based health education, to ensure that individual's social needs are met. In Minnesota, this is being done through initiatives focused on integrating care using SDOH factors: Integrated Health Partnership (IHP) and Integrated Care for High Risk Pregnancies (ICHRP). The definition of integration used in the initiatives includes screening and referral, population-based interventions, and community/culturally based initiatives along with traditional healthcare services.

IHP is Minnesota’s Medicaid Accountable Care Organization (ACO) and is responsible for value in a comprehensive set of healthcare services. This model includes shared risk arrangements with providers based on robust quality metrics and data. The model also includes a population based payment geared at addressing social determinants and care integration issues. A primary goal of this program is to understand patient populations and craft effective strategies to address the needs of these beneficiaries. Health improvement happens by focusing on provider requirements, direct and indirect payment-based incentives, along with facilitation and support of care delivery in addressing population needs. For example, the most successful initiative is the food insecurity screening and referral program, where referrals to community resources lead to holistic care of these individuals.
ICHRP addresses disparities in birth outcomes among African Americans and American Indians using a culturally tailored approach to identifying high-risk pregnancies and providing necessary medical treatment. This initiative uses a population-focused model, which includes identifying high-risk pregnancies, providing necessary medical treatment, as well as considering community and cultural factors. Therefore, key services provided include a wide variety of medical and nonmedical services such as prenatal care, social services, culturally appropriate family support, and treatment for substance use disorders to name a few. The goal of ICHRP is to address SDOH and mitigate psychosocial risk by attending to such issues as housing, domestic abuse, and financial instability via culturally sensitive pre-, peri-, and post-natal care.

Both IHP and ICHRP address the accountability of providers and are affected by the national opioid crisis/epidemic. An important and separate quality improvement program using measurement to address opioid prescribing practices is the Minnesota Opioid Prescribing Improvement Program (OPIP). This program focuses on prescriber behavior by evaluating prescribing variation in a tiered measurement model. OPIP developed statewide prescribing guidelines. It employs multilevel measures that capture individual prescribing variation (e.g., rates of prescribing to Medicaid recipients that exceed specific morphine milligram equivalent thresholds) and population outcomes (such as the rate of new chronic use of opioids) for the state as a whole. Prescribers whose practice is outside of threshold ranges will be required to participate in quality improvement and, if necessary, be dis-enrolled as Medicaid providers. OPIP’s goal is to reduce overprescribing by fostering adaptive culture change among providers and their clinical practice sites.

Based on MN Medicaid’s experience with these initiatives, Dr. Schiff highlighted the need for states to collect data on SDOH factors and use those data along with provider-focused accountability models to improve health outcomes for Medicaid populations. He also noted that these initiatives and measurement models need to take into account both clinical and community-based efforts to address the impact of SDOH on health outcomes. Dr. Schiff cautioned states about the gap in services between public/population health and clinical services provided by Medicaid. Therefore, the response to SDOH needs to extend well beyond traditional Medicaid medical services and include wrap-around social support services administered by other agencies, such as programs that can focus on single issues like housing or food insecurity, but will be more effective if they are integrated more fully into the diverse communities they serve.
MAP REVIEW OF THE ADULT CORE SET

MAP evaluated the measures in the Adult Core Set to provide recommendations to strengthen the Core Set while facilitating CMS’s goals for the program. Guided by the Measure Selection Criteria (MSC) (Appendix C), a defined decision algorithm (Appendix D), and feedback from the most recent year of state implementation, the Workgroup reviewed measures in the 2018 Adult Core Set. The MSC are not absolute rules; rather, they provide general guidance on measure selection decisions to ensure the inclusion of high-quality measures that address the National Quality Strategy’s three aims, fill critical measurement gaps, and increase alignment. Using the decision algorithm, MAP reviewed measures in the gap areas identified during previous annual reviews. NQF staff compiled measures in the following 13 gap areas:

- behavioral health;
- substance use;
- patient-reported outcomes;
- assessing and addressing of social determinants of health;
- care coordination;
- long-term supports and services including home and community-based services;
- maternal and perinatal;
- asthma;
- promotion of wellness;
- workforce and access to care;
- new or chronic opiate use;
- polypharmacy; and
- patient engagement and activation.

The Workgroup discussed measures recommended by individual Workgroup members largely based on their measure specifications, the MSC, and the feasibility of implementing them for statewide quality improvement. MAP recommended measures they judged to be a good fit. The Workgroup’s recommendations were informed by state Medicaid representatives’ experiences implementing and reporting on the Adult Core Set measures. MAP prefers NQF-endorsed measures; however, measures are not required to be NQF-endorsed to be on the Adult Core Set.

MAP generally favors ready-to-implement measures that promote parsimony and alignment, while addressing high-impact health conditions for adults enrolled in Medicaid. Therefore, NQF-endorsed measures are preferred because they have undergone a multi-stakeholder evaluation to ensure that their focus is evidence-based, they are reliable and valid, and they address aspects of care that are important and feasible to measure. However, NQF-endorsed measures are not always available to address gap areas deemed relevant for the Adult Core Set. Therefore, Workgroup members helped identify measures in development and/or undergoing endorsement for discussion and consideration. For example, the group examined a hepatitis C measure that has not been submitted for endorsement, but is very relevant for the Medicaid population. Monitoring NQF-endorsed measures and other measures in the development pipeline is imperative for facilitating successful future annual reviews of the Adult Core Set.

Following discussion of each measure and public comment, voting occurred to determine if there was sufficient support from Workgroup members to recommend the measure for addition to the Core Set. Measures evaluated by the Workgroup, but not supported for addition, are listed in Appendix G.

Additionally, CMS includes measures in both of the Core Sets that provide states with multiple options/formats for data collection and
reporting (i.e., electronically specified measures, administrative measures, and hybrid measures). Therefore, CMS will include electronic measure specifications and formats, (i.e., e-specification also known as an eMeasure) for measures in the Core Set, when available, not as a change but as an enhancement to the Core Set. For example, NQF measure #0418 has an eMeasure version, measure #0418e.

Measure-Specific Recommendations

Measures for Removal from the Adult Core Set

The Workgroup noted that states’ participation in reporting the Adult Core Set is strong and has steadily increased each year, though there is always room for improvement in both the total number of states submitting measurement data and the number of states reporting each measure. Forty-one states voluntarily reported at least one Adult Core Set measure for FFY 2016, with 31 states reporting at least 14 of the 30 FFY 2016 Adult Core Set measures. Two states reported Adult Core Set measures for the first time for FFY 2016.17 Maintaining stability in the measure set allows states to continue to gain experience in reporting these measures.

In general, MAP considers recommending the removal of a measure when the following factors are observed:

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

Not finding many significant implementation problems, MAP was comfortable supporting all but two of the current Adult Core Set measures for continued use. These measures were among the measures least reported by states in 2014, 2015, and 2016. Measures most burdensome for states to report tend to be measures that are not administrative or claims based. Both measures recommended for removal are specified as electronic health records/data and paper medical records.

NQF #0476 PC-03 Antenatal Steroids (The Joint Commission)

Initially, NQF #0476 PC 03 Antenatal Steroids was recommended for removal in 2017. Multiple state representatives noted reporting challenges related to data collection for this measure. In general, state representatives noted that the feasibility of collecting and reporting hospital-based measures is extremely difficult (e.g., measures collected via medical record review are resource intensive). In addition, the Workgroup members reiterated that this hospital-level measure is currently being reported to The Joint Commission. Therefore, collecting data on this measure leads to burden due to redundancies in data collection. MAP is aware that CMS continues to consider ways to coordinate with other entities, such as The Joint Commission, to share data already collected. For the same reasons noted in 2017, MAP recommended removal of this measure from the Adult Core Set to reduce duplication and burden of reporting at the state level while increasing bandwidth for reporting other measures. Two public commenters echoed the Workgroup’s concerns regarding duplicative reporting efforts and expressed support for the removal of this measure from the Core Set.
NQF #2082: HIV Viral Load Suppression (HRSA)
Multiple state representatives noted reporting challenges associated with NQF #2082 HIV Viral Load Suppression, including the measure’s data source (i.e., electronic health records and paper medical records) and strict confidentiality laws associated with accessing HIV and AIDS related clinical data. A Workgroup member suggested that this measure might be better suited as a provider level measure to adequately address adherence to care. Thus, this may not be the best measure for a state reported measurement set. MAP recommends removal of this measure from the Adult Core Set. One public commenter raised concerns about removing this measure from the Core Set, noting that it represents an outcome-focused measure for a population with critical needs.

Measures for Phased Addition to the Adult Core Set
MAP recommends that CMS consider up to eight measures for phased addition to the Adult Core Set ( Exhibit 1, below, and Appendix F). The Workgroup had a robust conversation regarding measures that address behavioral health conditions and substance use disorders during this review. Six of the eight measures recommended address these conditions and disorders. All recommended measures passed the consensus threshold to gain support or conditional support for phased addition by receiving more than 60 percent approval by voting Workgroup members.

MAP conditionally supports measures for several reasons, including pending endorsement from NQF, pending CMS confirmation of feasibility, pending removal of one measure before the addition of another similar measure, etc. MAP recommends that CMS add measures pending NQF endorsement once endorsement review is complete and the detailed technical specifications are publicly available. MAP is also aware that additional federal and state resources are required for each new measure added. Therefore, immediate addition of all eight recommended measures is unlikely. Given the burden of additional measurement requirements, MAP considered both parsimony and alignment when recommending measures that address gap areas. MAP’s Coordinating Committee emphasized the need for parsimony, recognizing states’ burden to collect and report Core Set measures. MAP also recognized states’ need for flexibility to ensure measures are relevant to their population. MAP acknowledged the need for a tailored set of measures, which focus on key gap areas in the Medicaid population, quality improvement efforts, and alignment with the private sector. MAP ranked the recommended measures based on their order of relative importance. Public commenters generally supported MAP’s recommendations to add the following measures, but also cautioned CMS to include measures that have been tested and specified at the state level to increase the feasibility of data collection and reporting.

The 2018 Adult Core Set includes 33 measures, the largest number of measures to date. Given this size, there is a critical need to maintain stability of the number of measures, which will increase the likelihood of states reporting the same measures consistently. Additionally, for a measure to be publicly reported, data must be provided to CMS by at least 25 states and meet internal standards for quality.
EXHIBIT 1. MEASURES RECOMMENDED FOR PHASED ADDITION TO THE ADULT CORE SET

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<td>NQF #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*</td>
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<td>NQF #0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment</td>
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<td>NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
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<td>NQF #0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category</td>
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* indicates conditional support

The addition of recommended measures would strengthen the Core Set on a variety of high-priority healthcare quality areas, including patient-reported outcomes, long-term services and supports, and behavioral health and substance use. Further explanation and rationale regarding MAP’s support for these measures follow, in order of ranking.

**NQF #2967 CAHPS® Home and Community-Based Services Experience Measures**

MAP supported the inclusion of this measure, noting the need for home and community-based metrics to measure care quality across the spectrum of settings where care is delivered. **CAHPS Home and Community-Based Services Experience measures** are survey based measures focused on collecting feedback from adult Medicaid beneficiaries receiving HCBS. The measures address the quality of services and supports that beneficiaries receive in the community, as well as services delivered under the auspices of a state Medicaid HCBS program.

If added to the Core Set, this will be the only measure that addresses long-term care services provided in a community setting, as “long-term services and supports” includes both institutional care, such as nursing home care, and HCBS. MAP initially supported this measure conditionally in 2017, pending confirmation from CMS on the feasibility of implementation at the state level. CMS confirmed that while it is unable to collect performance data from states, states are able to report whether they are using the measure.

Several public commenters expressed support for this measure. One commenter highlighted the importance of measure setting specificity (e.g., include specific HCBS populations in the measure) along with standardized infrastructure guidance (e.g., standardizing survey administration and certifying vendors to conduct the survey). If CMS were to include this measure in the 2019 Adult Core Set. Finally, one commenter noted concerns about the measure’s high reporting cost and burden as well as the longitudinal decrease in broader CAHPS response rates. In discussing the utility of this survey, the MAP Coordinating Committee re-emphasized the importance of patient-reported outcome measures, especially given the number of process measures already in the Core Set. The Committee noted an aspirational goal of moving beyond structural measures such as CAHPS reporting to eventually reporting top box scores.

