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Medicaid is the largest health insurance program in the United States, serving 76 million Americans in FY 2016. Almost 50 percent of people enrolled in Medicaid and the Children’s Health Insurance Program (CHIP) are children; 50 percent of all births are covered by Medicaid; and approximately two-thirds of women enrolled in Medicaid are in their child-bearing years.

The Children’s Health and Insurance Program Reauthorization Act of 2009 (CHIPRA) required the U.S. Department of Health and Human Services (HHS) to develop standards to assess the quality of children’s healthcare. This legislative mandate led to the identification of a Core Set of healthcare quality measures for children enrolled in Medicaid and CHIP. The Centers for Medicare & Medicaid Services (CMS) released the initial Child Core Set in 2010. Measures in the Child Core Set are relevant to children ages 0-18, as well as pregnant women, because these measures address both prenatal and postpartum quality-of-care issues. CHIPRA also required CMS to update the initial Child Core Set annually beginning in January 2013. The 2018 Child Core Set contains 26 healthcare quality measures.

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

MAP examined all measures based on each measure’s ability to effectively measure an important aspect of child health. MAP did not recommend any measures for removal. MAP recommends the phased addition of the six measures listed below (Exhibit ES1). These measures would strengthen the measure set by promoting measurement of a variety of high-priority quality issues, including access to care and behavioral health.

**EXHIBIT ES1. MEASURES RECOMMENDED BY MAP FOR PHASED ADDITION TO THE CHILD CORE SET**

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MAP recognizes that many priority areas for quality measurement lack fully developed metrics. MAP documents these gaps in current measures as future measurement needs for the developer community. During this Core Set review cycle, the Workgroup reprioritized the measure gaps identified during prior reviews. Additionally, they created a broad population health based framework including clinical and nonclinical/nonmedical setting measures to best address existing gaps in measurement.
The Workgroup’s strategic discussions included recommendations for improving quality measurement and Child 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.

As the Medicaid Child Core Set evolves, success in improving quality depends on reducing measurement burden, increasing data streamlining, and promoting holistic measurement, with the aim of increasing states’ implementation and reporting on these measures. These improvements will help states prepare for 2024 when mandatory reporting of the Child Core Set measures will take effect as part of the CHIP Reauthorization.

INTRODUCTION AND PURPOSE

The Measure Applications Partnership (MAP) (Appendix A) is a multistakeholder entity that provides recommendations on measures under consideration for use in federal programs by the U.S. Department of Health and Human Services (HHS). As part of this process, the National Quality Forum (NQF) convenes MAP for an intensive annual review of the quality measures HHS is considering for 20-plus federal health programs, including Medicaid and CHIP. The work of the Medicaid Child Workgroup is under the purview of the MAP. Beginning in 2017, NQF held a formal nomination process to seat the Medicaid committees as workgroups to ensure a broader representation of Medicaid expertise. Prior to this, Medicaid committees were task forces, and members were drawn from the MAP Coordinating Committee and other pre-rulemaking workgroups. The Medicaid Child Workgroup advises the MAP Coordinating Committee on changes and updates to the Child Core Set. The MAP Coordinating Committee serves as the final ratifying body that oversees the recommendations for HHS.

Each year, as part of MAP, the Medicaid Child Workgroup provides input to the MAP Coordinating Committee on recommendations to HHS for strengthening the Core Set of Health Care Quality Measures for Children Enrolled in Medicaid and CHIP (the Child Core Set) by: (1) reviewing states’ experiences reporting measures to date; (2) refining previously identified measure gap areas; and (3) recommending potential measures for addition or removal from the Child Core Set, with a focus on addressing high-priority measure gap areas. The Workgroup consists of individuals with relevant interests and expertise in Medicaid and the pediatric population (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 most recent available measure reporting data from states. The Centers for Medicare & Medicaid Services (CMS) provided several materials to inform the Workgroup’s review and recommendations, including summaries of the FFY 2016 measures reported by each state and detailed analyses of state performance on 21 publicly reported measures. This is the fifth set of recommendations for the Child Core Set.

This report summarizes states’ experience with collecting and reporting measures, the Medicaid Child Workgroup recommendations for addition to the 2019 Child Core Set, prioritized gap areas, and strategic considerations.
BACKGROUND ON MEDICAID AND THE CHILD CORE SET

As of February 2018, approximately 74 million people were enrolled in Medicaid and CHIP. Almost 50 percent of people enrolled in Medicaid and CHIP are children, and approximately two-thirds of women enrolled in Medicaid are in their child-bearing years. With almost 50 percent of all births and nearly 23 percent of the population covered by Medicaid, the program plays a vital role in providing the necessary services to ensure quality of care.

The Centers for Medicare & Medicaid Services (CMS) and states work closely to strengthen Medicaid and CHIP benefits especially in the realm of preventive services, mental health and substance use disorders, maternal and infant health, and services for children who need early and periodic screening, diagnostic, and treatment (EPSDT) services. Services that span a child’s life course and enhance access provide the needed support to ensure healthy pregnant women and children.

The Oral Health Initiative, discussed during the 2018 in-person meeting, is an example of one of the many initiatives launched to improve the quality of care and outcomes of beneficiaries enrolled in CHIP and/or Medicaid.

Oral Health Initiative: CMS launched this initiative in 2010 to continue improving access to dental and oral health services for children enrolled in Medicaid and CHIP. The overall goal is to understand state programs and to support states’ work in improving their oral health performance. CMS is working with states to improve access to dental care with the aim of increasing the proportion of Medicaid-enrolled children who receive any preventive dental service (PDENT) by 10 percentage points nationally. CMS is also tracking the proportion of Medicaid-enrolled children ages six to nine at risk for dental caries who receive a sealant on a permanent molar (SEAL). Overall, there has been steady progress on access to dental care nationally. As of FFY 2016, 50 states reported data on PDENT with 46 percent of children nationally receiving a PDENT, similar to FFY 2015 rates. Thirty-four states reported data on SEAL. Dental sealants are an effective evidence-based practice to prevent tooth decay, and CMS hopes that increases in reporting rates continue both within and across states.

CMS launched multiple initiatives to build oral health as part of states’ overall quality strategy as a mechanism to improve oral health. These include setting goals/incentives for health plans; performance improvement projects (PIPs); and determining provider payment incentives. A key highlight of this strategy is the value-based payment project that commenced in March 2017. CMS is providing targeted technical support to three state Medicaid/CHIP agencies (Washington, DC; New Hampshire; and Michigan) to select, design, and test evidence-based care modalities that will be financially sustainable as they scale up.

Health Issues for Children in Medicaid and CHIP

Focusing on clinical care is the most common pathway to addressing the needs of low-income pregnant women and children. The Workgroup also noted the importance of addressing social risk factors within the context of clinical care, as they are known to negatively affect health and healthcare outcomes. Similar to recommendations from the 2017 Task Force, the 2018 Workgroup members focused their attention on children with special healthcare needs, specifically those with chronic physical and behavioral health issues, including mental health and substance use disorders.
While the majority of children are healthy, approximately 19 percent of children have special healthcare needs, with 41 percent of them covered by Medicaid/CHIP only.9,10 Among children 12 to 17 years old, approximately 5 percent had a substance use disorder in 2015.10 Mental health and substance abuse tend to co-occur with approximately 88 percent of substance-dependent children between 15 and 17 years old having co-occurring mental health issues.11 Early intervention is key to mitigating the severity of physical and behavioral health issues that lead to poor health outcomes and the subsequent economic impacts of suffering from poor health. Through its infrastructure and state-federal partnerships, Medicaid is uniquely able to intervene early by linking necessary health services and non-health services, such as food and housing insecurity which are associated with health outcomes.8,12

The Workgroup also discussed the need to link measures to population health outcomes given the role social and demographic factors play in determining health and healthcare outcomes. As a result, the group emphasized addressing population health needs throughout the life course when deliberating over its recommendations for including or removing measures from the Child Core Set, as well as when discussing gap areas.

**Background and Use of the Child Core Set**

In February 2009, the Children’s Health and Insurance Program Reauthorization Act (CHIPRA) was signed into law.13 CHIPRA required HHS to identify and publish a core set of measures for voluntary reporting by state Medicaid/CHIP agencies.14 CMS released an initial Child Core Set in 2010 and began publishing annual updates in January 2013. The Child Core Set includes measures that address both physical and mental health.

