MEASURE APPLICATIONS PARTNERSHIP

Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2015

FINAL REPORT

AUGUST 31, 2015

NATIONAL QUALITY FORUM

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

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EXECUTIVE SUMMARY

Medicaid, the primary health insurance program for low-income Americans, served 72.8 million individuals in 2013.[1] Enrollment is growing as people become newly eligible for Medicaid under the low-income adult group established by the Affordable Care Act (ACA).[2] Medicaid has also traditionally offered healthcare coverage to many of the individuals with the highest medical and social needs. Among current working age Medicaid enrollees—the segment of the Medicaid population growing most rapidly—an estimated 57 percent of adults are overweight, have diabetes, hypertension, high cholesterol, or a combination of these conditions.[3,4,5] Understanding the needs of the adult Medicaid population in order to improve health and the quality of health care is paramount.

Legislators have called for the creation of a core set of annually updated healthcare quality measures for individual programs, including Medicaid. The version of the Adult Core Set being used in 2015 contains 26 measures, spanning many clinical conditions and relating to other quality programs and reporting initiatives. Changes to the Adult Core Set of measures are informed by the Measure Applications Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF). MAP provides input to the Department of Health and Human Services (HHS) on the use of performance measures to assess and improve the quality of care. Guided by MAP's Measure Selection Criteria and feedback from two years of state implementation, MAP is providing its latest round of annual recommendations to HHS for strengthening and revising measures in the Adult Core Set and identifying high-priority measure gaps.

MAP supports all but one of the current measures for continued use in the Adult Core Set. MAP recommends the removal of NQF #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) due to reports of low feasibility and lack of reporting by states. In addition, MAP supported or conditionally supported nine measures for phased addition to the measure set. MAP is aware that additional federal and state resources are required for each new measure; therefore, recommended measures are ranked to provide a clear sense of priority.

MAP recognizes that many important priorities for quality measurement and improvement do not yet have metrics available to address them. MAP documented these gaps in the Core Set as a starting point for future discussions. The identified gaps will guide annual revisions to further strengthen the Adult Core Set.

MAP received numerous public comments on its draft recommendations as part of its transparent and open process. Most comments supported the measurement changes MAP recommended and further amplified the strategic issues noted. These include the alignment of measures across programs, an approach to selecting measures that will maximize health outcomes, and enabling quality improvement activities within states.

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

Rank	Measure Name and NQF Number, if applicable
1	Use of Contraceptive Methods by Women Aged 21-44 Years (not NQF-endorsed)
2	NQF #2602: Controlling High Blood Pressure for People with Serious Mental Illness
3/4/5 (tie)	NQF #1927: Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
	NQF #1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
	Effective Postpartum Contraception Access (not NQF-endorsed)
6	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multiple-provider, high dosage (not NQF-endorsed)
7	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multiple prescribers and multiple pharmacies (not NQF-endorsed)
8/9 (tie)	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage (not NQF-endorsed)
	NQF #1799: Medication Management for People with Asthma

INTRODUCTION AND PURPOSE

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

The MAP Medicaid Adult Task Force advises the MAP Coordinating Committee on recommendations to HHS for strengthening and revising measures in the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set) as well as to identify high-priority measure gaps. The Task Force consists of MAP members from the MAP Coordinating Committee and MAP workgroups with relevant interests and expertise (Appendix B).

Guided by the MAP Measure Selection Criteria (MSC) (Appendix C), MAP considered states' experiences voluntarily implementing the Adult Core Set in making its recommendations. To inform MAP's review, the Centers for Medicare & Medicaid Services (CMS) provided summaries of the number of states reporting each measure, deviations from the published measure specifications, the number and type of technical assistance requests submitted, and actions taken in response to questions and challenges. This report summarizes selected states' feedback on collecting and reporting measures as it was presented to MAP during the Task Force's deliberations. It also includes measure-specific recommendations to fill high-priority gaps (Appendix D). In addition, MAP identified several strategic issues related to the programmatic context for the Adult Core Set and its relationship to the Child Core Set.