**NQF #2950 Use of Opioids from Multiple Providers in Persons without Cancer**

This measure examines the proportion of individuals without cancer receiving prescriptions for opioids from four or more prescribers and four or more pharmacies. This is a claims-based measure, which reduces the reporting burden for states. In 2015, MAP initially recommended this measure and two related measures (NQF #2940 and #2951) conditionally pending NQF endorsement. Subsequently, all three measures were endorsed in 2017. CMS added NQF #2940 to the 2016 Core Set, but did not accept the
recommendation for NQF #2950 and NQF #2951. MAP reaffirms its 2015 rationale and puts forth the same rationale to recommend the measure for inclusion in the 2019 Adult Core Set. This measure is timely and important for the Medicaid population because it helps identify patients at risk for opioid related morbidity and mortality, in that patients who see multiple prescribers or use multiple pharmacies are at a higher risk of death by drug overdose. The importance of substance use/abuse treatment was further highlighted during a presentation by Kirsten Beronio, Senior Policy Advisor on Behavioral Health Care, CMS. Ms. Beronio noted that Medicaid beneficiaries are at higher risk for substance and opioid use disorders than the general population and are less likely to receive treatment.\textsuperscript{18}

**NQF #0712e Depression Utilization of the PHQ-9 Tool**

This measure captures the number of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia who have had at least one PHQ-9 or PHQ-9M tool administered during a four month measurement period. The PHQ-9 tool is validated for use to assess the level of depression severity (for initial treatment decisions) and as an outcome tool (to determine treatment response).\textsuperscript{19} This process measure is paired with four outcome measures that were not recommended for addition to the Core Set (NQF #0710, #0711, #1884, and #1885). This measure’s data source is specified as electronic health records and paper medical records. A state Medicaid representative on the Workgroup expressed concern that reporting this measure will not be feasible for many states, since many states are unable to collect electronic health records and have moved away from resource-intensive paper chart audits. Several public commenters expressed concern that this measure exacerbates data collection and reporting burden. Ultimately, MAP supported the inclusion of this measure because it supports measurement-based care that systematically assesses patients for depression over time based on their response to treatment.

**NQF #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**

Tobacco use and smoking rates among Medicaid beneficiaries are significantly higher than the general population.\textsuperscript{20} NQF #0028 assesses the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation intervention, if identified as a tobacco user. MAP conditionally supported the inclusion of this measure in the Adult Core Set, pending the removal of NQF #0027 Medical Assistance with Smoking and Tobacco Use Cessation, which is currently in the Core Set. MAP agreed that NQF #0028 (and NQF #0028e) is a superior measure as the measure provides a variety of collection methods, including claims, registry, and electronic health records. In addition, this measure includes both screening rates and the percentage of individuals who received cessation intervention, whereas measure #0027 only addresses whether cessation assistance was offered. One public commenter expressed concern regarding the measure’s use at the state level, as it is specified for provider and facility levels of analysis.

**NQF #0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment**

This measure assesses the percentage of patients with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. Workgroup members noted that since this measure is only e-specified, it would pose significant reporting burden due to an inability to collect data for many states, if added to the Core Set, which may prevent its use. In addition, they noted that this measure lacks a detailed description of what counts as a suicide risk assessment and suggested that the developer clarify as well as modify the measure by including detailed specifications of acceptable risk assessment tools. Ultimately, MAP recommended
this measure for inclusion in the Adult Core Set, noting the importance of the topic of suicide amongst adults. Furthermore, the Workgroup agreed that the need for this measure outweighs the identified limitations mentioned above. Several commenters shared the Workgroup’s concerns regarding the potential reporting burden for many states. Commenters also suggested that CMS standardize which assessments/screenings are acceptable for states to use with the measure.

NQF #3175 Continuity of Pharmacotherapy for Opioid Use Disorder
This measure assesses the percentage of adults 18-64 years of age on pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment. MAP recommended the inclusion of this measure in the Adult Core Set, because it addresses continuity of treatment retention and care. The numerator of the measure includes patients who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days. The Workgroup noted that better patient outcomes are often associated with longer retention periods (i.e., ≥180 days).

NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
This measure assesses the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months and who received brief counseling if identified as an unhealthy alcohol user. The Workgroup discussed several barriers associated with this measure, including reporting burden (i.e., states’ inability to collect registry data) and broad screening tool specifications (i.e., current specification include a systematic screening method rather than a validated screening tool). Public commenters also expressed concern for these barriers. The decision to support this measure for inclusion was based on the importance of measuring alcohol screening and counseling rates, especially for vulnerable populations. In 2016, MAP also recommended this measure for addition noting that it fosters the principles of care coordination through screening and follow-up counseling.

NQF #0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
NQF #0541 assesses the percentage of patients 18 years of age and older who met the proportion of days covered (PDC) threshold of 80 percent during the measurement year. A performance rate is calculated separately for the following medication categories: Renin Angiotensin System (RAS) Antagonists, Diabetes Medications, and Statins. The inclusion of this measure would support alignment of other quality programs (e.g., Medicare Part D Star Ratings, Health Insurance Marketplace Quality Rating Systems, etc.) with the Medicaid Adult Core Set. MAP recommended this measure for addition during its 2016 review and again during this current review. The Workgroup again agreed that this measure is important because successful treatment of chronic conditions requires consistent medication management and patient adherence to taking prescribed medications.

Measure Concept Reviewed for Future Consideration
The Personal Outcome Measures survey, National Core Indicators (NCI) survey, and National Core Indicators – Aging and Disabilities (NCI-AD) Adult Consumer Survey were presented for future consideration for addition to the Adult Core Set.

- Personal Outcome Measures: Developed by the Council on Quality and Leadership (CQL), the Personal Outcome Measures survey is designed to determine the quality of life of people with disabilities in 21 different areas. The survey assesses if necessary supports are in place to assist individuals in achieving their desired outcomes.
• National Core Indicators: Developed in partnership with the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI), the NCI survey’s primary goal is to gather data on the performance of public intellectual/developmental disabilities (ID/DD) service systems.

• National Core Indicators – Aging and Disabilities: Developed through a collaborative effort between the National Association of States United for Aging and Disabilities (NASUAD) and HSRI. The NCI-AD was developed to obtain data on publicly funded programs for older adults and individuals with physical disabilities.

Workgroup discussions focused on the importance of capturing data for Medicaid beneficiaries with disabilities, specifically, community integration, beneficiary experience, and quality of life data. The surveys address priority gap areas for intellectually, developmentally, and physically disabled populations, such as beneficiary reported outcomes, long-term services and supports, and home and community-based services. The three survey instruments have been validated but do not include validated measures. MAP agreed that actionable measures addressing quality of life would be useful and encouraged future development of such measures, including those that can be applied across populations such as older adults and people with disabilities. Several public commenters expressed support for the NCI surveys and highlighted their widespread use among states.

Remaining High-Priority Gaps
State Medicaid agency medical director feedback, review of 2016 reporting, and data on prevalent conditions affecting the adult Medicaid population influenced the 2018 gap areas. The prioritization of specific gap areas is not meant to diminish the importance of all existing gaps in measurement. Rather, ranking along with broad discussions of these areas provides CMS with information on the collective importance of the gaps list, and is meant to inform the addition and removal of measures from the Core Set.

The Workgroup considered the previously ranked five key gap areas to guide their discussions. Following the review of the 2017 key priority gaps presented in Appendix I, the Workgroup members expressed the need to highlight a subset of the existing priority areas with some additions and clarifications:

• Interpregnancy interval

• Planning and transition to foster well woman care post-pregnancy
  – Minimize low value care

• Disparities and equity focused measures in conjunction with social determinants of health

• Beneficiary reported outcomes
  – Perception of care

• Behavioral health
  – Integration of substance use disorders with mental health

The Workgroup noted that many measurement priorities for quality improvement lack fully developed metrics. Therefore, the list above is meant to communicate measure development needs and areas of focus for the measure developer community. This list of measure gaps is a starting point for future discussions as well as a guide for annual revisions to the Adult Core Set.

Additionally, Workgroup members noted that measurement focus by topic areas in general are siloed; hence, gaps, needs, and priorities become siloed based on measure availability along with individual state Medicaid needs. However, all members of the Workgroup unanimously agreed that maternal health and postpartum measures remain an important gap for all Medicaid agencies. Medicaid state representatives emphasized that
even though an exhaustive list of gaps exist, each state is very different, and this variation in Medicaid populations leads to differing gaps and priorities. For example, cancer—specifically colorectal cancer—is a priority area for California Medicaid, whereas violence, accidents, and substance abuse are priority areas for Colorado Medicaid. For example, measures should be culturally appropriate versus merely culturally competent such that the measures will take into account all beneficiaries including people with disabilities, older adults, and multiple chronic conditions.

Given the variance in Medicaid needs among states, the Workgroup discussed the utility of population based cross-cutting measures addressing a set of core metrics. This approach to measurement reduces data collection and reporting burden while promoting consistency in reporting and allowing for a holistic view of care and services. Focusing on patient-reported outcomes allows for meaningful care delivery that is person-centric and appropriate. This approach will also allow states to gather data across primary, secondary, and tertiary care settings including behavioral health related information instead of collecting data based on subpopulations and specific conditions only. The group recommended that development of this core set of person-centric measures should focus on the “appropriateness” of measures across settings. For example, measures should be culturally appropriate versus merely culturally competent such that the measures will take into account all beneficiaries including people with disabilities, older adults, and multiple chronic conditions.

Public commenters expressed support for the Workgroup’s prioritization of high-priority measurement categories, including the integration of substance use disorders with mental health, the impact of social risk factors on health outcomes, home and community-based services, and long-term services and supports.

The Workgroup unanimously agreed that a core set of measures with robust, comprehensive data on medical, behavioral, and social risk factors can help state Medicaid programs address their resource constraints and data needs.
STRATEGIC CONSIDERATIONS FOR STATE-LEVEL REPORTING

The Adult and Child Medicaid Workgroups conducted joint deliberations regarding issues that affect measure-reporting rates along with strategies for increasing overall Core Set reporting. The discussion mainly focused on the impact of social determinants of health on care outcomes and patient experiences.

Both the Adult and Child Workgroups identified social risk factors as a way to address care quality while simultaneously minimizing disparities and increasing equity. Public commenters applauded the Workgroup’s discussions and recommendations regarding this topic. The discussion of social risk factors highlighted community level factors such as screening for and addressing food insecurity which not only improves overall nutrition and health, but also health equity issues like food deserts. Additionally, considering social risk factors allows measurement to focus on outcomes that are important to both populations and subpopulations of interest within Medicaid. For example, a measure may focus on maternal health and the subpopulation would be mothers with known substance use disorders. The group noted that this type of analysis—which involves stratifying data by social risk factors—allows for state-level quality improvement efforts to identify and address gaps in measurement and care.

Workgroup members suggested that state Medicaid agencies use social risk factors to customize programs according to their unique state needs. Additionally, state Medicaid directors on the Workgroup panels encouraged states to undertake the assessment of social risk factors in relation to disparities. For example, they recommended that people with multiple chronic conditions be considered a disparity-based subpopulation requiring additional services not necessary for the larger Medicaid population.

The Workgroup also discussed methodological considerations when analyzing social risk factors. State Medicaid directors recommended over-sampling of the Medicaid population of interest to allow for various analyses based on different social risk factors. They also suggested that states initially disaggregate the data at the state/systems level prior to undertaking further, more granular analyses. Subsequently, states should work with their Medicaid plans and providers and modify quality improvement strategies through shared accountability. To do this successfully, states need to track important social risk factors. However, a lack of social risk factor related data as well as inadequate tracking leads to a shortage of information, which ultimately hinders consideration of these factors for quality improvement efforts. The ultimate goal is to address quality from a broad state-level perspective as well as address nuances and care needs of each subpopulation within the larger Medicaid cohort.

Finally, the Workgroup revisited and reaffirmed past recommendations regarding cross-cutting measures that interface between medical and behavioral health, while acknowledging the fact that some measurement needs are community-based and outside the purview of healthcare. The group emphasized the need for parsimony in creating a core set of cross-cutting metrics with a focus on maximizing collection of social risk factor related data points. The group also reiterated and reemphasized the need to use social risk factors with patient-reported outcomes.

Workgroup members discussed their new and previous recommendations with an expanded patient-centric focus that addresses nonclinical factors such as social risk factors and the impact of these factors on overall care outcomes.
CONCLUSION

In order to meet the care needs of the nation’s most high risk, high needs individuals, states require high-value performance measures to support their delivery system reform efforts and improve outcomes. The Adult Medicaid Workgroup provided measure recommendations for the 2019 Adult Core Set to increase the number of states voluntarily reporting on Core Set measures and increase the number of Core Set measures reported by each state.

The MAP Coordinating Committee reiterated the Workgroup’s sentiments regarding the importance of parsimony and emphasized the importance of clarifying setting specificity in CMS’s technical assistance materials for state reporting. However, MAP noted that parsimony must be balanced with the need to provide states with flexibility to select measures best suited for their unique populations. MAP reemphasized the need for high-value measures that address critical gap areas that align with measures leveraged by the private sector.