As part of CHIPRA, CMS along with the Agency for Healthcare Research and Quality (AHRQ) established a program to improve pediatric quality measures to improve children’s quality of care and strengthen the Child Core Set. During the May 2018 in-person meeting, Kamila Mistry, PhD, MPH, presented an overview of this program and its status to date.

**Pediatric Quality Measures Program:** The Pediatric Quality Measures Program is a two-phase program aimed at developing and implementing quality measures to improve pediatric quality of care. The four main objectives are to: (1) Develop new measures; (2) Strengthen state and public/private partnerships to implement measures; (3) Build a knowledge base between measurement and facilitate measure use; and (4) Improve the quality of care and outcomes for the pediatric population, specifically children in Medicaid/CHIP. The first phase launched in 2011 as a response to the CHIPRA mandate to develop new measures. Phase 1 awarded institutions, referred to as Centers of Excellence, funding to develop measures in key gap areas such as perinatal care, management of acute/chronic conditions, and patient-reported outcomes. Over 100 measures were developed during phase 1. Phase 2, which launched in 2016, focuses on assessing the feasibility and usability of a subset of phase 1 measures at multiple levels (i.e., state, health plan, and provider levels). As part of phase 2, AHRQ launched a PQMP Learning Collaborative to share findings, obtain input on the implementation of measures, and improve best practices among phase 2 grantees and stakeholders.

For the 2018 Child Core Set update, the Center for Medicaid and CHIP Services (CMCS) issued changes informed by the 2017 Medicaid Child Task Force. Following the Task Force’s recommendation, CMCS added three measures: NQF #0418/0418e Screening for Clinical Depression and Follow-Up (CDF), NQF #2903 Contraceptive Care – Most and Moderately Effective Methods, and NQF #1800 Asthma Medication Ratio. These additions expand the measurement of quality of care for two populations—children with chronic health conditions and behavioral health—and address the gap area of access to contraception.
CMCS also retired four measures: NQF #1391 Frequency of Ongoing Prenatal Care, NQF #1799 Medication Management for People with Asthma, NQF #1365 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment, and Behavioral Health Risk Assessment (for pregnant women). The measure stewards retired NQF #1391 Frequency of Ongoing Prenatal Care and Behavioral Health Risk Assessment. Please note that Frequency of Ongoing Prenatal Care lost NQF endorsement in 2016. CMCS retired NQF #1365 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment due to challenges with state reporting and replaced the measure with NQF #0418/0418e Screening for Clinical Depression and Follow-Up (CDF). NQF #1800 Asthma Medication Ratio replaces NQF #1799 Medication Management for People with Asthma, a measure included in the Child Core Set since 2013.

The 2018 version of the Child Core Set contains 26 measures. Appendix E highlights the characteristics of the 2018 Child Core Set. Measures in the Child Core Set are relevant to children ages 0 to 18 as well as pregnant women. Core Set reporting is voluntary; however, mandatory reporting of the Child Core Set will take effect in 2024 as part of the H.R. 1892-112 Bipartisan Budget Act of 2018.

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

Presentations from invited state 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 programs as well as an overview of their experience with collecting, reporting, and using either the Adult and/or the Child Core Set. Additionally, they also highlight successful state specific programs and care models. This process solicits information from the field, prior to finalizing recommendations for changes to the Core Sets. Ultimately, the goal is to use experiential data to provide well-informed and targeted recommendations.

For the Child Core Set, the state Medicaid representatives from Florida and Minnesota provided the Workgroup with an overview of their state Medicaid demographics along with information related to Child Core Set use. The Florida presentation included oral health issues related to reporting and potential strategies for improving Child Core Set measure reporting rates. The Minnesota presenter provided an overview of his work addressing SDOH. Both representatives discussed program successes and challenges.

Florida

Rachel La Croix, PhD, PMP, Agency for Health Care Administrator, Florida Agency for Health Care Administration presented to the Child Workgroup. Her presentation focused on programs launched to improve oral health among children enrolled in Medicaid and CHIP. Florida represents the fourth largest Medicaid population (adults and children) in the nation with approximately 4 million Floridians enrolled. Florida has the fifth largest Medicaid expenditures, an estimated $26.8 billion in FFY 2017-18, nationwide. The majority of Medicaid recipients receive their care through a managed care plan. Overall, Florida reported 20 of the 26 Child Core Set Measures in January 2018.

Data and quality improvement activities in Florida include developing and programming a single, streamlined query, and establishing mandatory statewide Performance Improvement Plans (PIP) to better capture specific Core Set measures. For example, one of the PIPs ensures the capture of preventive dental services. Success in capturing dental services is fostered through internal support for PIPs (check-ins, quarterly meetings, and technical assistance); a consumer engagement/social media campaign; intensive technical assistance from federal partners, i.e. CMS; and with regulatory approaches such as specific targets for health plan contracts. Directed efforts in consumer and health plan engagement increased Florida’s annual dental visit by 15 percentage points since 2010. Preventive dental services also increased by 22 percentage points since 2011. Starting in March 2019, the Medicaid dental program expansion will include both children and adults as well.

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. Review of 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.19

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 ICHR 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 ICHR 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 reviewed the measures in the Child Core Set to provide recommendations to strengthen the measure set in support of CMS’ goals for the program. Measure Selection Criteria (MSC) (Appendix C), a preliminary analysis algorithm (Appendix D), state data and feedback on the measures reported in FFY 2016 and data on prevalent conditions affecting the Medicaid and CHIP populations all guided the Workgroup’s review. The MSC provide general guidance on measure selection decisions and are intended to assist the Workgroup in identifying what an ideal Core Set would be for this publicly reported measure set. The decision algorithm compiled by NQF staff is a summary profile of each measure under consideration. Both the MSC and decision algorithm are meant to be a starting point for stakeholder deliberations and discussion. Additionally, the Workgroup considered the voluntary nature of quality reporting.

Using measure gap areas identified in previous years’ reviews as a baseline, NQF staff compiled and presented measures in the following 13 topic areas: behavioral and mental health; substance use; injuries and trauma; care coordination; acute and chronic conditions; maternal and perinatal health; asthma; sickle-cell disease; overuse; patient-reported outcomes; dental care; duration of enrollment and coverage; and cost. Using the decision algorithm, Workgroup members submitted measure recommendations to NQF staff for addition to or removal from the Child Core Set. During the meeting, the Workgroup discussed measures recommended by individual members, invited public comment on each recommended measure, and voted whether to recommend that HHS remove a measure from or add it to the Child Core Set.

The Workgroup generally favors measures that can easily be implemented at the state level, encompass a broad population focus, and promote parsimony and alignment. NQF-endorsed measures are also preferred because they have successfully undergone a consensus-based review process for importance and scientific acceptability, amongst other rigorous criteria. Although preferred, MAP recognizes that a relevant measure may not always be NQF-endorsed. Therefore, recommended measures were not required to have NQF endorsement. Moreover, the continuous monitoring of new measures in the development pipeline is necessary to ensure the success of future annual reviews.

In 2017, CMCS began including the electronic measure specifications/formats (i.e., e-specifications also known as an eMeasure) to NQF measures already in the Core Sets. This addition provides states with multiple options/ formats for data collection and reporting (i.e., electronically specified measures, administrative measures, and hybrid measures). CMCS will add the e-specification, 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

The Workgroup noted that states’ participation in reporting the Child Core Set is strong, though there is always room for improvement in the number of states reporting each measure. Nationally, state participation in reporting has steadily increased each year. Notably, 50 states and the District of Columbia reported on at least one Child Core Set measure during FFY 2016, with 45 states voluntarily reporting at least 13 of the 26 FFY 2016 Child Core Set measures.14 Maintaining stability in the measure set allows states to continue to gain experience in reporting these measures.
The Workgroup had a robust discussion regarding available measures for potential removal and addition to the Child Core Set. During measure discussions, Workgroup members considered many factors, including whether measures address the health needs of the population, drive improvements in healthcare quality, and reduce or minimize reporting burden.

The Workgroup also considered CMS’ goal to streamline data collection (e.g., CMS collects data from other entities such as CDC and The Joint Commission) to increase the number of measures represented on the Core Set without increasing reporting burden.