This report is MAP's third set of annual recommendations on the Adult Core Set. It evaluates the measures in CMS's Adult Core Set being used in Federal Fiscal Year (FFY) 2015 and recommends changes that would be effective for FFY 2016 reporting. The recommendations have been vetted through an opportunity for public comment (Appendix E). The annual process has allowed for a deeper understanding of the Medicaid landscape, the measures in use, and how states engage with the program. HHS uses MAP's findings, including the state perspectives, to inform the statutorily required annual update of the Adult Core Set.

BACKGROUND ON MEDICAID AND THE ADULT CORE SET

Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals. Medicaid is financed through a federal-state partnership, in which each state designs and operates its own program within federal guidelines. Medicaid is a longstanding program that served 72.8 million individuals in 2013, about half of whom were adults.[6] This figure is expected to grow as it includes an increasing number of people newly eligible for Medicaid under the low-income adult group established by the Affordable Care Act.[7] Medicaid also provides coverage for low-income individuals with disabilities and those who are elderly, along with supplemental coverage for Medicare enrollees, also known as dual eligible beneficiaries.[8]

Medicaid covers a broad range of services to meet the diverse needs of its enrollees, and performance measurement should also be designed to address these diverse needs. States determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory" services through the Medicaid program (e.g., hospital care, laboratory services, and physician/nurse midwife/certified nurse practitioner services).[9] Many states also cover services that federal law designates as optional for adults, including prescription drugs, dental care, and durable medical equipment. Notably, Medicaid also covers a broad spectrum of long-term services and supports (LTSS) not provided by Medicare or private payers. As a result, Medicaid is the most significant source of financing for nursing home and community-based long-term care.

Medicaid Adult Population

Medicaid offers healthcare coverage to many of the individuals with the highest medical and social needs, many of whom could not obtain commercial insurance in the past. As a result, adults with Medicaid are both poorer and sicker than low-income adults with private health insurance. Even among adults with similarly low incomes, those with Medicaid report both worse health and worse mental health.[10] Adults with Medicaid also have higher rates of both multiple chronic conditions and functional activity limitations than those of the same income levels with employer sponsored insurance or even those who are uninsured.[11]

Among current working age adult Medicaid enrollees—the segment of the Medicaid population growing most rapidly—an estimated 57 percent of adults are overweight, have diabetes, hypertension, high cholesterol, or a combination of these conditions.[12,13,14] Behavioral health conditions are prevalent and often complicate the course of other medical conditions.[15] Racial and ethnic minority populations are disproportionately represented among Medicaid enrollees, warranting attention to addressing health disparities. All of these factors, and others, contributed to MAP's understanding of the healthcare needs of the adult Medicaid population and influenced its recommendations on the most important measures of quality.

Medicaid Adult Core Set

Legislation called for the creation of a core set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid. HHS established the Adult Core Set to standardize the measurement of healthcare quality across state Medicaid programs, assist states in collecting and reporting on the measures, and facilitate use of the measures for quality improvement.[16] HHS published the initial Adult Core Set of measures in January 2012 in partnership with a subcommittee to the Agency for Healthcare Research and

Quality's (AHRQ) National Advisory Council.[17] It has been updated annually since that time, with recent iterations reflecting input from MAP.

Since the Adult Core Set is a relatively new program, the early years have focused on helping states understand the Core Set measures and refining the reporting guidance provided. HHS also released a two-year grant funding opportunity to assist Medicaid agencies in building capacity to participate in the collection and reporting of the Core Set.

The Adult Core Set is often regarded as providing a snapshot of quality within Medicaid. It is not comprehensive, but prior to its creation and implementation, performance measurement varied greatly by state, and it was not possible to discern an overall picture of quality. Statute requires CMS to release annual reports on behalf of the Secretary on the reporting of state-specific adult Medicaid quality information. CMS also issues reports to Congress on this subject every three years.