The Adult Workgroup recommended the removal of two measures included in the 2018 Adult Core Set: NQF #0476 PC-03 Antenatal Steroids and NQF #2082 HIV Viral Load Suppression. The Workgroup also recommended the addition of eight measures which address critical gap areas in the Medicaid adult population: NQF #2967 CAHPS Home and Community-Based Services Measures, NQF #2950 Use of Opioids from Multiple Providers in Persons Without Cancer, NQF #0712 Depression Utilization of the PHQ-9 Tool, NQF #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, NQF #0104 Adult Major Depressive Disorder (MDD): Pharmacotherapy for Opioid Use Disorder, NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling, and NQF #0541 Proportion of Days Covered (PDC): Rates by Therapeutic Category.

MAP's recommendations for measure removal and addition reflect Workgroup members’ prioritization of patient and consumer-centered outcomes and states’ evolving needs. The Workgroup supported the continued use of all remaining measures included in the Core Set.

With the evolution of the Medicaid program, success in improving quality depends on maximizing data utility and harnessing the potential of addressing social risk factors. This new perspective enhances previous recommendations put forth by the group. Considering social risk factors increases the usefulness of data and addresses data granularity issues when looking at populations and subpopulations within Medicaid. In a person-centered health care environment, collecting data on and analyzing the effect of risk factors on outcomes will allow Medicaid to address measurement from a holistic view that includes both clinical and nonclinical factors spanning health care to public health to communities and individual residences. This expanded perspective allows for the analysis of factors—the majority of which are outside the purview of health care—that significantly impact the overall health of the Medicaid population. Assessing social risk factors will also enable the analysis of nonclinical factors such as community and patient related characteristics that shape the outcome of care more than the clinical attributes of Medicaid providers and traditional, services, and supports.
ENDNOTES


18. National Quality Forum (NQF). Medicaid Section 1115 Initiative to Address Opioid and Other Substance Use Disorders. Presented by Kirsten Beronio, Senior Policy Advisor on Behavioral Health Care Center for Medicaid and CHIP Services. Adult and Child Workgroup In-Person Meeting; May 8-10, 2018; Washington, DC.


22. National Quality Forum (NQF). Measure Deliberations. Adult and Child Workgroup In-Person Meeting; May 8-10, 2018; Washington, DC.
APPENDIX A: MAP Background

Description

The Patient Protection and Affordable Care Act (ACA) of 2010 requires that the U.S. Department of Health and Human Services (HHS) implement an annual, federal pre-rulemaking process to provide private-sector input to the quality and efficiency measures being considered for select federal public- reporting and performance-based payment programs. Since 2011, the National Quality Forum (NQF) has convened the Measure Applications Partnership (MAP) as a multistakeholder entity to provide recommendations on measures under consideration for use in federal programs by HHS. Under statute, HHS is required to publish a list of measures under consideration for rulemaking by December 1 of each year, and MAP then provides input to HHS on those measures by February 1 of the following year.

To accomplish this, NQF uses a three-step process to elicit multistakeholder input on measures under consideration:

- **Develop a program measure set framework.** Using CMS’ critical program objectives and NQF’s Measure Selection Criteria, NQF staff organize each program’s finalized measure set. These frameworks will be used to better understand the current measures in the program and how well any new measures might fit into the program by allowing Workgroup members to quickly identify gaps and other areas of needs.

- **Evaluate measures under consideration for what they would add to the program measure sets.** MAP uses the Measure Selection Criteria and a defined decision algorithm to determine whether the measures under consideration will enhance the program measure sets. Staff perform a preliminary analysis based on the algorithm, and MAP workgroups discuss their recommendations for each measure under consideration during December in-person meetings.

- **Identify and prioritize gaps for programs and settings.** MAP continues to identify gaps in measures within each program and provide measure ideas to spur development. MAP also considers the gaps across settings, prioritizing by importance and feasibility of addressing the gap when possible.

Approach

The pre-rulemaking process allows input from stakeholders affected by or interested in the use of quality measures. This process encompasses several steps:

1. Conduct an all-MAP orientation call to educate stakeholders on the role of MAP and the pre-rulemaking process;

2. Convene the MAP Coordinating Committee for a strategic planning meeting in the fall to provide input on the pre-rulemaking process and issues for the setting-specific workgroups to consider;

3. Convene the setting-specific workgroups for an orientation on the federal programs and conduct the feedback loop process;

4. Post the list of measures under consideration on or before December 1 of each year;

5. Conduct a public comment period on the measures under consideration to solicit input on them prior to the workgroups’ deliberations;

6. Convene the setting-specific workgroups via in-person meetings to provide initial recommendations;

7. Conduct a second public comment period to obtain input on the draft recommendations;

8. Convene the MAP Coordinating Committee to review public comments, review and finalize MAP recommendations, and consider strategic issues that may arise during the pre-rulemaking cycle; and
9. Solicit and review nominations for the annual MAP membership nominations process.

NQF solicits input on measures under consideration through a series of webinars and in-person meetings. In convening MAP, NQF brings together stakeholder groups in a unique collaboration that balances the interests of consumers, businesses and purchasers, health plans, clinicians and providers, communities and states, and suppliers. MAP’s Coordinating Committee and six workgroups consist of over 150 healthcare leaders and experts representing nearly 90 organizations, subject matter experts, and seven federal agencies (as ex officio members). The co-chairs of the Medicaid workgroups participate in the setting-specific workgroups as nonvoting liaisons to share the Medicaid perspectives during discussions regarding Medicaid-relevant measures.

Input is also provided on program considerations and specific measures for federal programs that are not included in MAP’s annual pre-rulemaking review, including the Medicaid Adult and Child Core Sets. Specifically, the Medicaid Adult Workgroup advises the MAP Coordinating Committee on recommendations to HHS for strengthening the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (the Adult Core Set).

Structure

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

EXHIBIT 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 meeting materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

Beginning in 2017, NQF held a formal nominations process to seat the Medicaid committees as workgroups to ensure a broader representation of Medicaid state expertise. Representatives are either organizational representatives or individuals with specific subject matter expertise. Prior to this, Medicaid committees were task forces and members were drawn from the MAP Coordinating Committee and other pre-rulemaking workgroups.

**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 (see [MAP 2017-2018 Pre-Rulemaking Deliberations](#)). Additionally, MAP engages in strategic activities throughout the year to inform MAP’s pre-rulemaking input. Please note that the Medicaid Workgroup’s deliberation happens off-cycle, (i.e., from January through August), from the rest of MAP’s work.
APPENDIX B:
Rosters for the NQF Medicaid Adult Workgroup and
MAP Coordinating Committee and NQF Staff

NQF Medicaid Adult Workgroup

CHAIRS (VOTING)
Harold Pincus, MD
Marissa Schlaifer, RPh, MS

ORGANIZATIONAL MEMBERS (VOTING)
American Association on Health and Disability
Clarke Ross, DPA
American Association of Retired Persons (AARP)
Lynda Flowers, JD, RN, MSN
American College of Obstetricians and Gynecologists (ACOG)
Michelle H. Moniz, MD, MSc
American Association of Nurse Practitioners (AANP)
Sue Kendig, JD, WHNP-BC, FAAPN
American Occupational Therapy Association
Joy Hammel, PhD
Association for Community Affiliated Plans (ACAP)
Deborah Kilstien, RN, MBA, JD
Human Services Research Institute
David Hughes, PhD
Intermountain Health
Jesse Spencer, MD
National Association of Medicaid Directors (NAMD)
Rachel LaCroix, PhD
Ohio Department of Medicaid
Mary Applegate, MD

INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)
Kim Elliott, PhD, CPHQ
Health Services Advisory Group
Diana Jolles, PhD, CNM, FACNM
Frontier Nursing University and El Rio Community Health Center
SreyRam Kuy, MD, MHS, FACS
Department of Veterans Affairs
Julia Logan, MD
California Department of Health Care
Lisa Patton, PhD
IBM Watson Health
Janice Tufte
Patient Representative

Judy Zerzan, MD
Colorado Department of Health Care Policy and Financing

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)
Health Resources and Services Administration (HRSA)
Maura Maloney and Sue Lin, PhD, MS
Substance Abuse and Mental Health Services Administration (SAMHSA)
Laura Jacobus-Kantor, PhD
Centers for Medicare & Medicaid Services (CMS)
Marsha Smith, MD, MPH, FAAP

Measure Applications Partnership Coordinating Committee

CO-CHAIRS (VOTING)
Charles Kahn, III, MPH
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)
Representatives

Academy of Managed Care Pharmacy
Marissa Schlaifer, RPh, MS
AFL-CIO
Shaun O’Brien, JD
America’s Health Insurance Plans
Rajesh Davda, MD
American Board of Medical Specialties
R. Barrett Noone, MD, FACS
American Academy of Family Physicians
Amy Mullins, MD FAAFP
American College of Physicians
Amir Qaseem, MD, PhD, MHA
American College of Surgeons
Bruce Hall, MD PhD, MBA, FACS
American HealthCare Association
David Gifford, MD, MPH
American Hospital Association
Maureen Kahn, MSN
American Medical Association
Carl Sirio, MD
APPENDIX C: MAP Measure Selection Criteria

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

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

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

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

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

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

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

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

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

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

   **Subcriterion 2.3** Affordable care

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

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

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

   **Subcriterion 3.2** Measure sets for public reporting programs should be meaningful for consumers and purchasers
Subcriterion 3.3  Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

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

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

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

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

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

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

5. Program measure set enables measurement of person- and family-centered care and services
Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

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

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

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

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

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

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

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

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

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

For the 2017-2018 cycle, to support the Workgroup’s review of potential measures, NQF staff provided a preliminary analysis of all measures under consideration using the NQF Medicaid Preliminary Analysis Algorithm derived from the Measure Selection Criteria.

<table>
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<tr>
<th>Assessment</th>
<th>Definition</th>
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</table>
| **The measure addresses a critical quality objective not adequately addressed by the measures in the program set.** | • The measure addresses the broad aims and one or more of the six National Quality Strategy priorities; or  
• The measure is responsive to specific program goals and statutory or regulatory requirements; or  
• The measure can distinguish differences in quality, is meaningful to patients and providers, and/or addresses a high-impact area or health condition.  
• Focus on high-impact areas and health conditions along with gap areas for Medicaid adult and child populations |
| **The measure is evidence-based and is either strongly linked to outcomes or is an outcome measure.** | • For process and structural measures: The measure has a strong scientific evidence-base to demonstrate that when implemented, it can lead to the desired outcome(s).  
• For outcome measures: The measure has a scientific evidence-base and a rationale for how the outcome is influenced by healthcare processes or structures. |
| **The measure addresses a quality challenge.** | • The measure addresses a topic with a performance gap or addresses a serious reportable event (i.e., a safety event that should never happen); or  
• The measure addresses unwarranted or significant variation in care that is evidence of a quality challenge. |
| **The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.** | • The measure is either not duplicative of an existing measure or measure under consideration in the program or is superior to an existing measure in the program; or  
• The measure captures a broad population; or  
• The measure contributes to alignment between measures in a particular program set (e.g., the measure could be used across programs or is included in a MAP “family of measures”); or  
• The value to patients/consumers outweighs any burden of implementation; or  
• Alignment across various non-Medicaid quality-related Core Sets is facilitated, such as CMS Quality Collaborative Core Set-Adult Set. |
| **The measure can be feasibly reported.** | 1. The measure can be operationalized (e.g., the measure is fully specified, specifications use data found in structured data fields, and data are captured before, during, or after the course of care.)  
2. The measure can be feasibly implemented at the state Medicaid level.  
3. Data for the measure can be collected easily.  
4. The measure does not pose undue resource constraints on the state.  
5. Medicaid agencies at the state level can implement the measure without tweaking it and or changing the level of analysis. |
### Assessment

The measure is reliable and valid for the level of analysis, program, and/or setting(s) for which it is being considered.

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<tr>
<th>Definition</th>
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<td>• The measure is NQF-endorsed; or</td>
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<tr>
<td>• The measure is fully developed and full specifications are provided; and</td>
</tr>
<tr>
<td>• Measure testing has demonstrated reliability and validity for the level of analysis, program, and/or setting(s) for which it is being considered.</td>
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If a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified.

<table>
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<tr>
<th>Definition</th>
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<tbody>
<tr>
<td>1. Feedback from end users has not identified any unreasonable implementation issues that outweigh the benefits of the measure; or</td>
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<tr>
<td>2. Feedback from implementers or end users has not identified any negative unintended consequences (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and</td>
</tr>
<tr>
<td>3. Feedback is supported by empirical evidence.</td>
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</tbody>
</table>
APPENDIX E: Characteristics of the Current Adult Core Set

The 2018 Adult Core Set measures are concentrated in the National Quality Strategy priority area of Healthy Living and Well-Being and Patient Safety (Exhibit E1). Measures are not exclusive to each alignment category and can span across more than one alignment category.