The Workgroup did not recommend measures for removal but did recommend six measures for phased addition. Below are MAP’s measure-specific recommendations. Appendix F provides details on the measures recommended for addition, and Appendix G lists additional measures considered for removal or addition to the Core Set. Although the measures in Appendix G were considered, they did not pass the consensus threshold (>60 percent of voting members) to gain support or conditional support for addition to or removal from the Child Core Set.

### Measures for Removal from the Child Core Set

Despite discussing four measures for potential removal, MAP was comfortable supporting all measures for continued use in the Child Core Set. The decision was based on the considerations listed below as well as allowing states sufficient time to build resources and infrastructure to collect and report the current measures in the Core Set. Maintaining stability in the Core Set allows states to continue to gain experience reporting measures, while increasing the number of measures they report and use to drive quality improvement. In general, during discussion of measure removals, the following factors are considered:

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

### Measures for Phased Addition to the Child Core Set

MAP recommends that CMS consider up to six measures for phased addition to the Child Core Set (Exhibit 1, below, and Appendix F). These measures passed the consensus threshold (>60 percent of voting members) to gain the group’s full support.

MAP recommended measures that address high-priority gap areas such as behavioral health, care coordination, and chronic health conditions (e.g., sickle cell disease). MAP understands that additional federal and state resources are required for each new measure added. MAP’s Coordinating Committee emphasized the need for parsimony, acknowledging 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 articulated 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. Therefore, the immediate addition of all measures supported by the group is highly unlikely. To help prioritize its recommendations to CMS, MAP rank ordered the measures it supports. Public commenters generally supported MAP’s recommendations to
add the following measures, but also cautioned CMS to include measures that have been fully tested and specified at the state level to increase the feasibility of implementation, data collection, and reporting. The Workgroup’s measure-specific recommendations are described below.

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

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NQF #3166 Antibiotic Prophylaxis Among Children with Sickle Cell Anemia
MAP ranked this measure as having highest priority out of the six measures recommended to CMS. This measure assesses the percentage of children ages 3 months to 5 years old with sickle cell anemia who were dispensed appropriate antibiotic prophylaxis for at least 300 days within the measurement year. Evidence exists to support the effectiveness of antibiotic prophylaxis for patients diagnosed with sickle cell anemia, but rates of utilization remain low.21 MAP agreed that the addition of this claims based measure to the Child Core Set could potentially have a large impact on the treatment of children with sickle cell anemia.

NQF #2393 Pediatric All-Condition Readmission Measure
MAP previously recommended this measure during the 2015 review cycle. This year’s prioritization placed the measure second on the ranked measure list for CMS’ consideration for addition to the Child Core Set. Supported by funding from PQMP, one of the Centers of Excellence for Pediatric Quality Measurement developed NQF #2393 to calculate case-mix-adjusted readmission rates to measure patients discharged from general acute care hospitals, including children’s hospitals. This measure is harmonized with NQF #1768 Plan All-Cause Readmission Rate, which is included in the Adult Core Set. MAP believes this outcome measure is important for Medicaid because it tracks readmissions and allows the system to address the lack of coordination or access to services and supports across settings. Public commenters supported the adoption of this measure; however, three commenters suggested that the measure may not adequately represent quality of care within clinical pediatric facilities. Additionally, clinical and nonclinical complexities that may influence pediatric readmission rates, are inadequately addressed by the measure.

NQF #2800 Metabolic Monitoring for Children on Multiple Antipsychotics
Initially recommended for addition in 2017, NQF #2800 Metabolic Monitoring for Children on Multiple Antipsychotics assesses the percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and metabolic testing. Several Workgroup members underscored the importance of this measure and the possibility of incentivizing providers to ensure that children prescribed these medications also receive metabolic monitoring. The addition of NQF #2800 would result in three antipsychotic medication related measures on the Child Core Set. The Core Set currently includes Use of Multiple Concurrent Antipsychotics in Children and Adolescents and NQF #2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. MAP members noted that including three measures addressing antipsychotics might not be very parsimonious. In the spirit of parsimony, one member recommended that this measure be considered as a replacement for the Use of...
**Multiple Concurrent Antipsychotics in Children and Adolescents.** Ultimately, MAP recommended this measure because implementing it is both feasible and important. Public comments supported the adoption of this measure because it highlights the impact of comorbidities associated with children on antipsychotic medications. Two commenters suggested that this measure also be specified for those with a single medication prescription, not just polypharmacy.

**NQF #1885 Depression Response at Twelve Months - Progress Towards Remission**
This measure assesses the percentage of patients 12 years of age and older with major depression or dysthymia who demonstrated a response to treatment 12 months (+/- 60 days) after an index visit. This outcome measure assesses improvements based on treatment in the target population. MAP noted the limitations in states’ capabilities to report on this measure because it is specified only for electronic health records and paper medical records. MAP recommended this measure for addition to the Core Set noting that NQF #1885 complements NQF #0418, already on the Core Set. NQF #0418 measures the percentage of screening and follow-up, and NQF #1885 systematically assesses patients’ response to treatment over time. Although this measure is paired with NQF #0712 Depression Utilization of the PHQ-9 or PHQ-9M Tool, MAP did not recommend NQF #0712. A number of commenters reiterated MAP’s concern regarding the reporting burden states encounter when measures, such as this one, are specified for data collection through EHRs and paper medical records. One commenter suggested that the measure be paired with NQF #0712 to ensure treatment response with depression is quantitatively measured, if added to the Core Set.

**NQF #2797 Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia**
MAP initially recommended this measure (supported with CHIPRA funding and PQMP) in 2016 to fill the children with sickle cell disease (SCD) gap area, a significant gap in Medicaid. NQF #2797 assesses the percentage of children ages two through 15 years of age with sickle cell anemia (Hemoglobin SS) who received at least one transcranial Doppler (TCD) screening within the measurement year. Strokes are a major cause of morbidity among children with SCD for whom TCD is an effective screening tool for primary prevention. This measure aligns with National Institutes of Health (NIH) National Heart, Lung, and Blood Institute (NHLBI) guidelines for annual TCD screening of children with sickle cell anemia. This claims based measure is feasible for states to report. MAP also noted that this measure addresses disparities in care for a population at risk for stroke at an early age. Public commenters supported the adoption of this measure because it is a step towards an increase in chronic disease data collection and reporting. One commenter cautioned that there is potential risk of misdiagnosing/miscoding patients with sickle cell disease and sickle cell C, which could lead to inaccurate denominator totals and inappropriate treatments for patients with sickle cell C.

**NQF #2548 Child Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)**
Developed through the PQMP, NQF #2548 Child Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) is a standardized inpatient hospital experience-of-care survey-based measure focused on evaluating the family’s experience. MAP initially recommended this measure during its 2014 review to help address the gap areas of inpatient care, patient experience, and care coordination. In 2015, CMCS agreed to pilot a reporting process for NQF #2548 to determine the feasibility of the measure for future Core Sets (e.g., the extent to which this hospital level measure can be reported at a state level). Currently, the measure is undergoing testing to determine the survey vendor’s ability to send hospital data directly to state agencies. Many hospitals have already adopted this measure for
use, but the information is not publicly available. Broad adoption of this CAHPS family survey will ultimately enhance comparability of patient experience related data across hospitals and populations.

In general, the public and NQF members supported the six recommended measures for addition to the Core Set. They also encouraged MAP to focus on adding the following: evidence-based and/or evidence-informed measures; measures that reflect the diversity of pediatric populations; pediatric care measures, prevention and early intervention measures as they relate to social risk factors; and measures that focus on prescription medications, medication management, and counseling.

Remaining High-Priority Gaps
During the 2018 review, the Workgroup began its discussion of gaps by considering the 2017 gap areas. Subsequently, the conversation shifted from a gaps list to focusing on the overall needs of the Medicaid/CHIP population and how their lifespan needs should dictate the gap area discussion. Additionally, this discussion considered the relationship between health and social risk factors within health-specific settings and conditions. The Workgroup reprioritized the current gaps list from the 2017 report and expanded on it using a broader population health perspective. This included creating two main domains and then filling them with subdomains. The group also noted that subdomains were not domain exclusive and in some cases were attributable to more than one domain.

The ensuing discussion addressed the need for a cascade approach to measurement that includes nonclinical/nonmedical setting measures along with measures that flow from diagnosis to initial treatment to maintenance and finally to outcomes. The Workgroup noted that cascade measures are essentially a bundle of related measures such as well-woman care, prenatal, perinatal, and postnatal measures. Together these measures provide a holistic view of a woman’s health and promote prevention, intervention, follow-up, and recovery through grouping of measures that promote public health at large. Various factors challenge creation of these holistic measure cascades, such as jurisdiction issues related to measurement and data collection, state resource constraints, as well as the necessary overflow of measurement into nonclinical and non-behavioral health arenas such as community, education, and social determinants of health.