Characteristics of the Current Adult Core Set

The 2015 version of the Adult Core Set contains 26 measures that are a mix of structure, process, outcome, and experience-of-care measures (Exhibit 1, below, and **Appendix D**). There has been an increase in uptake of measure reporting by states, particularly for measures that states perceive as straightforward to collect. For example, the most frequently submitted measures are generally claims-based and aligned with other quality programs and reporting initiatives, such as the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS). Out of the 26 measures, 23 are used in one or more other federal programs.

The measures in the Adult Core Set cover all six of the National Quality Strategy (NQS) Priorities (Exhibit 2). Additionally, the Adult Core Set measures span many clinical conditions to represent the diverse health needs of Medicaid enrollees (Exhibit 3).

EXHIBIT 1. CHARACTERISTICS OF MEASURES IN THE 2015 ADULT CORE SET

Medicaid Adult Core Set Characteristics		# of Measures
NQF Endorsement Status	Endorsed	24
	Not Endorsed	2
Measure Type	Structure	0
	Process	19
	Outcome	6
	Consumer Experience of Care	1
Data Collection Method	Administrative Claims	21
	Electronic Clinical Data	18
	eMeasure Available	8
	Survey Data	3
Alignment	In use in one or more Federal Programs	23
	In the Child Core Set	3

EXHIBIT 2. MEASURES IN THE ADULT CORE SET BY NQS PRIORITY

National Quality Strategy Priorities	Number of Measures (n = 26)
Patient Safety	7
Person- and Family-Centered Experience of Care	1
Effective Communication and Care Coordination	6
Prevention and Treatment of Chronic Disease	3
Healthy Living and Well-Being	8
Affordability	1

EXHIBIT 3. MEASURES IN THE ADULT CORE SET BY CLINICAL AREA

Clinical Areas	Number of Measures (n = 26)
Preventive Care	6
Maternal and Perinatal Health	3
Behavioral Health and Substance Use	5
Care of Acute and Chronic Conditions	10
Care Coordination	1
Experience of Care	1

STATE EXPERIENCE COLLECTING AND REPORTING THE ADULT CORE SET

MAP values implementation information about measures and uses it to inform its decisionmaking. MAP received feedback on the implementation of the Adult Core Set in several formats, including summary statistics on 2014 reporting rates from CMS and presentations from participating states. Medicaid agency representatives from Pennsylvania and Washington shared their experiences with implementation, measure-specific challenges, and quality improvement strategies related to the Adult Core Set. States also provided feedback on strategic issues and measure gap areas to guide MAP's decisionmaking. These perspectives are a sample and not necessarily representative of all state Medicaid programs, but they informed MAP's strategic and measure-specific recommendations for the Medicaid Adult Core Set.

Washington

Washington selects measures for reporting that are most straightforward to submit, meaning that they use administrative data, are clearly defined, and have had adequate lead time for data specification updates. Administrative measures are favored because measures derived from survey, hybrid claims-chart data, and medical records are more costly. The Medicaid agency is managing multiple reporting requirements, including the Child Core Set, Health Homes, and a State Innovation Model. Other data collection barriers include low response rates for Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys administered by managed care plans and challenges with granularity of data for services that are reimbursed as a bundle. CAHPS data would be more useful to the state if the methodology were enhanced to include the geographic location and healthcare provider(s) of the respondent.

Washington's medical and mental health delivery systems are currently operated through separate managed care plans. Long-term care and home and community-based services (HCBS) are outside the managed care plans, and therefore dual eligible beneficiaries are mainly in fee-for-service

programs. Among the state's quality improvement activities is a focus on building cross-system integration, including reducing re-hospitalizations from both psychiatric facilities and nursing homes. Both initiatives have resulted in system-wide savings and fewer readmissions by targeting consumers with repeat readmissions and engaging them in care.