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

With respect to measure types, the set contains no structural measures, 22 process measures, 10 outcome measures, and one experience-of-care measure. Even though the Adult and Child Core Sets do not contain structural measures, they are part of the Medicaid program portfolio in which structural issues are addressed through programs such as home health and patient-centered medical home, among others. Additionally, the Adult Core Set is well aligned with other quality and reporting initiatives: 13 of the measures are used in one or more federal programs, including the Child Core Set and the Merit-Based Incentive Payment System (MIPS). Representing the diverse health needs of the Medicaid population, the Adult Core Set measures span many clinical topic areas (Exhibit E2).

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

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APPENDIX F:
Current Adult Core Set and Adult Workgroup Recommendations for Addition

There are 33 measures in the 2018 Adult Core Set. The Workgroup recommended two measures for removal from the 2019 Adult Core Set and eight measures for phased addition. Exhibit F1 below lists the measures included in the 2018 version of the Adult Core Set along with their current NQF endorsement number and status, including rates of state participation in FFY 2016 reporting. The 2017 reporting data were unavailable during the 2018 review. In FFY 2018, states will voluntarily collect the Adult Core Set measures using the 2018 Technical Specifications and Resource Manual. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF’s Quality Positioning System. Exhibit F2 lists the measures supported by the Workgroup for potential addition to the Adult Core Set.

EXHIBIT F1. 2018 ADULT CORE SET OF MEASURES WITH FFY 2016 REPORTING DATA

<table>
<thead>
<tr>
<th>Measure #, NQF Status, Title, and Steward</th>
<th>Measure Description</th>
<th>Number of States Reporting to CMS FFY 2016 and Alignment</th>
<th>MAP Recommendation or Removal Rationale</th>
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<tbody>
<tr>
<td>0004 Endorsed Initiating and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment Measure Steward: National Committee for Quality Assurance (NCQA)</td>
<td>The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.</td>
<td>27 states reported FFY 2016 Alignment: Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), Merit-Based Incentive Payment System (MIPS) Program (Finalized), and Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td>Measure #, NQF Status, Title, and Steward</td>
<td>Measure Description</td>
<td>Number of States Reporting to CMS FFY 2016 and Alignment</td>
<td>MAP Recommendation or Removal Rationale</td>
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<tr>
<td><strong>The Adult Core Set</strong> includes the NCQA version of the measure, which is adapted from the AHRQ measure (NQF #0006) Not NQF-Endorsed** Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid)** Measure Steward: NCQA</td>
<td>This measure provides information on beneficiaries’ experiences with their health care and gives a general indication of how well the health care meets the beneficiaries’ expectations. Results summarize beneficiaries’ experiences through ratings, composites, and question summary rates. Four global rating questions reflect overall satisfaction: • Rating of All Health Care • Rating of Health Plan • Rating of Personal Doctor • Rating of Specialist Seen Most Often 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 Item-specific question summary rates are reported for the rating questions and each composite question, the “written materials/Internet provided needed information” question, and the “forms were easy to fill out” question. Question summary rates are also reported individually for two items summarizing the following concepts: • Health Promotion and Education • Coordination of Care</td>
<td>27 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>0018 Endorsed Controlling High Blood Pressure</strong> Measure Steward: NCQA</td>
<td>The percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled during the measurement year based on the following criteria: 1. Patients 18-59 years of age whose blood pressure was &lt;140/90 mm Hg. 2. Patients 60-85 years of age with a diagnosis of diabetes whose blood pressure was &lt;140/90 mm Hg. 3. Patients 60-85 years of age without a diagnosis of diabetes whose blood pressure was &lt;150/90 mm Hg.</td>
<td>26 states reported FFY 2016 Alignment: Medicare Shared Savings Program (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), MIPS (Finalized), and QHP QRS (Implemented)</td>
<td>Support for continued use in the program</td>
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<tr>
<td>Measure #, NQF Status, Title, and Steward</td>
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<td>Number of States Reporting to CMS FFY 2016 and Alignment</td>
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<tr>
<td><strong>0027</strong> Endorsed Medical Assistance With Smoking and Tobacco Use Cessation Measure Steward: NCQA</td>
<td>The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of patients 18 years of age and older who are current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of patients 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of patients 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.</td>
<td>18 states reported FFY 2016 Alignment: QHP QRS (Implemented)</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>0032</strong> Endorsed Cervical Cancer Screening Measure Steward: NCQA</td>
<td>Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: 1. Women age 21-64 who had cervical cytology performed every 3 years. 2. Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.</td>
<td>39 states reported FFY 2016 Alignment: Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), MIPS (Finalized), and QHP QRS (Implemented)</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>0033</strong> Endorsed Chlamydia Screening in Women [ages 21-24] Measure Steward: NCQA</td>
<td>Percentage of women ages 21 to 24 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.</td>
<td>37 stated reported FFY 2016 Alignment: 2018 Child Core Set, Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), MIPS (Finalized), and QHP QRS (Implemented)</td>
<td>Support for continued use in the program</td>
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<tr>
<td>Measure #, NQF Status, Title, and Steward</td>
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<tr>
<td>0039 Endorsed</td>
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<tr>
<td>Flu Vaccinations for Adults Ages 18 to 64 Measure Steward: NCQA</td>
<td>Percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1 of the measurement year and the date when the CAHPS 5.0H Adult Survey was completed.</td>
<td>18 states reported FFY 2016 Alignment: QHP QRS (Implemented)</td>
<td>Support for continued use in the program</td>
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<tr>
<td>0057 Endorsed</td>
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<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing Measure Steward: NCQA</td>
<td>The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.</td>
<td>37 states reported FFY 2016 Alignment: QHP QRS (Implemented)</td>
<td>Support for continued use in the program</td>
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<tr>
<td>0059 Endorsed</td>
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<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) Measure Steward: NCQA</td>
<td>The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is &gt;9.0% during the measurement year.</td>
<td>24 states reported FY 2016 Alignment: Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (Implemented), MIPS (Finalized)</td>
<td>Support for continued use in the program</td>
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<tr>
<td>0105 Endorsed</td>
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<tr>
<td>Antidepressant Medication Management (AMM) Measure Steward: NCQA</td>
<td>The percentage of members 18 years of age and older who were treated antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported. 1. Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). 2. Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).</td>
<td>33 states reported FFY 2016 Alignment: Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), MIPS (Finalized), QHP QRS (Implemented)</td>
<td>Support for continued use in the program</td>
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<tr>
<td>0272 Endorsed</td>
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<tr>
<td>PQI 01: Diabetes Short-Term Complications Admissions Rate Measure Steward: Agency for Healthcare Research and Quality (AHRQ)</td>
<td>Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions.</td>
<td>25 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
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<tr>
<td>Measure #, NQF Status, Title, and Steward</td>
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<tr>
<td><strong>0275</strong> Endorsed</td>
<td>Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 1,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.</td>
<td>23 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td>PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate Measure Steward: AHRQ</td>
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<tr>
<td><strong>0277</strong> Endorsed</td>
<td>Admissions with a principal diagnosis of heart failure per 100,000 population, ages 18 years and older. Excludes cardiac procedure admissions, obstetric admissions, and transfers from other institutions.</td>
<td>25 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
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<tr>
<td>PQI 08: Congestive Heart Failure Rate Measure Steward: AHRQ</td>
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<tr>
<td><strong>0283</strong> Endorsed</td>
<td>Admissions for a principal diagnosis of asthma per 1,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.</td>
<td>23 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
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<tr>
<td>PQI 15: Asthma in Younger Adults Admission Rate Measure Steward: AHRQ</td>
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<tr>
<td><strong>0418 : 0418e</strong> Endorsed</td>
<td>Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.</td>
<td>7 states reported FFY 2016 Alignment: 2018 Child Core Set, Medicare Shared Savings Program (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (Implemented), MIPS (Finalized)</td>
<td>Support for continued use in the program</td>
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<tr>
<td>Preventive Care and Screening: Screening for Depression and Follow-Up Plan Measure Steward: Centers for Medicare &amp; Medicaid Services (CMS)</td>
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<tr>
<td><strong>0469 : 0469e</strong> Endorsed</td>
<td>This measure assesses patients with elective vaginal deliveries or elective cesarean births at &gt;=37 and &lt;39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Birth, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)</td>
<td>11 states reported FFY 2016 Alignment: Hospital Inpatient Quality Reporting (Implemented), Hospital Value-Based Purchasing (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals (Implemented)</td>
<td>Support for continued use in the program</td>
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<tr>
<td>PC-01: Elective Delivery Measure Steward: The Joint Commission</td>
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<tr>
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<tr>
<td><strong>0476 Endorsed</strong>&lt;br&gt;PC-03: Antenatal Steroids&lt;br&gt;Measure Steward: The Joint Commission</td>
<td>This measure assesses patients at risk of preterm delivery at &gt;=24 and &lt;34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Birth, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).</td>
<td>4 states reported FFY 2016 Alignment: N/A</td>
<td>The Workgroup recommends the removal of this measure from the Core Set. The Workgroup recommended removal to reduce duplication and burden at the state level as well as increase bandwidth for reporting other measures.</td>
</tr>
<tr>
<td><strong>0576 Endorsed</strong>&lt;br&gt;Follow-Up After Hospitalization for Mental Illness: Age 21 and Older&lt;br&gt;Measure Steward: NCQA</td>
<td>Percentage of discharges for beneficiaries age 21 and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: &lt;br&gt;• Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge &lt;br&gt;• Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge</td>
<td>36 states reported FFY 2016 Alignment: 2018 Child Core Set, Hospital Compare (Implemented), Inpatient Psychiatric Facility Quality Reporting (Implemented), Medicare Physician Quality Reporting System (Implemented), MIPS (Finalized), Physician Feedback/Quality Resource Use Report (Implemented), Physician Value-Based Payment Modifier (Implemented), QHP QRS (Implemented)</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td>Not NQF-Endorsed (NQF #1517 is no longer endorsed)&lt;br&gt;Prenatal &amp; Postpartum Care [postpartum care rate only]&lt;br&gt;Measure Steward: NCQA</td>
<td>Percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.</td>
<td>37 states reported FFY 2016 Alignment: 2018 Child Core Set, QHP QRS (Implemented)</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td>Measure #, NQF Status, Title, and Steward</td>
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<tr>
<td><strong>1768</strong> Endorsed</td>
<td>Plan All-Cause Readmissions Measure Steward: NCQA</td>
<td>For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: • Count of Index Hospital Stays* (denominator) • Count of 30-Day Readmissions (numerator) • Average Adjusted Probability of Readmission • An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).</td>
<td>22 states reported FFY 2016 Alignment: Hospital Inpatient Quality Reporting (No Status), QHP QRS (Implemented)</td>
</tr>
<tr>
<td><strong>1800</strong> Endorsed</td>
<td>Asthma Medication Ratio: Ages 19-64 Measure Steward: National Committee for Quality Assurance</td>
<td>The percentage of beneficiaries ages 19 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.</td>
<td>Added to the Core Set in 2018 Alignment: N/A</td>
</tr>
<tr>
<td>Not NQF-Endorsed</td>
<td>The Adult Core Set includes the NCQA version of the measure, which is adapted from the CMS measure (NQF #1879) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) Measure Steward: National Committee for Quality Assurance</td>
<td>Percentage of beneficiaries ages 19 to 64 with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period during the measurement year.</td>
<td>30 states reported FFY 2016 Alignment: Medicare Physician Quality Reporting System (Implemented), MIPS (Finalized), Physician Feedback/Quality Resource Use Report (Implemented), Physician Value-Based Payment Modifier (Implemented)</td>
</tr>
<tr>
<td>Measure #, NQF Status, Title, and Steward</td>
<td>Measure Description</td>
<td>Number of States Reporting to CMS FFY 2016 and Alignment</td>
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<tr>
<td>1932 Endorsed Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Measure Steward: NCQA</td>
<td>The percentage of patients 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.</td>
<td>25 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td>2082 Endorsed HIV Viral Load Suppression Measure Steward: Health Resources and Services Administration - HIV/AIDS Bureau</td>
<td>Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.</td>
<td>4 states reported FFY 2016 Alignment: Medicare Physician Quality Reporting System (Implemented), MIPS (Finalized), Physician Feedback/Quality Resource Use Report (Implemented), Physician Value-Based Payment Modifier (Implemented)</td>
<td>The Workgroup recommends the removal of this measure from the Core Set. The Workgroup recommended removal due to reporting challenges (e.g., data source and strict confidentiality laws associated with HIV and AIDS related clinical data).</td>
</tr>
<tr>
<td>2371 Endorsed Annual Monitoring for Patients on Persistent Medications Measure Steward: NCQA</td>
<td>This measure assesses the percentage of patients 18 years of age and older who received a least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report the following three rates and a total rate: • Rate 1: Annual Monitoring for patients on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB): At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. • Rate 2: Annual monitoring for patients on diuretics: At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. • Total rate (the sum of the two numerators divided by the sum of the two denominators)</td>
<td>32 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td>Measure #, NQF Status, Title, and Steward</td>
<td>Measure Description</td>
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<tr>
<td><strong>2372</strong> Endorsed Breast Cancer Screening Measure Steward: NCQA</td>
<td>Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer</td>
<td>35 states reported FFY 2016 Alignment: Medicare Shared Savings Program (Implemented), MIPS (Finalized), QHP QRS (Implemented)</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>2605</strong> Endorsed Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence Measure Steward: NCQA</td>
<td>The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported: • The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge. • The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge. • The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge. • The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.</td>
<td>Added to the Core Set in 2017 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>2607</strong> Endorsed Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) Measure Steward: NCQA</td>
<td>The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is &gt;9.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control &gt;9.0%). This measure is endorsed by NQF and is stewarded by NCQA.</td>
<td>Added to the Core Set in 2017 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td>Measure #, NQF Status, Title, and Steward</td>
<td>Measure Description</td>
<td>Number of States Reporting to CMS FFY 2016 and Alignment</td>
<td>MAP Recommendation or Removal Rationale</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>--------------------</td>
<td>----------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>2902 Endorsed</strong></td>
<td>Contraceptive Care – Postpartum Women Ages 21-44</td>
<td>Among women ages 21 to 44 who had a live birth, the percentage that: 1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery. 2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods during the postpartum period. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods during the postpartum period. These rates are reported at two points in time: contraceptive provision within 3 days of delivery is used to monitor the provision of contraception in the immediate postpartum period, while contraceptive provision within 60 days of delivery is used to monitor the provision of contraception throughout the postpartum period. (A 60-day period is used because the American Congress of Obstetricians and Gynecologists [ACOG] recommends a postpartum visit at 6 weeks, and two additional weeks are allowed for women whose postpartum care visit is delayed.)</td>
<td>Added to the Core Set in 2017 Alignment: 2018 Child Core Set</td>
</tr>
<tr>
<td>Measure #, NQF Status, Title, and Steward</td>
<td>Measure Description</td>
<td>Number of States Reporting to CMS FFY 2016 and Alignment</td>
<td>MAP Recommendation or Removal Rationale</td>
</tr>
<tr>
<td>------------------------------------------</td>
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<td>----------------------------------------</td>
</tr>
</tbody>
</table>
| 2903 Endorsed
Contraceptive Care – Most and Moderately Effective Methods: Ages 21-44 Measure Steward: U.S. Office of Population Affairs | Among women ages 21 to 44 at risk of unintended pregnancy, the percentage that:
1. Were provided a most effective or moderately effective method of contraception.
2. Were provided a long-acting reversible method of contraception (LARC).
The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods. A state should exercise caution in using this measure for payment purposes, because performance on this measure is a function of a woman’s preferences. The goal is to provide an indicator for states to assess the provision of most or moderately effective contraceptive methods within the state, and see where there is room for improvement. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods. | Added to the Core Set in 2018 Alignment: 2018 Child Core Set | Support for continued use in the program |
| 2940 Endorsed
Use of Opioids at High Dosage in Persons Without Cancer Measure Steward: Pharmacy Quality Alliance (PQA) | The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer. | 14 states reported in FFY 2016 Alignment: N/A | Support for continued use in the program |
| Not NQF-endorsed
Adult Body Mass Index Assessment Measure Steward: NCQA | Percentage of beneficiaries ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year. | 33 states reported FFY 2016 Alignment: QHP QRS (Implemented) | Support for continued use in the program |
| Not NQF-endorsed
Concurrent Use of Opioids and Benzodiazepines (COB) Measure Steward: Pharmacy Quality Alliance (PQA) | Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Patients with a cancer diagnosis or in hospice are excluded. | Added to the Core Set in 2018 Alignment: N/A | Support for continued use in the program |
Measures in Exhibit F2 are listed in the order in which the Workgroup prioritized them for inclusion. Workgroup members equally prioritized NQF #0712e Depression Utilization of the PHQ-9 Tool and NQF #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention as well as NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling and NQF #0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category.