Using this broad perspective and measure framework, the Workgroup created two main domains: behavioral health and public health. Then, many of the individual categories from the gaps list were placed in each domain. It was noted that the domains and/or subdomains are not mutually exclusive; overlap exists as a representation of the connectedness of health and community. This overlap illustrates the interconnected nature of a bundle of measures that address health from a care continuum/cascade perspective. See Appendix H for the list of gaps under these two domains.

The Workgroup also added to, edited, and ranked the gap areas from previous discussions. This process was subsumed as part of the creation of the domains and subdomains as a way to organize the exhaustive list. Please refer to Exhibit 2 below for more information. The behavioral health domain included the following areas: abuse and neglect, substance abuse disorder, mental health, and care coordination. The public health domain included the following areas: behavioral health, social determinants of health, care coordination, cost of specific behavioral health services, and duration of insurance coverage for children.

Overall, comments from the public supported the Workgroups’ discussion on parsimony of measures, social risk factors, as well as the discussions regarding substance use disorders and the need for integration with behavioral health. Regarding the domains below in Exhibit 2, commenters suggested adding the following under the behavioral health domain: (1) ‘seclusion or restraints’ within the gap area of abuse and
neglect; and (2) ‘family engagement’ within the gap area of care coordination.

**EXHIBIT 2. DOMAINS BASED ON THE WORKGROUP GAP DISCUSSION**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Identified Gap Areas</th>
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<tbody>
<tr>
<td>Behavioral Health Domain</td>
<td>Abuse and Neglect (part of primary care as well)</td>
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<tr>
<td></td>
<td>Substance Use Disorder</td>
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<tr>
<td></td>
<td>Mental Health</td>
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<td></td>
<td>Care Coordination/Integration</td>
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<tr>
<td>Public Health Domain</td>
<td>Behavioral Health</td>
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<tr>
<td></td>
<td>Social Determinants</td>
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<tr>
<td></td>
<td>Maternity Care</td>
</tr>
<tr>
<td></td>
<td>Cost (including finance reform for behavioral health)</td>
</tr>
<tr>
<td></td>
<td>Duration of Child Health Insurance Coverage Over 12 Months</td>
</tr>
<tr>
<td></td>
<td>Care Coordination</td>
</tr>
</tbody>
</table>
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 as examples 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

With almost 50 percent of all births and nearly 23 percent of the population covered by Medicaid, MAP provided measure recommendations for the 2019 Child Core Set to address the needs of this significant and growing population. These recommendations aim to increase the number of states voluntarily reporting on measures included in the Child Core Set, the number of measures reported by each state, and the number of states using Child Core Set measures to drive quality improvement. MAP’s recommendations were informed by state Medicaid representatives’ experiences implementing, reporting, and leveraging the Child Core Set measures, as well as the latest Child Core Set reporting data.

The MAP Coordinating Committee reiterated the Workgroup’s prioritization of parsimony and emphasized the importance of clarifying setting specificity in CMS’s technical assistance materials for state reporting, but also 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, which align with measures leveraged by the private sector.

MAP supported the continued use of all current measures included in the 2018 Child Core Set and recommended the phased addition of six measures: NQF #3166 Antibiotic Prophylaxis Among Children with Sickle Cell Anemia, NQF #2393 Pediatric All-Condition Readmission Measure, NQF #2800 Metabolic Monitoring for Children on Multiple Antipsychotics, NQF #1885 Depression Response at Twelve Months - Progress Towards Remission, NQF #2797 Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia, and NQF #2548 Child Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS).

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 patient-centered healthcare environment, collecting data on and analyzing the effect of social risk factors on outcomes will allow Medicaid to address measurement from a holistic view that includes both clinical and nonclinical factors spanning healthcare to public health to communities and homes. This expanded perspective will allow Medicaid and other stakeholders to analyze factors—the majority of which are outside the purview of healthcare—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 influence health outcomes.


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 utilizes a three-step process to elicit multistakeholder input on measures under consideration:

1. 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.

2. 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.

3. 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:

- Conduct an all-MAP orientation call to educate stakeholders on the role of MAP and the pre-rulemaking process;
- 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;
- Convene the setting-specific workgroups for an orientation on the federal programs and conduct the feedback loop process;
- Post the list of measures under consideration on or before December 1 of each year;
- Conduct a public comment period on the measures under consideration to solicit input on them prior to the workgroups’ deliberations;
- Convene the setting-specific workgroups via in-person meetings to provide initial recommendations;
- Conduct a second public comment period to
obtain input on the draft recommendations;

- 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

- 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 Child Workgroup advises the MAP Coordinating Committee on recommendations to HHS for strengthening the Core Set of Health Care Quality Measures for Children Enrolled in Medicaid and CHIP (the Child Core Set).

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 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 Child Workgroup and MAP Coordinating Committee and NQF Staff

NQF Medicaid Child Workgroup

CHAIRS (VOTING)
Richard Antonelli, MD
Lindsay Cogan, PhD

ORGANIZATIONAL MEMBERS (VOTING)

Aetna Medicaid
Angela N Moemeka MD MBA FAAP
American Academy of Pediatrics (AAP)
Terry Adirim, MD, MPH
American Nurses Association (ANA)
Rhonda Anderson, RN
Anthem Indiana Medicaid
Julie Keck, MD
Children's Hospital Association (CHA)
Gary Freed, MD, MPH
National Association of Medicaid Directors (NAMD)
Fred Oraene
National Association of Pediatric Nurse Practitioners (NAPNAP)
Shayna Dahan, BSN, RN, MSN, CPNP, PMHS
National Partnership for Women & Families
Carol Sakala, PhD, MSPH
Ohio Department of Medicaid
Mary Applegate, MD
Sargent Shriver National Center on Poverty Law
Stephanie Altman, JD

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Kamala Allen, MHS
David Einzig, MD
Amy Houtrow, MD, PhD
David Kelley, MD, MPA
Stephen Lawless, BS, MD, MBA, FAAP, FCCM, FSMB
Kenneth Schellhase, MD
Jeff Schiff, MD, MBA
Margaret Tomcho, MD, MPH

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)

Agency for Healthcare Research and Quality
Kamila Mistry, PhD, MPH
Centers for Medicare & Medicaid Services
Marsha Smith, MD, MPH, FAAP
Health Resources and Services Administration
Suma Nair, MS, RD

Measure Applications Partnership Coordinating Committee

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

ORGANIZATIONAL MEMBERS (VOTING)

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
American Nurses Association
Mary Beth Bresch White
AMGA
Samuel Lin, MD, PhD, MBA, MPA, MS
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:
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 MAP Medicaid Preliminary Analysis Algorithm derived from the Measure Selection Criteria.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Definition</th>
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| 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. | • The measure can be operationalized (e.g., the measure is fully specified, specifications use data found in structured data fields, and data are captured before, during, or after the course of care.)  
  • The measure can be feasibly implemented at the state Medicaid level.  
  • Data for the measure can be collected easily.  
  • The measure does not pose undue resource constrains on the state.  
  • 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. |
| If a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified. |

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| • The measure is NQF-endorsed; or  
• The measure is fully developed and full specifications are provided; and  
• Measure testing has demonstrated reliability and validity for the level of analysis, program, and/or setting(s) for which it is being considered. |
| • Feedback from end users has not identified any unreasonable implementation issues that outweigh the benefits of the measure; or  
• Feedback from implementers or end users has not identified any negative unintended consequences (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and  
• Feedback is supported by empirical evidence. |
APPENDIX E: Characteristics of the Current Child Core Set

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

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

With respect to measure types, the set contains no structural measures, 19 process measures, five outcome measures, and one experience-of-care measure. Even though the Adult and Child Core Sets do not contain structural measures, they are part of the Medicaid program portfolio in which structural issues are addressed through programs such as home health and patient-centered medical home, among others. Additionally, the Child Core Set is well aligned with other quality and reporting initiatives: 17 of the measures are used in one or more federal programs, including the Adult Core Set and the Merit-Based Incentive Payment System.a Representing the diverse health needs of the Medicaid and CHIP population, the Child Core Set measures span many clinical topic areas (Exhibit E2).