Washington's representative recommended that measure specifications be examined to ensure that inclusion/exclusion criteria are clear and fairly constructed. Additionally, MAP's discussion centered on the importance of risk adjusting measures used for comparative performance assessment to account for the complexity of consumers being served across facilities/providers and to direct quality improvement energy and incentives appropriately. Washington identified HCBS and psychiatric outcome measures as two measure gaps in the Adult Core Set.

Pennsylvania

Pennsylvania primarily uses Medicaid managed care organizations across all of its counties. The current landscape includes eight plans and a total of 1.6 million enrollees in their Health Choices Program, which is expected to grow due to the state's Medicaid expansion. Since most of Pennsylvania's managed care plans are currently NCQA-accredited and use a statewide core set called the Pennsylvania Performance Measures, these plans do not experience many reporting inconsistencies. As a result of the Adult Medicaid Quality Grant from CMS, the state has been able to improve measurement and quality outcomes on behavioral health and obstetrical care.

The representative from Pennsylvania discussed the future state of measurement, emphasizing that claims data is not going to remain the most significant source of performance improvement information. Pennsylvania encouraged that all of the Adult Core Set measures be converted into eMeasures and be reported using the Quality Reporting Data Architecture (QRDA) standardized format. Barriers to reporting and extraction should be reduced by state and federal collaboration with electronic health record vendors on data extraction abilities. Pennsylvania has had success with electronic extraction of certain measures. Measures that require robust chart audit, particularly those in the hospital or physician office settings, are less feasible for states. Finally, Pennsylvania's representative recommended that any measures added to the Core Set be consistently implemented across all states, aligned with Medicare programs and Meaningful Use requirements, and be reportable through electronic extraction to reduce data collection burden.

MAP REVIEW OF THE ADULT CORE SET

MAP reviewed the measures in the Adult Core Set to provide recommendations to strengthen the measure set in support of CMS's goals for the program. Guided by MAP's Measure Selection Criteria (MSC) (Appendix C) and feedback from the most recent year of state implementation, MAP carefully evaluated current measures. The MSC are not absolute rules; rather, they provide general guidance for selecting measures that would contribute to a balanced measure set. The MSC dictate that the measure set should address the National Quality Strategy's three aims, be responsive to specific program goals, and include an appropriate mix of measure types, among other factors.

MAP also used the MSC to review currently available measures and identify those with the best potential to fill gaps in the current set. Using measure gap areas identified in the 2014 review as a starting place, NQF staff compiled and presented measures in the following topic areas: access, behavioral health, and maternal/perinatal care. MAP discussed a small number of measures that staff judged to be a good fit for the Core Set largely based on their specifications, and the MSC, and the feasibility of implementing them for statewide quality improvement. All MAP Task Force members also had the opportunity to raise other available measures for discussion and consideration.

MAP examined NQF-endorsed measures and other measures in the development pipeline. MAP generally favored measures that are able to be implemented at the state level, promote parsimony and alignment, and address prevalent and/or high-impact health conditions for adults enrolled in Medicaid. NQF-endorsed measures were also favored because they have been successfully evaluated through a separate consensus-based process for importance, evidence, scientific acceptability of measure properties, and other rigorous criteria. Following discussion of each measure, MAP voted to determine if there was sufficient support from Task Force members to consider it for addition to the Core Set. Measures MAP examined but did not ultimately support for use in the program at this time are listed in Appendix F.

NQF-endorsed measures are not available in all relevant topic areas. Understanding this, MAP did not restrict its review to endorsed measures. Public commenters participating in the process helped to bring measures in the development and endorsement pipeline forward. For example, MAP examined numerous measures related to maternal/perinatal care and safe prescribing of opioid medication that have not yet been reviewed for endorsement. Monitoring the development of new measures will continue to be relevant for future annual reviews.