EXHIBIT F2. MEASURES SUPPORTED BY THE ADULT WORKGROUP FOR PHASED ADDITION TO THE ADULT CORE SET

<table>
<thead>
<tr>
<th>Measure &amp; NQF Endorsement Status</th>
<th>Measure Description</th>
<th>Alignment</th>
<th>Workgroup Recommendation and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>2967 Endorsed</td>
<td>CAHPS® Home- and Community-Based Services measures derive from a cross disability survey to elicit feedback from adult Medicaid beneficiaries receiving home and community based services (HCBS) about the quality of the long-term services and supports they receive in the community and delivered to them under the auspices of a state Medicaid HCBS program. The unit of analysis is the Medicaid HCBS program, and the accountable entity is the operating entity responsible for managing and overseeing a specific HCBS program within a given state. (For additional information on the accountable entity, see Measures Testing form item #1.5 below.) The measures consist of seven scale measures, 6 global rating and recommendation measures, and 6 individual measures: Scale Measures • Staff are reliable and helpful – top-box score composed of 6 survey items • Staff listen and communicate well – top-box score composed of 11 survey items • Case manager is helpful – top-box score composed of 3 survey items • Choosing the services that matter to you – top-box score composed of 2 survey items • Transportation to medical appointments – top-box score composed of 3 survey items • Personal safety and respect – top-box score composed of 3 survey items • Planning your time and activities – top-box score composed of 6 survey items – Global Ratings Measures • Global rating of personal assistance and behavioral health staff – top-box score on a 0-10 scale • Global rating of homemaker – top-box score on a 0-10 scale • Global rating of case manager – top-box score on a 0-10 scale</td>
<td>N/A</td>
<td>Support for inclusion in the 2019 Adult Core Set The Workgroup supported the inclusion of this measure, noting the need for home and community-based metrics. If added to the Core Set, this will be the only measure that addresses long-term care services provided in a community setting.</td>
</tr>
<tr>
<td>Measure &amp; NQF Endorsement Status</td>
<td>Measure Description</td>
<td>Alignment</td>
<td>Workgroup Recommendation and Rationale</td>
</tr>
<tr>
<td>-------------------------------</td>
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</tr>
</tbody>
</table>
| Recommendations Measures | - Would recommend personal assistance/behavioral health staff to family and friends – top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes)  
- Would recommend homemaker to family and friends – top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes)  
- Would recommend case manager to family and friends – top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes)  
- Unmet Needs Measures  
  - Unmet need in dressing/bathing due to lack of help – top-box score on a Yes, No scale  
  - Unmet need in meal preparation/eating due to lack of help – top-box score on a Yes, No scale  
  - Unmet need in medication administration due to lack of help – top-box score on a Yes, No scale  
  - Unmet need in toileting due to lack of help – top-box score on a Yes, No scale  
  - Unmet need with household tasks due to lack of help – top-box score on a Yes, No scale  
- Physical Safety Measure  
  - Hit or hurt by staff – top-box score on a Yes, No scale | | |

**2950 Endorsed**  
**Use of Opioids from Multiple Providers in Persons Without Cancer**  
Measure Steward: Pharmacy Quality Alliance  
The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.  
N/A  
Support for inclusion in the 2019 Adult Core Set  
The Workgroup recommended the inclusion of this measure in the Adult Core Set because it addresses the epidemic of opioid morbidity and mortality.  

**0712e Endorsed**  
**Depression Utilization of the PHQ-9 Tool**  
Measure Steward: MN Community Measurement  
The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia who have a completed PHQ-9 or PHQ-9M tool during the measurement period.  
Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status) and Merit-Based Incentive Payment System (MIPS) Program (Finalized)  
Support for inclusion in the 2019 Adult Core Set  
The Workgroup supported the inclusion of this measure because it supports measurement-based care, systematically assessing patients for depression over time based on their response to treatment.
<table>
<thead>
<tr>
<th>Measure &amp; NQF Endorsement Status</th>
<th>Measure Description</th>
<th>Alignment</th>
<th>Workgroup Recommendation and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>0028 Endorsed</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Measure Steward: PCPI Foundation</td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user</td>
<td>Medicare Shared Savings Program (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), and Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0104e Endorsed</td>
<td>Adult Major Depressive Disorder (MDD): Suicide Risk Assessment Measure Steward: PCPI</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified</td>
<td>Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status) and Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>3175 Endorsed</td>
<td>Continuity of Pharmacotherapy for Opioid Use Disorder Measure Steward: University of Southern California</td>
<td>Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment</td>
<td>N/A</td>
</tr>
<tr>
<td>Measure &amp; NQF Endorsement Status</td>
<td>Measure Description</td>
<td>Alignment</td>
<td>Workgroup Recommendation and Rationale</td>
</tr>
<tr>
<td>---------------------------------</td>
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</tr>
<tr>
<td><strong>2152 Endorsed</strong> Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
<td>Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user</td>
<td>Medicare Physician Quality Reporting System (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Physician Feedback/Quality Resource Use Report (Finalized), Physician Value-Based Payment Modifier (Finalized)</td>
<td>The Workgroup supported this measure for inclusion in the Adult Core Set because of its importance to measure, despite the burden to report and broad definition of qualifying screening assessment.</td>
</tr>
<tr>
<td><strong>0541 Endorsed</strong> Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category</td>
<td>The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Renin Angiotensin System (RAS) Antagonists, Diabetes Medications, Statins. A higher score indicates better quality.</td>
<td>Medicare Part D Star Rating (Implemented)</td>
<td>The Workgroup agreed that this measure is important because successful treatment of chronic conditions requires consistent medication management and patient adherence to prescribed medications.</td>
</tr>
</tbody>
</table>

Measure Steward: PCPI Foundation

Measure Steward: Pharmacy Quality Alliance
APPENDIX G:
Additional Measures Considered

The Adult Workgroup discussed but did not ultimately recommend the addition of eleven measures to the 2019 Core Set. The Workgroup either voted on these measures and did not achieve the consensus threshold (>60 percent of voting members) to gain support or conditional support for use in the Adult Core Set or the measures did not receive two motions of support from Workgroup members to initiate a vote. The Workgroup needed to limit the number of measures it supported for the sake of parsimony and practicality; lack of support for these measures does not indicate that the measures are flawed or unimportant. These measures and others could be reconsidered during a future review of the Adult Core Set.

<table>
<thead>
<tr>
<th>NQF Measure Number</th>
<th>Measure Title</th>
<th>Measure Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>0008</td>
<td>Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)</td>
<td>Agency for Healthcare Research and Quality</td>
</tr>
<tr>
<td>0055</td>
<td>Comprehensive Diabetes Care: Eye Exam (retinal) performed</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>0061</td>
<td>Comprehensive Diabetes Care: Blood Pressure Control (&lt;140/90 mm Hg)</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>0097</td>
<td>Medication Reconciliation Post-Discharge</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>0421</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>0575</td>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (&lt;8.0%)</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>0710e</td>
<td>Depression Remission at Twelve Months</td>
<td>MN Community Measurement</td>
</tr>
<tr>
<td>0711</td>
<td>Depression Remission at Six Months</td>
<td>MN Community Measurement</td>
</tr>
<tr>
<td>0726</td>
<td>Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)</td>
<td>National Assoc. of State Mental Health Program Directors Research Institute, Inc. (NRI)</td>
</tr>
<tr>
<td>2600</td>
<td>Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>N/A</td>
<td>Treatment of Chronic Hepatitis C: Completion of Therapy</td>
<td>Pharmacy Quality Alliance</td>
</tr>
</tbody>
</table>
APPENDIX H: Withdrawn Measures

NQF solicited Adult Workgroup members’ measure recommendations for addition and removal prior to the in-person meeting and requested that they serve as the lead discussants for their measures during deliberations. Four lead discussants withdrew six measures preliminarily recommended for addition and two measures preliminarily recommended for removal based on measure discussions, input from the states, or CMS’ feedback on the Core Set’s architecture.

<table>
<thead>
<tr>
<th>NQF Measure Number</th>
<th>Measure Title</th>
<th>Measure Steward</th>
<th>Recommendation Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>0275</td>
<td>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05)</td>
<td>Agency for Healthcare Research and Quality</td>
<td>Removal</td>
</tr>
<tr>
<td>0277</td>
<td>Congestive Heart Failure Rate (PQI 08)</td>
<td>Agency for Healthcare Research and Quality</td>
<td>Removal</td>
</tr>
<tr>
<td>0326</td>
<td>Advance Care Plan</td>
<td>National Committee for Quality Assurance</td>
<td>Addition</td>
</tr>
<tr>
<td>1927</td>
<td>Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications</td>
<td>National Committee for Quality Assurance</td>
<td>Addition</td>
</tr>
<tr>
<td>1934</td>
<td>Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)</td>
<td>National Committee for Quality Assurance</td>
<td>Addition</td>
</tr>
<tr>
<td>1888</td>
<td>Workforce Development Measure Derived from Workforce Development Domain of the C-CAT</td>
<td>American Medical Association</td>
<td>Addition</td>
</tr>
<tr>
<td>1892</td>
<td>Individual Engagement Measure Derived from the Individual Engagement Domain of the C-CAT</td>
<td>American Medical Association</td>
<td>Addition</td>
</tr>
<tr>
<td>2483</td>
<td>Gains in Patient Activation (PAM) Scores at 12 Months</td>
<td>Insignia Health</td>
<td>Addition</td>
</tr>
</tbody>
</table>
APPENDIX I:  
Key Gap Areas in the Adult Core Set

The Adult Workgroup identified several gap areas in the Adult Core Set of measures. Newly identified gap areas are denoted with an asterisk (*). All other gap areas presented below are recurring gap areas identified by the Task Forces in previous review years.