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

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APPENDIX F:  
Current Child Core Set and Recommendations for Addition

There are 26 measures in the 2018 Child Core Set. MAP recommended six measures for phased addition to the 2019 Child Core Set. Exhibit F1 below lists the measures included in the 2018 version of the Child Core Set along with their current NQF endorsement number and status, including rates of state participation in FFY 2016 reporting. In FFY 2018, states will be voluntarily collecting the Child 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 MAP for potential addition to the Child Core Set.

EXHIBIT F1. 2018 CHILD 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 Recommendations</th>
</tr>
</thead>
</table>
| 0024 Endorsed                           | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)  
Measure Steward: National Committee for Quality Assurance (NCQA) | Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year:  
• Body mass index (BMI) percentile documentation  
• Counseling for nutrition  
• Counseling for physical activity | 39 states reported FFY 2016 Alignment: Merit-Based Incentive Payment System (MIPS), Qualified Health Plan (QHP) Quality Rating System (QRS), America’s Health Insurance Plan (AHIP) Pediatric Core Set, Certified Community Behavioral Health Clinics (CCBHC) | Support for continued use in the program |
| 0033 Endorsed                           | Chlamydia Screening in Women (CHL)  
Measure Steward: National Committee for Quality Assurance (NCQA) | The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year | 45 states reported FFY 2016 Alignment: MIPS, Medicaid Adult Core Set, Qualified Health Plan (QHP) Quality Rating System (QRS), AHIP Pediatric Core Set | Support for continued use in the program |
| 0038 Endorsed                           | Childhood Immunization Status (CIS)  
Measure Steward: National Committee for Quality Assurance (NCQA) | Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B(Hib); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. | 45 states reported FFY 2016 Alignment: MIPS, Medicare Physician Quality Reporting System (PQRS), Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier, Qualified Health Plan (QHP) Quality Rating System (QRS), AHIP Pediatric Core Set | Support for continued use in the program |
<table>
<thead>
<tr>
<th>Measure #, NQF Status, Title, and Steward</th>
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</tr>
</thead>
<tbody>
<tr>
<td>0108 Endorsed</td>
<td>Follow-Up Care for Children Prescribed ADHD Medication (ADD)</td>
<td>The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.</td>
<td>40 states reported FFY 2016 Alignment: MIPS, Qualified Health Plan (QHP) Quality Rating System (QRS), CCBHC</td>
</tr>
<tr>
<td>Measure Steward: National Committee for Quality Assurance (NCQA)</td>
<td>• Initiation Phase. The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.</td>
<td></td>
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<td></td>
<td>• Continuation and Maintenance (C&amp;M) Phase. The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.</td>
<td></td>
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</tr>
<tr>
<td>0139 Endorsed</td>
<td>National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure</td>
<td>Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations:</td>
<td>52 states reported FFY 2014* Alignment: N/A</td>
</tr>
<tr>
<td>Measure Steward: Centers for Disease Control and Prevention (CDC)</td>
<td>• Intensive Care Units (ICUs)</td>
<td>*Data separately collected by CDC’s National Healthcare Safety Network since FFY 2012. States include the District of Columbia and Puerto Rico.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Specialty Care Areas (SCAs) – adult and pediatric: long-term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations</td>
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</tr>
<tr>
<td></td>
<td>• Other inpatient locations. (Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long-term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.</td>
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</tr>
<tr>
<td>Measure #, NQF Status, Title, and Steward</td>
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</tr>
<tr>
<td><strong>0418/0418e Endorsed</strong> Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan Measure Steward: Centers for Medicare and Medicaid Services (CMS)</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>New measure added to 2018 Core Set Alignment: CCBHC, Health Home Core Set, Duals Family of Measures</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>0471 Endorsed PC-02 Cesarean Birth Measure Steward: The Joint Commission</strong></td>
<td>This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01 Elective Delivery, PC-03 Antenatal Steroids, PC-04 Health Care-Associated Bloodstream Infections in Newborns, PC-05 Exclusive Breast Milk Feeding).</td>
<td>18 states reported FFY 2016 Alignment: AHIP OB/GYN Core Set</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>0576 Endorsed Follow-Up After Hospitalization for Mental Illness (FUH) Measure Steward: National Committee for Quality Assurance (NCQA)</strong></td>
<td>The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the patient received follow-up within 30 days of discharge • The percentage of discharges for which the patient received follow-up within 7 days of discharge</td>
<td>42 states reported FFY 2016 Alignment: Inpatient Psychiatric Facility Quality Reporting (IOPFQR), MIPS, Hospital Compare, PQRS, Physician Feedback/Quality Resource Use Report, Physician Value-Based Payment Modifier, Qualified Health Plan (QHP) Quality Rating System (QRS), Health Home Core Set</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>1360 Endorsed Audiological Evaluation No Later Than 3 Months of Age (AUD) Measure Steward: Centers for Disease Control and Prevention (CDC)</strong></td>
<td>This measure assesses the percentage of newborns who did not pass hearing screening and have an audiological evaluation no later than 3 months of age.</td>
<td>1 state reported FFY2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>1382 Endorsed Percentage of Low Birthweight Births Measure Steward: Centers for Disease Control and Prevention (CDC)</strong></td>
<td>The percentage of births with birth weight &lt;2,500 grams</td>
<td>30 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td>Measure #, NQF</td>
<td>Measure Description</td>
<td>Number of States Reporting to CMS FFY 2016 and Alignment</td>
<td>MAP Recommendations</td>
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</table>
| **1392** Endorsed | **Well-Child Visits in the First 15 Months of Life** Measure Steward: *National Committee for Quality Assurance (NCQA)* | Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported:  
• No well-child visits  
• One well-child visit  
• Two well-child visits  
• Three well-child visits  
• Four well-child visits  
• Five well-child visits  
• Six or more well-child visits | 46 states reported FFY 2016 Alignment: Qualified Health Plan (QHP) Quality Rating System (QRS) | Support for continued use in the program |
| **1407** Endorsed | **Immunizations for Adolescents (IMA)** Measure Steward: *National Committee for Quality Assurance (NCQA)* | The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday. | 44 states reported FFY 2016 Alignment: Qualified Health Plan (QHP) Quality Rating System (QRS) | Support for continued use in the program |
| **1448** Endorsement Removed | **Developmental Screening in the First Three Years of Life** Measure Steward: *Oregon Health & Science University* | The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age. | 26 states reported FFY 2016 Alignment: AHIP Pediatric Core Set | Support for continued use in the program |
| **1516** Endorsed | **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life** Measure Steward: *National Committee for Quality Assurance (NCQA)* | Percentage of patients 3-6 years of age who received one or more well-child visits with a PCP during the measurement year | 47 states reported FFY 2016 Alignment: Qualified Health Plan (QHP) Quality Rating System (QRS), AHIP Pediatric Core Set | Support for continued use in the program |