Measure-Specific Recommendations

Current Measures and Recommendation for Removal

MAP noted that states' participation in reporting the Adult Core Set is strong, though there is much room for improvement in both the total number of states submitting measurement data and the number of states reporting each measure. Given the relative newness of the program, participation is expected to be lower than for the Child Core Set, but ideally would increase each year. Not finding many significant implementation problems with the current measures, MAP was comfortable supporting all but one for continued use. Maintaining stability in the measure set will allow states to continue to gain experience reporting the measures, potentially increasing the number of states submitting quality information to CMS and using the measures locally to drive quality improvement.

In general, MAP considers removing a measure when the following factors are observed:

- Consistently high levels of performance (e.g., >95 percent), indicating little opportunity for additional gains in quality
- Multiple years of very few states reporting a measure, indicating that it is not feasible 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

Multiple state representatives gave negative feedback about their attempts to collect and use measure #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care). While generally supportive of the need to measure care coordination, this measure was thought to be too facility-centric for the state Medicaid agency to influence quality improvement. States also faced difficulty collecting all of the data required for the measure. Low feasibility is evident in the consistently low levels of state reporting of the measure, with just four states submitting data for the past two years. MAP recommends CMS remove this measure from the Adult Core Set since doing so may free up bandwidth to use more effective measures. Public commenters generally agreed with the MAP recommendation to remove this measure, though one comment dissented due to the importance of care coordination.

Measures for Phased Addition to the Adult Core Set

MAP recommends that CMS consider up to nine measures for phased addition to the Adult Core Set (Exhibit 4 and Appendix D). These measures passed consensus threshold to gain MAP's support or conditional support for phased addition by receiving more than 60 percent approval by voting MAP Task Force members. Measures that are not currently NQF-endorsed are supported conditionally; MAP recommends that CMS add them to the programs once endorsement review is complete and the detailed technical specifications are made publicly available.

MAP is aware that additional federal and state resources are required for each new measure; immediate addition of all nine recommended measures supported by MAP is highly unlikely. MAP members decided to support a larger than usual number of measures to highlight the existence of measures beyond the Adult Core Set that the states and other entities could use in other quality improvement work. In particular, NQF has recently endorsed a bundle of measures that monitor care for co-occurring mental illness and other chronic conditions (e.g., diabetes, cardiovascular disease).

EXHIBIT 4. MEASURES RECOMMENDED FOR PHASED ADDITION TO THE ADULT CORE SET

Ranking	Measure Number and Title	MAP Recommendation
1	Use of Contraceptive Methods by Women Aged 21-44 Years (*not NQF endorsed*)	Conditional Support, pending successful NQF endorsement
2	NQF #2602: Controlling High Blood Pressure for People with Serious Mental Illness	Support
3/4/5 (tie)	NQF #1927: Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	Support
	NQF #1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Support
	Effective Postpartum Contraception Access (*not NQF endorsed*)	Conditional Support, pending successful NQF endorsement
6	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multi-provider, High Dosage (*not NQF endorsed*)	Conditional Support, pending successful NQF endorsement
7	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multiple Prescribers and Multiple Pharmacies (*not NQF endorsed*)	Conditional Support, pending successful NQF endorsement
8/9 (tie)	NQF #1799: Medication Management for People with Asthma (MMA)	Conditional Support, pending update from NQF annual review
	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage (*not NQF endorsed*)	Conditional Support, pending successful NQF endorsement

The use of recommended measures would strengthen the measure set by promoting measurement of a variety of high-priority quality issues, including reproductive health, chronic disease management for people with serious mental illness, and the prevention of substance abuse. Further explanation and rationale regarding MAP's support for these measures follows, in order of topic area beginning with maternal/perinatal care. Overall, public comments indicated support for MAP's recommended additions to the measure set. A small number of commenters requested addition of other measures; these were either reviewed and failed to gain MAP's support or did not correspond to a gap area noted by MAP.