Behavioral Health and Integration with Primary Care
- Integration of substance use disorders with mental health*

Assessing and Addressing of Social Determinants of Health
- Disparities and equity focused measures in conjunction with social determinants of health*

Maternal/Reproductive Health
- Inter-conception care to address risk factors
- Poor birth outcomes (e.g., premature birth)
- Postpartum complications
- Support with breastfeeding after hospitalization
- Interpregnancy interval*

Planning And Transition To Well Woman Care*
  • Minimize low value care

Long-Term Supports and Services
  • Home and community-based services

New or Chronic Opiate Use (45 days)

Efficiency
  • Inappropriate emergency department utilization

Beneficiary-Reported Outcomes
  • Health-related quality of life
  • Perception of care*

Access to Primary, Specialty, and Behavioral Healthcare
  • Access to care by a behavioral health professional

Polypharmacy

Workforce/Access

Treatment Outcomes for Behavioral Health Conditions and Substance Use Disorders

Care Coordination
APPENDIX J: Public Comments

General Comments on the Report

Adult Vaccine Access Coalition
Lisa Foster
The Adult Vaccine Access Coalition (AVAC) appreciates the opportunity to comment on the National Quality Forum (NQF) Measures Application Partnership (MAP) 2018 Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (the Adult Core Set). We appreciate NQF’s leadership in recognizing the importance of quality measures in improving the health of individuals and but also their significance to improving the health of entire communities.

AVAC consists of over 50 organizational leaders in health and public health that are committed to addressing the range of barriers to adult immunization and to raising awareness of the importance of adult immunization. AVAC works towards common legislative and regulatory solutions that will strengthen and enhance access to adult immunization across the health care system. Our priorities and objectives are driven by a consensus process with the goal of enabling the range of stakeholders to have a voice in the effort to improve access and utilization of adult immunizations.

One of our key coalition priorities is to advocate for federal benchmarks and quality measures to encourage improved tracking and reporting of immunization status that will result in increased adult immunization rates. Immunization quality measures are a crucial tool for health care quality improvement and have demonstrated effectiveness in improving immunization coverage across adult populations.

Opportunities to assess the immunization status of Medicaid beneficiaries, particularly pregnant women and individuals with chronic conditions such as diabetes and heart disease, should be done by the range of clinicians who care for them, including primary care and specialty providers. Taking advantage of each and every patient encounter to ensure that counseling and education on vaccines, based on their age and health status, and a strong provider recommendation have been found to improve the likelihood of a patient being immunized. Published literature indicates that integrating immunization assessment and additional providers offering these critical preventive services will result in greater opportunities for immunization.1 The National Vaccine Advisory Committee’s (NVAC) Adult Immunization Standards call for all providers caring for adult patients to assess, recommend, vaccinate or refer, and document vaccinations.

American Psychiatric Association
Samantha Shugarman
The American Psychiatric Association (APA), the leading psychiatric organization in the world, represents about 38,000 members who work together to ensure humane care and effective treatment for all persons with mental illness, including substance use disorders. As the voice and conscience of modern psychiatry, APA envisions a society that has available, accessible quality psychiatric diagnosis and treatment. As such, we appreciate the opportunity to comment on the recommendations detailed in the MAP draft reports, “Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2018” and “Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2018.”

Community Catalyst
Ann Hwang
We appreciate the opportunity to provide comments on Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2018. Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. Community Catalyst has been working to...
improve care for Medicaid and Medicare beneficiaries for many years. There is significant need to improve quality measurement in order to capture the outcomes that are most meaningful to consumers.

In addition to offering comments on several specific measures, we wish to highlight several of the important measurement gaps that the committee identifies in its report.

We commend the committee for newly identifying “integration of substance use disorders with mental health” and “disparities and equity focused measures in conjunction with social determinants of health” as key gaps in the measure set. We also support the continued presence on the “gap” list of home and community-based services, health-related quality of life, and treatment outcomes for behavioral health conditions and substance use disorders. We believe that all of these areas should be the focus on intensive measure development efforts in order to help ensure that Medicaid beneficiaries get the best quality services and that these services address the full range of consumer needs from social determinants to integrated treatment to community based services and supports. We urge the committee to focus on filling these measurement gaps, rather than prioritizing addition of measures that address areas that are already well-covered.

CVS/Caremark (Corporate HQ)

Virginia Rego

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

With regard to specific measures for inclusion, CVS Health highly recommends the inclusion of the “Proportion of Days Covered (PDC) – three rates” in the Medicaid Adult Core Set due to its proven ability to help improve medication adherence and health outcomes in the Medicare Stars program. Proportion of Days Covered (PDC) is the Pharmacy Quality Alliance (PQA)-recommended metric for estimation of medication adherence for patients using chronic medications and the metric is also endorsed by NQF. The metric identifies the percentage of patients taking medications in a particular drug class that have high adherence (PDC > 80% for the individual). The measure tracks medication adherence for conditions that are highly prevalent in Medicare-Medicaid populations. It includes three rates - one for blood pressure medications (renin angiotensin system antagonists [RASA]), one for cholesterol medications (statins), and one for diabetes medications (roll-up across 4 classes of oral diabetes drugs). The measure is currently being used in Medicare STARS and the Health Insurance marketplaces. Inclusion in the Medicaid Adult Core Set would allow further alignment across programs to promote consistent performance measurement where it can have the most impact and give a more complete view of the quality of care delivered across healthcare settings.

Thank you for the opportunity to provide comments in support of these NQF recommendations.

Federation of American Hospitals

Claudia Salzberg

The Federation of American Hospitals (“FAH”) appreciates the opportunity to comment on the National Quality Forum Measures Applications Partnerships (MAP) draft 2018 report on the core set of healthcare quality measures for children enrolled in Chip and Medicaid and adults enrolled in Medicaid.

For the MAP Medicaid Child report the FAH supports the proposed refinements to the draft set but recommends that the MAP consider whether adding Measure #1885 Depression Response at Twelve Months - Progress Towards Remission is reasonable in light of the concerns voiced on similar measures that rely on paper and electronic medical record data. The FAH notes that other measures were recommended for removal due to concerns over data collection challenges. In addition, this measure is specified for those aged 18 years and older and does not apply to children and adolescents at this time. The FAH
also questions the inclusion of #2548 Child Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) as it is currently specified at the facility level and the feasibility of data collection and reporting at the state level is not known.

For the MAP Medicaid Adult report the FAH supports the proposed refinements to the draft set but recommends that the MAP consider whether adding Measure #104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment is reasonable in light of the concerns voiced on similar measures that rely on paper and electronic medical record data. The FAH notes that a similar measure for children and adolescents was recommended for removal from the Child Core Set due to concerns over data collection challenges. Since these measures have similar specifications, we anticipate that the states will encounter the same issues with data collection.

The FAH values the robust discussion held on the impact that social determinants of health have on the Medicaid child and adult populations. Additional work is needed to ensure that the data are collected across states in a standardized way and further our understanding on how we can work together to improve the health and well being of these at-risk populations. In addition, the FAH supports the recommendation to move toward population-based, cross-cutting measures in future iterations of these core sets.

**Human Services Research Institute**

**Alexandra Bonardi**

In addition to comments on the specific measures, we offer the following corrections:

On page 16, it should be noted that NCI-AD is a product of a collaboration between Human Services Research Institute (HSRI) and NASUAD (National Association of States United for Aging and Disability).

Additionally, please clarify that NCI-AD like NCI collects data to measure the performance of publicly funded programs.

**MLHCT**

**Darlene Jones**

Adult Measures for Medicaid.

I am a parent of a adult son on ventilator at home. He is in the HCBS program under AHCCCS. We have no quality improvement phone numbers and the providers we have do not have any either. There is no way that we have any voice in anything to do with our healthcare. We have hardly any Doctors that know our son’s conditions that we can see. The Doctor’s we can see are residents that only practice about 2 years and move one. We do not get appropriate staffing because the system does not have enough providers and they do not pay enough to provider to get them to sign on. We have absolutely no way to make improvements in any area of Medicaid but especially in our health. When we run into problems with our health or DME the contractor we have, DDD, has no idea how to help us. It take every inch of the parents/family to try and decipher the system and event then so many people like my son go to step down units or into group homes due to the lack of concern and care in our State. I love that you constantly try and improve the system but I see no end to the horrors we live. If there are no consequences then there is no improvements on anyone’s part. Sanctions are not enough. It seems every contractor pays sanctions. This is our taxes too. I am tiered of having a child in a system that just refuses to improve and says that they have had their demonstration waiver since the 1980’s and this is how it has always ran. This is true. They have withheld good health care from all the vaunerable populations in our State and they continue to get away with it. It seems that if they had to loose some of their control when they deliberately refuse to do what CMS has required it may be more effective. We all have consequences. Not Medicaid. They pay our money out and keep what they do not spend and even CMS can not fix these type of situations. We need real rules that do not allow the abuse of power. Thank you very much.
NASDDDS
Mary Lou Bourne

We appreciate the commitment made by the committee to identify LTSS measures for use within the Medicaid Adult Core Measures. On page 13, the report explicitly states that “data must be provided to CMS by at least 25 states and meet internal standards for quality”. We would like to assure the committee that NCI for the Developmental Disability population is currently in use in 46 states and the District of Columbia. Validated measures are in use in these states to drive quality improvement, identify strategic planning initiatives, and to improve the overall experience of the people served by the state DD service systems. Fidelity of implementation is ensured in each participating state through the standardized administrative protocols developed and guided by the national project teams, standardized interviewer training, and through centralized data analysis. Assuring the measures have been designed and validated specifically to this select population assures the data can be comparable and benchmarked for the states, and improve the actionable nature of the measures. We believe it is very important for the LTSS systems to compare people from the same population base for core measures. Choice, for example, is a very different performance metric for people who are aging, compared with those with physical, developmental, or intellectual disabilities.

National Association of States United for Aging and Disabilities
Camille Dobson

The National Association of States United for Aging and Disabilities (NASUAD) is pleased to offer comments on the draft Medicaid Adult report. NASUAD represents the nation’s 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support home and community based services for older adults and individuals with disabilities. The Association’s mission is “to design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability, and their caregivers.”

We appreciate that the MAP members recognize a key measurement gap area in home and community based services (HCBS). HCBS as it is more commonly known has been delivered by states to Medicaid consumers for over 30 years. Because HCBS are unique to each person, standardized measures – such as those found in the health care sector – are challenging. More useful and important in terms of measuring quality are person-reported outcomes such as those secured from consumer surveys. While the HCBS CAHPS survey does have NQF endorsed measures, it is in use in less than 1/3 of states. Moreover, lack of NQF endorsed measures should NOT be a disqualifier from being added to the Core Set. The National Core Indicators - Aging and Disability survey is currently deployed in 20 states, with more states on the horizon. This survey is not an experience of care survey but rather a holistic assessment of the services received by individuals and their impact on the individual’s quality of life. Because it is unlikely that there will be one consumer survey widely adopted across the states (due to state program decisions), NASUAD urges the MAP to expand recommended measures to include the NCI-AD survey, as well as the National Core Indicators survey for individuals with intellectual and developmental disabilities.

Specific Measures

Adult Vaccine Access Coalition
Lisa Foster

NQF # 0039 Flu Measure.

AVAC is pleased to see that Appendix F of the draft report supports continued use of the following adult flu measure in the Medicaid program: “Percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1 of the measurement year and the date when the CAHPS 5.0H Adult Survey was completed”. However, we were disappointed to note a small decline in the number of states reporting this measure from 19 in FFY 2015 down to 18 in FFY 2016. AVAC urges NQF to take steps to promote greater use of the flu measure across all state Medicaid programs. The Department of Health and Human Services (HHS) recognizes that immunization is an important tool to keep people healthy and reduce avoidable
health care costs. In its Strategic Plan FY 2018 –2022, HHS acknowledges that “infectious diseases are a major health and economic burden for the United States.” Additionally, strategic objective 2.1 makes a commitment to “support access to preventive services including immunizations and screenings, especially for high-risk, high-need populations.” Unfortunately, access to vaccines is not equal across a person’s lifespan. Despite the well-known benefits of immunizations, more than 50,000 adults die from vaccine-preventable diseases while adult coverage lag behind Healthy People 2020 targets for most commonly recommended vaccines: influenza, pneumococcal, tetanus, hepatitis B, herpes zoster, and HPV.