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*a* The stand-alone *HPV Vaccine for Female Adolescents (NQF #1959)* has been retired by the measure steward and added to the IMA measure.
<table>
<thead>
<tr>
<th>Measure #, NQF Status, Title, and Steward</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>1517 Endorsement Removed</strong>&lt;br&gt;Prenatal &amp; Postpartum Care (PPC) - Timeliness of Prenatal Care*&lt;br&gt;Measure Steward: National Committee for Quality Assurance (NCQA)&lt;br&gt;*Child Core Set includes “Timeliness of Prenatal Care” rate only.&lt;br&gt;“Postpartum Care” rate is evaluated in Medicaid Adult Core Set.</td>
<td>The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.&lt;br&gt;• Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization.&lt;br&gt;• Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</td>
<td>40 states reported FFY 2016 Alignment: Medicaid Adult Core Set, Qualified Health Plan (QHP) Quality Rating System (QRS)</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>1800 Endorsed</strong>&lt;br&gt;Asthma Medication Ratio&lt;br&gt;Measure Steward: National Committee for Quality Assurance (NCQA)</td>
<td>The percentage of patients 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.</td>
<td>New measure added to 2018 Core Set Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>2508 Endorsement Removed</strong>&lt;br&gt;Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk&lt;br&gt;Measure Steward: American Dental Association on behalf of the Dental Quality Alliance</td>
<td>Percentage of enrolled children in the age category of 6-9 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth within the reporting year</td>
<td>34 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>2801 Endorsed</strong>&lt;br&gt;Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics&lt;br&gt;Measure Steward: National Committee for Quality Assurance (NCQA)</td>
<td>Percentage of children and adolescents 1-17 years of age with a new prescription for an antipsychotic, but no indication for antipsychotics, who had documentation of psychosocial care as first-line treatment.</td>
<td>0 states reported FFY 2016 (New for 2017) Alignment: N/A</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>2902 Endorsed</strong>&lt;br&gt;Contraceptive Care-Postpartum Women (Ages 15-20)*&lt;br&gt;Measure Steward: U.S. Office of Population Affairs&lt;br&gt;*Child Core Set includes ages 15-20 only. Adult Core Set evaluates ages 21-44.</td>
<td>Among women ages 15 through 44 who had a live birth, the percentage that is provided:&lt;br&gt;1. A most effective (i.e., sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) method of contraception within 3 and 60 days of delivery.&lt;br&gt;2. A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.&lt;br&gt;Two time periods are proposed (i.e., within 3 and within 60 days of delivery) because each reflects important clinical recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care.</td>
<td>0 states reported FFY 2016 (New for 2017)&lt;br&gt;Alignment: Medicaid Adult Core Set</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>2903 Endorsed</strong>&lt;br&gt;Contraceptive Care – Most and Moderately Effective Methods (Ages 15-20)*&lt;br&gt;Measure Steward: U.S. Office of Population Affairs&lt;br&gt;*Child Core Set includes ages 15-20 only. Adult Core Set evaluates ages 21-44.</td>
<td>The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) methods of contraception.&lt;br&gt;The proposed measure is an intermediate outcome measure because it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman will use, and because of the strong association between type of contraceptive method used and risk of unintended pregnancy.</td>
<td>New measure added to 2018 Core Set&lt;br&gt;Alignment: Medicaid Adult Core Set</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>Not NQF-endorsed Children and Adolescents' Access to Primary Care Practitioners Measure Steward: National Committee for Quality Assurance (NCQA)</td>
<td>The percentage of children 12 months – 19 years of age who had a visit with a primary care practitioner. Four separate percentages are reported: Children 12 through 24 months and children 25 months through 6 years who had a visit with a primary care practitioner during the measurement year; Children 7 through 11 years and adolescents 12 through 19 years who had a visit with a primary care practitioner during the measurement year or the year prior to the measurement year.</td>
<td>46 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td>Not NQF-endorsed Adolescent Well-Care Visits Measure Steward: National Committee for Quality Assurance (NCQA)</td>
<td>The percentage of enrolled adolescents 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.</td>
<td>46 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>
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<tr>
<td><strong>Not NQF-endorsed</strong>&lt;br&gt;Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)&lt;br&gt;Measure Steward: National Committee for Quality Assurance (NCQA)**</td>
<td>This measure provides information on parents’ experiences with their child’s health care and gives a general indication of how well the health care meets their expectations. Results summarize children’s experiences through ratings, composites, and individual question summary rates. Four global rating questions reflect overall satisfaction: Rating of All Health Care Rating of Personal Doctor Rating of Specialist Seen Most Often Rating of Health Plan Five composite scores summarize responses in key areas: Customer Service Getting Care Quickly Getting Needed Care How Well Doctors Communicate Shared Decision Making Item-specific question summary rates are reported for the rating questions and each composite question. Question summary rates are also reported individually for two items summarizing the following concepts: Health Promotion and Education Coordination of Care A.2 Children With Chronic Conditions (CCC) This measure provides information on parents experience with their child’s health care for the population of children with chronic conditions. Results include the same ratings, composites, and individual question summary rates as those reported for the CAHPS Health Plan Survey 5.0H, Child Version. In addition, three CCC composites summarize satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions: (1) Access to Specialized Services; (2) Family Centered Care: Personal Doctor Who Knows Child; (3) Coordination of Care for Children With Chronic Conditions. Item-specific question summary rates are reported for each composite question. Question summary rates are also reported individually for two items summarizing the following concepts: (1) Access to Prescription Medicines; (2) Family Centered Care: Getting Needed Information.</td>
<td>40 states reported FFY 2016 Alignment: MLTSS Quality Framework (one question only)</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>
<tr>
<td><strong>Not NQF-endorsed</strong>&lt;br&gt;Percentage of Eligibles Who Received Preventive Dental Services&lt;br&gt;Measure Steward: Centers for Medicare &amp; Medicaid Services (CMS)</td>
<td>The percentage of individuals ages one to twenty years old eligible for Medicaid or CHIP Medicaid Expansion programs (that is, individuals eligible to receive EPSDT services) who received preventive dental services</td>
<td>50 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>Not NQF-endorsed</strong>&lt;br&gt;Ambulatory Care: Emergency Department Visits&lt;br&gt;Measure Steward: National Committee for Quality Assurance (NCQA)</td>
<td>The rate of emergency department visits per 1,000 member months among children up to age 19</td>
<td>45 states reported FFY 2016 Alignment: Health Home Core Set</td>
<td>Support for continued use in the program</td>
</tr>
<tr>
<td><strong>Not NQF-endorsed</strong>&lt;br&gt;Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)&lt;br&gt;Measure Steward: National Committee for Quality Assurance (NCQA)</td>
<td>The percentage of children and adolescents 1-17 years of age who were on two or more concurrent antipsychotic medications.</td>
<td>32 states reported FFY 2016 Alignment: N/A</td>
<td>Support for continued use in the program</td>
</tr>
</tbody>
</table>
Measures in Exhibit F2 are listed in the order in which MAP prioritized them for inclusion.

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

<table>
<thead>
<tr>
<th>Measure #, NQF Status, Title, and Steward</th>
<th>Measure Description</th>
<th>Alignment</th>
<th>MAP Recommendation and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>3166 Endorsed</td>
<td>Antibiotic Prophylaxis Among Children with Sickle Cell Anemia</td>
<td>The percentage of children ages 3 months to 5 years old with sickle cell anemia (SCA, hemoglobin [Hb] SS) who were dispensed appropriate antibiotic prophylaxis for at least 300 days within the measurement year.</td>
<td>N/A</td>
</tr>
<tr>
<td>2393 Endorsed</td>
<td>Pediatric All-Condition Readmission Measure</td>
<td>This measure calculates case-mix-adjusted readmission rates, defined as the percentage of admissions followed by 1 or more readmissions within 30 days, for patients less than 18 years old. The measure covers patients discharged from general acute care hospitals, including children's hospitals.</td>
<td>N/A</td>
</tr>
<tr>
<td>2800 Endorsed</td>
<td>Metabolic Monitoring for Children and Adolescents on Antipsychotics</td>
<td>The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.</td>
<td>N/A</td>
</tr>
<tr>
<td>1885 Endorsed</td>
<td>Depression Response at Twelve Months - Progress Towards Remission</td>
<td>The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with major depression or dysthymia who demonstrated a response to treatment twelve months (+/- 60 days) after an index visit.</td>
<td>N/A</td>
</tr>
<tr>
<td>2797 Endorsed</td>
<td>Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia</td>
<td>The percentage of children ages 2 through 15 years old with sickle cell anemia (Hemoglobin SS) who received at least one transcranial Doppler (TCD) screening within a year.</td>
<td>N/A</td>
</tr>
<tr>
<td>Measure #, NQF Status, Title, and Steward</td>
<td>Measure Description</td>
<td>Alignment</td>
<td>MAP Recommendation and Rationale</td>
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<tr>
<td>2548 Endorsed Child HCAHPS&lt;br&gt;Measure Steward: Agency for Healthcare Research and Quality</td>
<td>The Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS) is a standardized survey instrument that asks parents and guardians (henceforth referred to as parents) of children under 18 years old to report on their and their child’s experiences with inpatient hospital care. The performance measures of the Child HCAHPS survey consist of 39 items organized by overarching groups into 18 composite and single-item measures.</td>
<td>N/A</td>
<td>Support addition of this measure to the program. Many hospitals have already adopted this measure. Therefore, broad adoption of this CAHPS family survey will ultimately enhance comparability of patient experience related data across hospitals and populations.</td>
</tr>
</tbody>
</table>
APPENDIX G:
Additional Measures Considered

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

EXHIBIT G1. MEASURES VOTED ON FOR ADDITION TO THE CHILD CORE SET—CONSENSUS NOT REACHED

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Title</th>
<th>Measure Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>0712</td>
<td>Depression Utilization of the PHQ-9 Tool</td>
<td>MN Community Measurement</td>
</tr>
<tr>
<td>1884</td>
<td>Depression Response at Six Months- Progress Towards Remission</td>
<td>MN Community Measurement</td>
</tr>
</tbody>
</table>

EXHIBIT G2. MEASURES VOTED ON FOR REMOVAL FROM THE CHILD CORE SET—CONSENSUS NOT REACHED

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Title</th>
<th>Measure Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>0024</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- Body Mass Index Assessment for Children/Adolescents</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>0108</td>
<td>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>1360</td>
<td>Audiological Evaluation no later than 3 months of age</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>N/A</td>
<td>Use of Multiple Concurrent Antipsychotics in Children and Adolescents</td>
<td>National Committee for Quality Assurance</td>
</tr>
</tbody>
</table>
APPENDIX H: Gap Areas in the Child Core Set

In 2018, the Child Workgroup members discussed several gap areas in the Child Core Set of measures. The Workgroup’s discussion centered on overall domains with large gap areas, primarily behavioral health and public health. The gap areas listed below are structured under each domain.