Recognizing that three-quarters of women enrolled in Medicaid are in their reproductive years, MAP conducted a lengthy discussion of the maternal and perinatal care measures.[18] Measures in this topic area are currently included in both the Child Core Set and Adult Core Set of measures. The group reviewed a large volume of available measures to determine which measures would be the most effective additions to state-level reporting. MAP conditionally supports two reproductive health measures related to contraception use.

Use of Contraceptive Methods by Women Aged 21-44 Years (not NQF-endorsed)

This measures the rate of contraceptive use among women who could experience unintended pregnancy. It complements a related measure of a different age group (15-20) that MAP conditionally supported for the Child Core Set. The measure captures use of both moderately (e.g., injectables) and highly (e.g., LARC)

effective forms of contraception. After detailed discussion of potential ethical implications and strong agreement that the target rate for this measure would be well below 100 percent, MAP conditionally supported the measure and recommended that it be reviewed by NQF for endorsement. Several commenters supported the inclusion of this contraceptive measure, but emphasized the importance of NQF endorsement to clarify and make transparent the detailed measure specifications.

Effective Postpartum Contraception Access (not NQF-endorsed)

This measure assesses the utilization of postpartum contraception for women who have had a live birth. Members noted the importance of family planning, specifically that pregnancy within a year of giving birth is associated with an increased risk of placental abruption, preterm birth, and other negative effects. MAP members commented that one strength of the measure is that it can be stratified by the time period during which the consumer was prescribed contraception, including during the hospital stay immediately following birth. Seeking alignment across programs, MAP also conditionally supported this measure for addition to the Child Core Set. Several commenters supported the inclusion of this contraceptive measure, but emphasized the importance of NQF endorsement to clarify and make transparent the detailed measure specifications.

NQF #2602: Controlling High Blood Pressure for People with Serious Mental Illness

MAP had a robust conversation regarding measures for mental health conditions and substance use disorders during this review, building on themes from the 2014 process. MAP supports the addition of three measures from National Committee for Quality Assurance (NCQA) about managing co-occurring chronic disease in individuals with serious mental illness. Cardiovascular disease and diabetes contribute to significant morbidity and early mortality in the behavioral health population. MAP favored the use of measures to integrate behavioral health and primary care and engage consumers in self-management. The first of these measures, #2602 Controlling High Blood Pressure for People with Serious Mental Illness, targets a very important intermediate clinical outcome. The measure is harmonized with other existing measures on related topics.

NQF #1927: Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications and NQF #1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

NQF #1927 and NQF #1932 assess the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who are using antipsychotic medication and who received a cardiovascular health and diabetes screening, respectively, during the measurement year. Antipsychotic medication has metabolic side effects that place individuals at increased risk for these co-occurring conditions. Similar to the other behavioral health measure supported by MAP, these measures were developed and are owned by NCQA and are harmonized with other existing measures.

Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer; Opioid High Dosage, Multiple Prescribers and Multiple Pharmacies, and Multi-Provider/High Dosage (not NQF-endorsed)

After hearing from states that early intervention for people who are prescribed opioid medications is important to prevent addiction and a pathway to illegal heroin use, MAP conditionally supported three measures recently developed by the Pharmacy Quality Alliance (PQA). They are three closely related measures of potential overuse that address the epidemic of narcotic morbidity and mortality.[19] All are supported conditionally pending successful NQF endorsement.

NQF #1799: Medication Management for People with Asthma (MMA)

MAP conditionally supports NQF measure #1799 pending completion of the measure's annual

update without significant changes being made to the measure. Annual update is expected to proceed smoothly, but MAP members wanted the opportunity to reconsider the measure if it diverges from the information they reviewed. The measure evaluates the percentage of patients who are identified as having persistent asthma and who were dispensed and used appropriate medications during the treatment period. MAP initially recommended this measure during its 2014 review, but CMS has not yet added it to the Adult Core Set. MAP continues to recommend it be considered for phased addition. Adding this measure would also support the MAP alignment goal, as it is also included in the Child Core Set.