Preventing transmission of influenza and other infectious conditions requires a multi-faceted approach and quality measurement programs through Medicaid, Medicare and private payers play a critical role in promoting improved quality and encouraging adherence to and consistent utilization of the annual influenza vaccine. The Advisory Committee on Immunization Practices (ACIP) recommends an annual influenza vaccination for all people age 6 months or older.

Each year, influenza causes approximately 200,000 hospitalizations and an average of 36,000 deaths in the United States alone. Influenza immunization measures help increase access and utilization of this important vaccine by patients and health care providers alike. Immunizations provide especially high value among patients with chronic conditions, such as diabetes or chronic heart disease, who are at higher risk of adverse health consequences resulting from vaccine-preventable diseases. A recent study found that people with underlying conditions accounted for the greatest share of total costs avoided due to influenza vaccination.

Vaccine preventable diseases such as influenza have a significant direct economic impact in terms of missed work days (absenteeism) or reduced productivity as a result of illness (presenteeism). Such conditions not only affect the person who is sick but can disrupt entire families when the primary caregiver is unable to perform their normal duties.

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**American Association on Health and Disability**

**E. Clarke Ross**

**NQF Measure #2967 – CAHPS HCBS Experience Measures –**

Consumer Assessment of Healthcare Providers and Systems (CAHPS), Home and Community-Based Services (HCBS) Experience Survey

We commend the report for including this item and its discussion in the report (pages 3, 4, 13, 14, 19, and 39). We commend the NQF MAP workgroup for recommending that the CAHPS HCBS Experience Survey be the number one ranked “measures recommended for phased addition to the Adult Core Set.”

One of the National Quality Strategy triple aim is improving the patient experience of care (including quality and satisfaction).

In July 2012, the Consortium for Citizens with Disabilities (CCD) Task Force on Long-Term Services and Supports (LTSS) identified six gaps in existing quality standards as they directly relate to persons with disabilities and persons dually eligible for Medicare and Medicaid. Two were/are:

1. Consumer Choice and Participant-Directed Services
2. Satisfaction: Individual Experience with Services and Supports

In its July 12, 2013 National Quality Forum (NQF) to CMS Preliminary Findings report on quality measures and persons dually eligible for Medicare and Medicaid, reaffirmed in the February 28, 2014 NQF Interim Report to CMS, and further reaffirmed in 2015 & 2016 NQF reports to CMS on persons dually eligible for Medicare and Medicaid) – 7 High Priority Measure Gaps for Persons Dually Eligible for Medicare and Medicaid were identified, explained, and shared. Three of these were/are:

Shared decision-making
Beneficiary sense of control/autonomy/self-determination
Community integration/inclusion and participation

Two of the 13 high priority gap areas identified by the NQF Medicaid adult workgroup in this draft report for public comment (page 11) are:

Patient-Reported Outcomes
Patient Engagement and Activation
One of the remaining high priority gaps identified by the NQF Medicaid adult workgroup in this draft report for public comment (pages 16-17) is: Beneficiary-Reported Outcomes

This draft report observes that 16 state Medicaid programs are currently using the CAHPS HCBS experience survey.

We reinforce the report's recognitions, recommendations, and discussion.

Integration of Behavioral Health and Primary Care; Interface Between Medical and Behavioral Health (pages 19 and 43)

We appreciate the pages 19 & 43 recognition of the need for quality measures on the integration of behavioral health and physical health. We appreciate the continuing focus throughout the report on behavioral health quality measures. As documented in NQF committee on behavioral health reports, existing behavioral health quality measures are inadequate and modest, as well as almost exclusively clinically focused. We appreciate that behavioral health is an identified high priority gap (pages 11 and 16-17).

We ask NQF to clarify and provide examples of the following page 19 statement: “Some measurement needs are community-based and outside the purview of healthcare.” Continuing community behavioral health services and supports are intended to promote health and wellness. Please clarify.

We request that the report include a summary of the potential, need, and implementation frustrations discussed at the workgroup meeting regarding ECHO (Experience of Care and Health Outcomes in Behavioral Health) (page 41).

Pennsylvania Integrated Care Program (Behavioral Health and Physical Health) (pages 7-8)

This is an outstanding initiative and outstanding summary. Thank you for inclusion.

We recommend that the NQF MAP and the larger NQF discuss how to more effectively pull out and highlight state-specific use of measures (possibly a new website page?). State innovations should be more visible and accessible to NQF members and NQF website users.

Social Determinants of Health

The report discusses, throughout, the challenges and gaps of social determinants of health measures.

Thank you. Thank you for the pages 8-10 discussion of Minnesota initiatives. We recommend that the NQF MAP and the larger NQF discuss how to more effectively pull out and highlight state-specific use of measures (possibly a new website page?). State innovations should be more visible and accessible to NQF members and NQF website users.

American Psychiatric Association

Samantha Shugarman

Several measures recommended for use in the Child and Adult Core Sets are not specified or tested for use at the state-level. APA recommends that measures untested at the state-level of measurement not be used for public reporting or used in the CMS Five Star Ratings System. Without testing to confirm the measures’ validity and reliability, CMS cannot confirm that the performance data reports true quality performance rates at the state-level. Considering the lag time between rulemaking and phased-in measure implementation, we further recommend that the measure developers test the measures’ use at the state-plan level.

NQF #1885 Depression Response at Twelve Months - Progress Towards Remission: The Adult Draft Report explains that states face reporting burden when measures are specified for data collection through EHRs and paper medical records. Given this measure’s data sources are EHRs and paper medical records, and CMS’s Meaningful Measurement Initiative was implemented to reduce measure burden, we question MAP’s decision to recommend this measure for addition to the Child Core Set.

APA recommends its use at the NQF endorsed provider and facility-level of measurement, but we question the ability for states to use this data as a way to measure state-level quality of care. We question the value of states collecting performance data, without being able to submit it to CMS. Should states choose to submit reporting data to CMS, it would create additional burden because CMS could not determine the level of quality care performed by the state Medicaid programs.

We are interested in MAP’s decision not to recommend NQF #0712: Depression Utilization of
the PHQ-9. By not recommending NQF # 712 or some other validated, standardized tool, measure users will find it challenging to capture treatment data and patient outcomes in a meaningful way. As a result, we are concerned that the treatment response will not be quantitatively measured. Absent of NQF #712 or another standardized tool to measure treatment response with depression, this measure is not meaningful. Therefore, should MAP finalize their recommendation to include NQF #1885 into the Child Core Set recommendations, APA strongly recommends they also include of NQF #712 within their recommendations to HHS as a means to support the use of NQF #1885.

• **NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling:** We echo the MAP acknowledged pros and cons of recommending this measure for inclusion into the Adult Core Set. Yes, this measure will help increase monitoring of unhealthy alcohol use for this vulnerable population and foster care coordination efforts. However, it is specified for registry reporting only. Since this reporting option is completely unavailable to states, it presents implementation problems for states. Given this measure is specified, tested, and endorsed for use at the physician-level of measurement, and does not appear to have been tested or endorsed for use at the state-level, we recommend MAP consider an alternative quality measure for recommendation into the Adult Core Set or communicate with the developers that an alternative data source be considered and this measure be tested at the state-level.

• **NQF #0712e Depression Utilization of the PHQ-9 Tool:** APA understands the value of measurement-based care (MBC) in behavioral health. We are pleased by the evidence that demonstrates improved outcomes related to clinicians using standardized tools to quantify symptoms and use them to determine when to adjust treatment. Given our understanding of MBC and comparisons between patient encounters, we would support the recommendation of this measure if another PHQ-9 measure were recommended for use during standardized times that coincide with follow-up visits.

We question the MAP’s decision to recommend this measure into the Adult Core Set, but not into the Child Core Set. We also question why MAP selected to recommend NQF #712e without a paired follow-up measure, like NQF #1885 Depression Response at Twelve Months - Progress Towards Remission, which was recommended into the Child Core Set (despite problems with state-level reporting).

Since this measure is specified for EHRs and paper medical records, which present reporting burden for states, we question the likelihood that the state Medicaid programs will collect this data. Furthermore, should states collect the measure-use data, and not the performance data, they will have spent resources to capture information that says very little about the quality of care administered. Overall, we agree with MAP’s idea that including this measure supports the integration of MBC in psychiatric practice but are unsure if the burdens imposed on performance data reporting will hinder the measure’s capacity to enact change.

Several measures recommended for use in the Child and Adult Core Sets are not specified or tested for use at the state-level. APA recommends that measures untested at the state-level of measurement not be used for public reporting or used in the CMS Five Star Ratings System. Without testing to confirm the measures’ validity and reliability, CMS cannot confirm that the performance data reports true quality performance rates at the state-level. Considering the lag time between rulemaking and phased-in measure implementation, we further recommend that the measure developers test the measures’ use at the state-plan level.

• **NQF #3175 Continuity of Pharmacotherapy for Opioid Use Disorder:** We support MAP’s recognition that better health outcomes for patients with OUD (and other diagnoses) are associated with continuity of medications and other treatments. And given our concerns with several measures endorsed at other levels of measurement and recommend for inclusion into the Adult Core Set, we are pleased that this recommended measure has been specified, tested, and endorsed for use at the state-level.

Our concern with this measure’s specifications and its recommended inclusion into the Adult Core Set include EHRs being one of the two data sources (claims is the other). Since EHRs present reporting
burden for states, we question Medicaid state programs’ abilities to submit performance data on these measures. Also, while claims are a supported method of state-level data collection and reporting, we question the type of claims used (i.e., pharmacy, administrative) and the ability of that claim-type to illustrate the provision of high quality care.

- NQF #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (conditionally supported): Support MAP’s reasoning for recommending this measure into the Adult Core Set. We agree that this measure is superior to NQF #0027 Medical Assistance with Smoking and Tobacco Use Cessation, which is currently in the Adult Core Set. NQF #0028 includes screening and information on cessation intervention, as well as options for reporting through multiple collection methods. However, as desirable as multiple collection methods, like claims, registry, and EHR at the provider – or facility – level might be, registry reporting is not possible at the state-level, and EHRs present reporting burden for states. Of the measure’s three data sources, claims may be used by state Medicaid programs to submit data to CMS, but the data and level of clinical detail available within claims (pharmacy, administrative) is lacking and says very little about the quality of care provided.

Though this measure is detailed for use at the provider – and facility – levels of measurement, and it is unlikely to present harm to patients included in the denominator, we recommend that MAP caution HHS and CMS with publicly reporting state-level data from untested measures. We also recommend that the MAP or CMS work with the developers to secure test results from state-level measurement.

NQF #104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment measures an inherent symptom of multiple mental illnesses. Due to the threat this symptom imposes on patients’ and their family members’ lives, assessing for suicidality and measuring the assessment rate is very important. This is particularly true for primary care physicians and other healthcare providers who do not possess expertise in the assessment, management, and treatment of suicidality and other symptoms associated with mental illnesses.

APA is concerned by limitations imposed by the measure’s denominator. As currently specified, the denominator limits screening for suicide to patients with new onset or a recurrent episode of Major Depressive Disorder (MDD), instead of applying it to patients with mood disorders in general as supported by the measure’s rationale and evidence to measure. Moreover, current evidence supports suicide risk assessments for an even broader population, like patients with other mental illnesses that present an increased safety risk. Some examples include anxiety, posttraumatic stress, and substance use disorders. Other conditions that pose an increased suicide risk are schizophrenia and other psychotic disorders; eating disorders and Borderline Personality Disorder. Therefore, the denominator of a better specified quality measure that assesses rates of suicide assessments should consist of patients with comorbid-multiple psychiatric illnesses paired with increased substance use and medical conditions (i.e., chronic pain).

APA agrees with MAP in that the specifications should better define the term “assessment.” And though we support non-proscriptive language on what tools are used to make the assessment, we question the reliability of the measure data given the developers not defining the term “assessment.”

This measure, like others recommended by MAP within the Draft Report, are specified, tested, and endorsed at the provider – and facility – levels of measurement. It has not been tested to determine the validity and reliability of the data at the state-level. Therefore, we recommend that MAP caution HHS (should MAP continue to support its inclusion in the Adult Core Set) not to use this measure for public reporting of state-level data and address with the developer that this measure should be tested for use at the state-level.

Community Catalyst
Ann Hwang
Home and Community Based Services

We applaud the recommendation for prioritizing the newly NQF endorsed CAHPS HCBS measure (NQF #2967) for addition to the measure set. There is a clear gap for patient-reported outcome measures, and as the committee notes, this would be the only measure in the Adult Core Set of long-term services...
and supports (LTSS) in a community setting. More consumers than ever are gaining access to HCBS in Medicaid through re-balancing of LTSS and through the ongoing shift to managed care. This elevates the need for quality monitoring that can detect problems that may occur with such a major program change. Broad use of this measure has been supported by a wide array of consumer and disability advocates, and many states are already using this survey. Inclusion in the Adult Core Set will encourage even greater use, to the benefit of consumers.