Behavioral Health Domain:
- Screening Abuse and Neglect (part of primary care as well)
- Substance Abuse
- Mental Health (including primary care integration)
- Care Coordination/Integration

Public Health Domain:
- Behavioral Health
- Social Determinants of Health
  - Adverse Childhood Experiences
- Maternity Care (including experience of care and breastfeeding)
- Cost (including finance reform for behavioral health)
- Duration of child health insurance coverage over 12 months
- Care Coordination
APPENDIX I:
Public Comments

General Comments on the Report

American Academy of Pediatrics
Judith Dolins
The AAP appreciates the opportunity to comment on this report. We recognize that payers, health plans, ACOs, consumers, and physicians are utilizing quality measures in various forms to improve the overall quality of care; therefore, we are working to promote quality measures that are meaningful to child health and can be used for value-based payment. The AAP encourages the NQF to promote measures that meet the following criteria for pediatrics:

1. Impact on Child Health - Measures should represent what pediatricians can do to promote the health of every child.
2. Evidence-based or evidence informed – Measures should promote child health and be evidence based or evidence informed.
3. Feasible – Measures should be feasible for pediatricians and those who care for children to collect.
4. Reflect the diversity of pediatric care – Measures should cover the broad range and complexity of pediatrics within a social determinants of health context

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.”

Children’s Hospital Association
Sally Turbyville
The Children’s Hospital Association (CHA) appreciates the opportunity to comment on the Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2018 draft report. We applaud CMS’ effort to ensure the best care and health outcomes for children regardless of where they live. We look forward to continued partnership with CMS through this and other relevant efforts to improve the Medicaid Child Core Set, and help states and providers prepare for the Child Core Set measures 2024 mandatory reporting.

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.

n/a
Lauren Agoratus

Thank you for the opportunity to comment on the “Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2018.” SPAN is New Jersey’s one-stop for families of children birth to 26 across systems; our special priority is children and families at greatest risk due to poverty, disability and special healthcare needs, discrimination based on race, ethnicity, immigrant or language status, or other special circumstances. Family Voices-NJ is the New Jersey affiliate for Family Voices, dedicated to supporting the family voice in children’s healthcare. SPAN also serves as the Parent to Parent USA affiliate for New Jersey; the New Jersey Parent Training and Information Center and Family to Family Health Information Center; and a chapter of the National Federation of Families for Children’s Mental Health. Our comments today are based on our extensive experience providing support to families around health care and health coverage including in particular Medicaid and the State Children’s Health Insurance Program.

We were pleased to see the acknowledgement that almost 20% of children have special healthcare needs and almost half of them are covered solely by Medicaid. We strongly support the framework of new measures, public/private partnerships, facilitating measure use, and quality of care. We are concerned with measure 2800 as being inadequate, discontinuance of the prenatal care measure, and with identified gap areas and our comments regarding these areas appear under the sections of specific measures and strategy respectively.
Specific Measures

American Academy of Pediatrics
Judith Dolins

NQF #3166 Antibiotic Prophylaxis Among Children with Sickle Cell Anemia. The AAP is supportive of this measure and believes that a concentration on sickle cell disease is the right next step to move us into more chronic disease data collection and reporting at the health plan level.

NQF #2393 Pediatric All-Condition Readmission Measure. A body of evidence suggests that an all-condition readmission measure may not correlate to quality care within pediatric clinical settings. Literature suggest that there are intricate factors such as medical complexity and social determinants of health that are outside the influence of hospital care but account for pediatric readmission rates. The AAP has concerns that the addition of this measure may be premature until health care delivery models and systems are supported to more fully address the medical and social complexity of the pediatric population. We encourage the development of studies that explore how such factors as those noted above influence pediatric readmissions.

NQF #2800 Metabolic Monitoring for Children on Multiple Antipsychotics. The AAP is in support of this measure addition.

NQF #1885 Depression Response at Twelve Months - Progress Towards Remission. The AAP is in support of this measure addition.

NQF #2797 Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia. The AAP is supportive of this measure and believes that a concentration on sickle cell disease is the right next step to move us into more chronic disease data collection and reporting at the health plan level.

NQF #2548 Child Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS). The AAP is supportive of this measure addition and the intent of linking patient experience to quality measurement and reporting. We however caution NQF that patient satisfaction does not always correlate to optimal care and that this measure does not often represent enough granularity to be highly meaningful for children and families. We recognize that CAHPS represents what is currently available and valid; therefore, we are supportive of this as a baseline measure, but it may not be meaningful to measure overall experience and impact. Additionally, some patients and families have concerns that the tool does not truly capture the patient/caregiver experience, as it was not co-created with patients and families to identify the domains that matter most to them. For these reasons, it is unclear whether it would be feasible to spread.

We would like to see more about how states are reporting this measure; more specifically whether states with standalone children’s hospitals have superior patient and family experience. We also recommend that feedback be gathered from state Medicaid agencies as to how they would implement and use data from this measure.

American Psychiatric Association
Samantha Shugarman

NQF #2393 Pediatric All-Condition Readmission Measure: This facility-level quality measure inappropriately excludes pediatric patients treated at inpatient psychiatric units within general acute care hospitals. With few stand-alone inpatient child psychiatric facilities and those existing facilities decreasing inpatient bed capacity across the country, many more children are admitted to general or children’s hospitals and “boarded” on the medical units. Therefore, we strongly recommend the removal exclusion criteria #7. As cited in the NQF-QPS exclusion criteria # 7 states, “The primary ICD-9 or principal ICD-10 diagnosis code was for a mental health condition. Rationale: Hospitalizations for mental health conditions are excluded because patients admitted for psychiatric treatment are typically cared for in separate psychiatric centers that are not comparable to short-term acute care hospitals.”

With the increased prevalence of pediatric patients treated in general acute medical hospitals, APA recommends using this measure to assess the quality of psychiatric care at these facilities.

NQF #2800 Metabolic Monitoring for Children on Multiple Antipsychotics: APA supports this measure for use in the Child Core Set. In addition to being specified, tested, and endorsed for use at the
state-level, this measure is non-duplicative of other antipsychotic measures in the Child Set, promotes preventive care, and brings attention to physical and mental health comorbidities for children on antipsychotic medications. 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 the 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.

Arkansas Medicaid
William Golden
A key issue for the new sickle cell measures – the substantial miscoding/misdiagnosis of sickle cell C – I have done studies that demonstrate that many charts use SSC to mean sickle cell anemia and also sickle cell C. The problem comes up in the sickle cell C does not require the prophylaxis or the ultrasounds that are important for sickle cell anemia---- there will be a lot of inappropriate patients in the denominator and potentially inappropriate treatments of patients with sickle cell C.

Children’s Hospital Association
Sally Turbyville
3166 Antibiotic Prophylaxis Among Children with Sickle Cell Anemia: CHA supports the addition of this measure could potentially have a large impact on the treatment of children with sickle cell anemia.