We also were pleased to see that the committee considered three broadly used consumer surveys for future inclusion in the measure set. All three – the Personal Outcomes Measures, and two versions of the National Core Indicators – are widely used to assess consumer quality of life as well as other patient-reported indicators. We agree with the committee on the urgent need for development of measures drawn from these surveys.

Substance use disorders

We applaud the committee’s focus on substance use disorders as a critically important part of Medicaid adult core measures. Substance use disorders affects millions of people with Medicaid coverage, and a full range of treatment for substance use disorders is lacking in many Medicaid programs. Adding core quality measures on substance use will help spur improvements in services that are desperately needed by consumers.

We applaud the recommendation that “Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling” (NQF #2152) be added to the Adult Core Set. Alcohol misuse continues to take more lives than any other substance, including opioids. Screening and Brief Counseling is an essential step in identifying alcohol misuse and intervening quickly, before addiction fully develops. Because of the extent of alcohol misuse, because that misuse underlies so many other illnesses, and because screening and brief counseling is so underused, we urge the committee to move this measure up (to #2) on the list. We feel this measure will have a far greater effect on consumers’ lives than the measure currently ranked at #2 (monitoring use of opioids from multiple providers (NQF #2950)). Because of the need for additional substance use measures, and especially for outcomes measures, we urge the committee to recommend the Experience of Care and Health Outcomes (ECHO) Survey for behavioral health to measure developers as a potential source of measures, in the same way it recommended the POM and NCI surveys for LTSS.

CVS/Caremark (Corporate HQ)

Virginia Rego

CVS Health recommends the “Use of Opioids from Multiple Providers in Persons without Cancer” measure be included in the Medicaid Adult Core set due to its ability to close the gap on the co-occurring challenges of polypharmacy and provider shopping specific to the opioid epidemic and places a lower burden on health plans through pharmacy claims data collection.

CVS Health supports the recommendation of “Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention” to be included in the Medicaid Adult Core set of measures. As indicated in the Draft report, the current measure, “Medical Assistance with Smoking and Tobacco Use Cessation,” is inevitably weaker than NQF 0027 because it relies on survey data in order to gauge quality improvement efforts. As smoking and tobacco use cessation is a major priority for the Medicaid population, NQF 0028 will do a more effective job, through claims data submission, to evaluate and compare quality improvement efforts across states.

CVS Health also supports NQF’s recommendation of the removal of NQF #0476 “PC-03 Antenatal Steroids” to reduce duplication and burden of reporting at the state level.

Thank you for the opportunity to provide comments in support of these NQF recommendations.

Human Services Research Institute

Alexandra Bonardi

Thank you for the opportunity to submit comments on this DRAFT report.

The Human Services Research Institute (HSRI) is a member of NQF. We support National Core Indicators with our colleagues at the National Association of Directors of Developmental Disabilities (NASDDDS).
and the National Core Indicators for Aging and Disability with colleagues at National Association of States United for Aging and Disability (NASUAD). Both NCI and NCI-AD in-person surveys are tools to measure Quality of Life and outcomes of LTSS recipients; NCI is for recipients of IDD system LTSS, NCI-AD is for recipients of aging and Physical Disability system Long Term Supports and Services. We agree with the emphasis on the gap areas in social determinants. Both tools and especially NCI-AD contain several items relevant to measuring social determinants of health.

The report references ongoing challenges with collecting adequate national data. On page 13 the report explicitly states that “data must be provided to CMS by at least 25 states and meet internal standards for quality”. Both NCI and NCI-AD are widely used - NCI for 20 yrs and now in 46 states, NCI-AD for 3 yrs and now in ~20 states. Furthermore, quality and fidelity of implementation are ensured in each participating state by having standardized administration protocols developed and overseen by the national project teams, standardized interviewer training, centralized data analysis. Data analysis accounts for variation between states in types of programs and populations included. In addition, outcome data are not only available to CMS, but are available publicly. By contrast, according to the report, HCBS CAHPS is used in 16 states, and actual data are not available to CMS (or publicly) (page 14).

Page 16 states that “survey instruments have been validated but do not include validated measures”. We take issue with this statement. There is a difference between measures not being submitted to NQF for endorsement with validation evidence and specifications, and measures not having been validated. We are currently working on specifying individual measures from within the NCI and NCI-AD tools and providing and documenting additional evidence on validity and reliability of those measures. This is a part of an ACL-funded project; will be submitting at least 20 measures for NQF endorsement and development is underway. Measures submitted will meet NQF’s gap areas and gap areas identified by the UMN RRTC’s measure scan; and/or will be those suggested for adoption into existing LTSS quality monitoring by others (e.g. MLTSS association); AND will have strong psychometric properties appropriate for quality measures within LTSS. Will be submitting ‘intent to submit’ paperwork in 2019.

National MLTSS Health Plan Association
G. Lawrence Atkins

The National MLTSS Health Plan Association is an association of health plans that contract with states to provide managed long-term services and supports (MLTSS). Our members currently cover about 75 percent of enrollees in MLTSS plans and assist States in delivering high quality services at the same or lower cost as the fee for service system with a particular focus on ensuring beneficiaries’ quality of life and ability to live in the community instead of an institution. Responsibility for managing an LTSS benefit also extends to our members’ offerings through D-SNPs and Medicare-Medicaid Plans (MMPs). Member organizations include Aetna Inc., AmeriHealth Caritas, Anthem Inc., CareSource, Centene Corp., Commonwealth Care Alliance, Health Plan of San Mateo, L.A. Care Health Plan, Molina Health Care Inc., Tufts Health Plan, UPMC Health Plan, and WellCare Health Plans Inc.

The Association strongly supports efforts to include HCBS measures in the Adult Core Set. We support the workgroup’s recommendation to include NQF #2967 CAHPS HCBS composite measure. Incorporating this measure into the Adult Core Set will bring national consistency to MLTSS outcome measurement. Currently, 13 states that operate MLTSS programs have independently implemented HCBS quality measures, with another 3 states actively developing such measures. Without national standards or guidance, states developing and implementing MLTSS quality measures struggle with validity and reliability concerns. Nearly all LTSS measures are state-specific, with states either choosing different quality metrics than their neighbors or implementing different definitions of the same metrics. Additionally, most state MLTSS measures have not been tested for validity and reliability. NQF’s efforts to create nationally-recognized HCBS quality measures will improve states’ abilities to hold health plans accountable, make meaningful and reliable comparisons of plans’ performance, and facilitate more effective quality improvement initiatives.
The Association is committed to implementing meaningful and feasible measurement of MLTSS plan members’ patient-reported outcomes. Over the past year, the Association has been working with our member plans to find effective ways to implement measures that address HCBS outcomes, including some of the items included in NQF #2967. We would welcome the opportunity to meet with you on HCBS quality measurement.

For the future, we encourage the workgroup to look beyond the CAHPS HCBS survey to identify metrics that address other quality concerns of LTSS consumers and advocates. For example, the CAHPS HCBS survey does not address members’ satisfaction with where they live, or their ability to work or volunteer in their community. We encourage the MAP to recommend HCBS quality measures that address consumers’ needs parsimoniously, while still covering the broad range of issues that matter to LTSS users and their caregivers.

**New York State Department of Health**  
**Lindsay Cogan**

The NYS DOH does not support the removal of Viral Load Supression from the Adult Core Set. As we are charged with thinking about moving the Adult Core set to more outcome based measures, you cannot deny the importance that viral load suppression plays in improving health outcomes and reducing HIV transmission. We would encourage stakeholders to explore the possibility of matching Medicaid data with state based HIV-viral load registries. Similar to the strategy CMS encourages with matching to vital records. This allows the calculation of this measure across a state Medicaid population.

The NYS DOH supports the removal of NQF #0476 PC-03 Antenatal Steroids (The Joint Commission). This measure is already being collected and reported on by the Joint Commission. To require state Medicaid agencies to also collect and report and potentially report conflicting information is not a good use of resources.

The NYS DOH does not support the inclusion of NQF #2950 Use of Opioids from Multiple Providers in Persons Without Cancer. This measure would be more relevant at a health plan or provider level and not a state Medicaid agency level where very few states are contracting directly with providers for the provision of services. There are also many issues with the implementation of this measure and the use of the National Provider Identifier (NPI) to determine if the prescriber for medication dispensing events was the same or different. The NPI does not help to roll prescribers up into a practice or group-level so providers in the same medical group will all appear as separate and distinct providers.

The NYS DOH does not support the inclusion of NQF #2967 CAHPS® Home and Community-Based Services Experience Measures. The coverage of home and community based services across different Medicaid programs can vary widely leading to the risk of measuring a benefit package change rather than real change in care. The cost and burden of administering CAHPS survey at the state level and a decreasing response rate seen for other CAHPS survey’s are two additional reasons we also do not support this measure.

**State of NH DHHS**  
**Andrea Stewart**

NQF #2967 CAHPS® Home and Community Based Services (HCBS) Measures: All CAHPS measures in the current CMS Core Sets are from the CAHPS Survey for Health Plans. These measures highly benefit from utilization by NCQA which is prescriptive in standardizing the administration of the survey and certifying vendors to conduct the survey. The HCBS CAHPS does not benefit from the same infrastructure and resulting data may not be comparable by states who use a wide variety of different survey methodologies. In addition the HCBS CAHPS can be used for a wide variety of different populations, that would impact the ability to
compare state results. CMS should be specific about the HCBS populations included in these measures if adopted in the Core Set.

NQF #0712e Depression Utilization of the PHQ-9 Tool: There are concerns with the addition of measures that depend on access to provider EHR systems. If CMS continues to add EHR based measures to the Core Set, there is a need to provide technical assistance to states on collecting these data from providers.

NQF #0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment: For measures requiring assessments and screening, we request that CMS be prescriptive in standardizing the assessments and/or screenings that could be used to satisfy the measure.

NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling: For measures requiring assessments and screening, we request that CMS be prescriptive in standardizing the assessments and/or screenings that could be used to satisfy the measure.

Strategy

**Adult Vaccine Access Coalition**

Lisa Foster

New, Streamlined Measures for Adult Immunization.

We value the important work of the MAP to evaluate and recommend new quality measures for future inclusion in federal health care programs such as Medicaid and Medicare. AVAC encourages the MAP to consider taking a focused, concerted approach to adult immunizations as a means of improving population health as well as the overall health of Medicaid patients. The HHS National Vaccine Program Office (NVPO) and the CDC in collaboration with the National Adult Immunization and Influenza Summit Quality Working group have been spearheading the development and testing of a new composite measure for adult immunization, along with measures for maternal immunization and end-stage renal disease. AVAC encourages NQF to support rigorous review, endorsement and future adoption of an adult immunization composite measure. Doing so would provide a sound, reliable and comprehensive means to assesses the receipt of routine adult vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP) while streamlining the patchwork of existing adult immunization measures, reducing the reporting burden on providers, and provide meaningful data to the Medicaid programs on access to this important preventive service.

Quality measures capture and create incentives for appropriate adult vaccinations can prevent illness and death, reduce caregiving demands, save unnecessary healthcare spending, and set the foundation for healthy aging. There is evidence that a composite measure of the adult immunization schedule, such as those demonstrated by the Northwest Tribal Epidemiology Center and by the National Nursing Home Quality Care Collaborative, can improve patient health outcomes. Such a measure would put vaccination coverage rates into a larger context and encourage a more systematic approach for all vaccines.

In the meantime, the lack of pneumococcal quality measures in Medicaid quality reporting programs is a missed opportunity to improve health and reduce federal expenditures on treatment and hospitalizations. Vaccination against pneumonia is an effective intervention against the high cost of medical care and rates of preventable death associated, particularly among medically vulnerable populations and the elderly. That is why the 2014 ACIP recommendations call for adults aged 65 years or older and individuals with underlying immunocompromising health conditions between 19 and 64 years of age to receive both PCV13 and PPSV23. ACIP also recommends PPSV23 for adults 19 through 64 years of age with underlying chronic health conditions like diabetes, heart disease, liver disease or lung disease (including people who smoke or have asthma). We encourage NQF to prioritize the NCQA Pneumococcal Vaccination Coverage for Older Adults measure pneumococcal immunization measurement for inclusion in the 2018 Medicaid adult core measure set.

**American Psychiatric Association**

Samantha Shugarman

Given APA’s mission of promoting the highest quality care for individuals with mental illness, including substance use disorders, and their families, we
support MAP’s continued recognition of behavioral health as a high priority area for adults and children under Medicaid. More specifically, we are pleased by the emphasis on substance use disorders integration with mental health. Given the increased rate of mental health and substance use comorbidity, in addition to the social risk factors contributing to Medicaid beneficiaries’ health outcomes, we are pleased that MAP included social determinants of health within their recommended strategy to reduce disparities while improving health equity and quality of care for the Medicaid population.