2393 Pediatric All-Condition Readmission Measure: Having a valid, well-tested standardized measure assessing pediatric readmissions is critical. While measures recommended by the MAP are for state-level reporting, we think it is important to share concerns we have using the measure to compare facilities or make inferences about quality for a particular facility. Specifically, CHA does not support this measure being used to differentiate on quality between facilities for three primary reasons: 1) wide confidence intervals; 2) known shortcomings of risk adjustments, including the inability to adequately account for children with high psychosocial risk levels; and 3) relatively low rates (lower is better performance). Confidence intervals should accompany any facility-level reporting. It is our experience that facility-level estimates using this (and other similar measures) consistently have wide confidence intervals precluding comparative quality assessments overall low readmission rates. Evidence suggests that overall unplanned readmissions among
children is not a priority quality area of concern. With the high degree of attention that readmissions get, it is critical that users understand that overall readmissions rates for children are relatively low (5 – 10%), and assess the consequences of diverting resources from quality efforts that may have a higher impact on the health of children. However, we do agree that unplanned readmissions should be avoided, and support the use of this measure to assess whether there may be a local quality problem, or within specific populations. As with many measures, risk adjustment and the impact of SODH on hospital performance are of concern. Using this measure to penalize or reward hospitals based on their performance is problematic for hospitals that treat proportionately more high clinical or psychosocial risk, which may in turn put children with the greatest need at risk. We ask policy- and decision-makers to use caution in how the measure performance is used.

2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics: CHA Supports the addition of this measure because implementing it is both feasible and important; also this measure is a potential replacement of Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure (Not NQF-endorsed Measure).

1885 Depression Response at Twelve Months- Progress Towards Remission: CHA supports the addition of this measure because implementing it is both feasible and important; also this measure is a potential replacement of Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure (Not NQF-endorsed Measure).

2797 Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia: CHA supports the addition of this measure as it addresses the Medicaid gap area: sickle cell disease.

2548 Child HCAHPS: CHA supports the addition of this measure in hopes of addressing the gap areas of inpatient care, patient experience, and care coordination.

NQF 2393 recognizes the importance of preventable rehospitalization. NQF 2800 recommends metabolic monitoring for psychotropics but we suggest this should be for a single medication, not just polypharmacy. NQF 1885 recognizes the importance of mental health follow-up for recovery and wellness. NQF 2797 indicates the increased need for ultrasound for children with sickle cell for stroke prevention. NQF 2548 will improve the family experience for inpatient pediatric hospitalization.

We were somewhat concerned with discontinuation of measures on prenatal care, asthma, and depression/suicide (due to reporting challenges) but were reassured to see that asthma medication monitoring will occur and that the mental health measure was replaced by screening/follow-up. We remain concerned about prenatal care as black infant mortality remains triple that of white infants in our state. Overall we agree with the aims of increasing state reporting, which measures are reported, and driving quality improvement. We acknowledge measure removal due to high performance, changes in clinical evidence, non-priority for states, no actionable items, or replacement with a better measure.

New York State Department of Health
Lindsay Cogan

We do not recommend the inclusion of #3166 Antibiotic Prophylaxis Among Children with Sickle Cell Anemia or #2797 Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia into the Child core set. We feel that the core sets should be reserved for measures already in use in State Medicaid agencies. We feel these measures could benefit from further testing and exploration in state’s before inclusion to the Child core set. This core set should not be the place to further test and refine new measures.

We do not feel that measure #2548 Child Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) should be included in the Medicaid Child Core Set. This measure is an all payer view of patient satisfaction that asks parents and guardians (henceforth referred to as parents) of children under 18 years old to report on their and their child’s experiences with inpatient hospital care.
The measure included in the survey constitute a fairly low bar of quality and do not adequately address the kinds of care coordination that is important as a person transitions from an inpatient setting to the community. The lever here is the hospital and it is unclear how the state Medicaid agency will use this information to drive improvement in this population.

#1885 Depression Response at Twelve Months-Progress Towards Remission. We do not recommend the inclusion of this measure in the Child core set. While an outcome based-measure of depression remission is an important gap area, the Screening for Clinical Depression measure was just added to the child core set last year and has not been able to reach maturity in its reporting to understand the level of depression screening, prevalence and follow-up occurring in this population. We think it best to allow this measure to be fully implemented by states before adding an additional depression measure. This measure is also labor intensive and will be costly for state Medicaid agency to collect and report on.

We do not support the inclusion of the #2393 Pediatric All-Condition Readmission Measure. We feel that the core sets should be reserved for measures already in use by State Medicaid agencies. We feel these measures could benefit from further testing and exploration in additional state Medicaid agencies before inclusion to the Child core set. This core set is not be the place to further test and refine new measures.

University of Vermont Medical Center
David Rettew

As someone who has worked and published on antipsychotic medication use in children, it isn’t clear to me why the new proposal on metabolic monitoring with antipsychotic medications requires a child to be taking two medications. The metabolic risks associated with this class of medications can occur with the taking of just one medication, as the scientific literature clearly shows.

Strategy

American Academy of Pediatrics
Judith Dolins

America’s child population is more diverse in race, ethnicity, and languages than any other age group. The child population in the United States also has higher rates of poverty than adults. As more is learned about the impact of childhood adversity on adult health outcomes, more emphasis will be needed on prevention, early intervention, and attending to the social determinants of health (SDOH). We applaud your efforts to examine and measure SDOH as nonclinical community level factors that affect health outcomes. We agree that measuring and addressing the social determinants of child health are as critical as clinical care and are major contributors to health outcomes in pediatrics.

The AAP recognizes that measurement burden can be quite high for practices, particularly if measurement is not automated. We acknowledge that time spent on data collection in the front lines can be a distraction and take time away from conducting health assessments and providing impactful interventions.

The AAP also encourages CMS to continue to fund pediatric measures development and validation so that there are more meaningful measures and to focus on glaring gaps as highlighted in our comments about the all hospital readmission measure. Addressing gaps in care is even more important now that state reporting will become mandatory by FFY 2024.

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.

Children’s Hospital Association
Sally Turbyville
CHA supports the continued strategic discussions on efforts to improve quality measurement and Child Core Set reporting at the state level. We support this years discussions, which included the need to maximize data utility and lower data collection burden. We would like to add that both – maximizing utility and reducing collection burden – are true for stakeholders throughout the measurement enterprise – children and families, providers, systems, states, regulators… Further, we agree that strategies must include how to incorporate (capture and how it is used) on social determinants of health (SDOH).

n/a
Lauren Agoratus
We appreciated the discussion of gap areas such as community, education, and social determinants of health which were under the domains of behavioral health and public health. Under the behavioral health domain, one of the gap areas was prevention of abuse and neglect. We would recommend the addition of restraints and seclusion in keeping statements from SAMHSA Alternatives to Seclusion and Restraint https://www.samhsa.gov/trauma-violence/seclusion; COPAA Trauma Informed Care: Child Safety without Seclusion and Restraint https://www.copaa.org/blogpost/895540/234517/Trauma-Informed-Care-Child-Safety-Without-Seclusion-and-Restraint; and NASMHPD Promoting Alternatives to Seclusion and Restraint Through Trauma-Informed Practices https://www.nasmhpd.org/content/seclusion-and-restraint-alternatives. The inappropriate use of restraints, seclusion, and other aversive interventions result in injury and at times death per USDE Restraint and Seclusion Resource Document https://www2.ed.gov/policy/seclusion/restraints-and-seclusion-resources.pdf; GAO Seclusions and Restraints: Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers http://www.gao.gov/new.items/d09719t.pdf; NDRN School is Not Supposed to Hurt: Investigative Report on Abusive Restraint and Seclusion in Schools http://www.ndrn.org/images/Documents/Resources/Publications/Reports/SR-Report2009.pdf; and TASH Shouldn’t School be Safe? http://www.cpacinc.org/wp-content/uploads/2009/11/TASH_Shouldnt-School-Be-Safe.pdf. This would include institutional abuse such as in schools per The AAP guidelines on Maltreatment of Children with Disabilities (more likely to experience abuse) and which includes restraints http://pediatrics.aappublications.org/content/119/5/1018. These interventions are ineffective at behavioral modification and experienced as trauma by those subjected to them. There also needs to be awareness that restraints disproportionately affect students with disabilities and children with mental illness. Even in this population, there is a subgroup that is even more affected which includes boys more than girls, and children of color; see GAO Disciple Disparities for Black Students, Boys, and Students with Disabilities https://www.gao.gov/assets/700/690828.pdf. Care coordination was another gap area which should include family engagement. Overall, we think the aforementioned strategies will result in NQFs 3 aims of better care, healthy people/communities, and affordable care.