MAP received comments that alternative asthma medication management measures, NQF #1800: Asthma Medication Ratio (AMR) and NQF #0548: Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT), may be superior. Because MAP did not have the opportunity to conduct a detailed review of the suggested measures prior to these recommendations being due, it was determined that all of the asthma measures will be deliberately examined in the next annual review of the Adult and Child Core Sets.

Remaining High Priority Gaps

MAP recommended that the Core Set be strengthened by the addition of measures in key areas. Gap areas were identified from state feedback, review of 2014 reporting, and data on prevalent conditions affecting the adult Medicaid population. Although the Core Set includes measures pertaining to some of these topics, MAP did not perceive them as comprehensive. Some gaps identified during this review were also identified during MAP's 2014 deliberations. An asterisk (*) denotes newly identified gap areas. This list of measure gaps will be a starting point for future discussions and will guide MAP's input on strengthening the Adult Core Set.

Adult Core Set Measure Gaps

- Access to primary, specialty, and behavioral health care
- Beneficiary-reported outcomes
  - Health-related quality of life*
- Care coordination
  - Integration of medical and psychosocial services
  - Primary care and behavioral health integration
- Cultural competency of providers
- Efficiency
  - Inappropriate emergency department utilization
- Long-term supports and services
  - Home and community-based services*
- Maternal health
  - Inter-conception care to address risk factors
  - Poor birth outcomes (e.g. premature birth)
  - Postpartum complications
  - Support with breastfeeding after hospitalization*
- Promotion of wellness
- Treatment outcomes for behavioral health conditions and substance use disorders
  - Psychiatric re-hospitalization*
- Workforce
- New chronic opiate use (45 days)*
- Polypharmacy*
- Engagement and activation in healthcare*
- Trauma-informed care*

Public commenters supported MAP's assessment of high priority measure gaps for the Adult Medicaid population, noting the relevance of these issues in the enrollee population. One commenter particularly emphasized the gap areas of psychiatric re-hospitalizations, new chronic opiate use, polypharmacy, trauma-informed care, and engagement and activation in health care. Another comment suggested MAP could more systematically analyze measurement needs to determine if current efforts are adequate.

STRATEGIC ISSUES

For its 2015 review of the Child and Adult Core Sets, MAP conducted joint deliberations of the Medicaid Adult Task Force and the Medicaid Child Task Force to explore shared issues of strategic importance. These included alignment of measures across programs, the approach to selecting measures that will maximize health outcomes, and enabling quality improvement activities within states.

Alignment

The Child Core Set and Adult Core Set reporting programs were authorized by separate pieces of legislation, at separate times, but CMS and states generally regard them as working together to provide a picture of quality across Medicaid. The two sets differ in the measures they include because of the distinctly different health and medical needs of the pediatric and adult populations, but as we increasingly adopt a lifespan view of wellness, it becomes clear that the two measurement efforts should be synchronized to the extent possible.

Alignment of measures has macro-level considerations. Across the health system, but especially in the context of resource-constrained state Medicaid programs, investments in quality measurement and improvement have a finite budget. Often this forces trade-offs between competing priorities. When measures in the Adult and Child Core Sets are also used in other programs relevant to Medicaid, efficiencies are gained by reducing the number of measures that need to be collected. State panelists emphasized the importance of alignment with HEDIS, health insurance exchanges, Medicaid Health Homes, and Meaningful Use incentive programs, in particular. Another essential aspect of alignment is the use of the same measurement specifications in each of the programs, unless there are compelling reasons why they should be different. When measures are edited by one program and not others, these changes reduce comparability and add complexity to data collection and reporting.

MAP's discussion also acknowledged that if alignment is over-emphasized, it could lead to a few measures having an outsized effect on provider behavior. For example, if a small number of measures become part of multiple influential programs, it could sharpen focus on them to the detriment of other opportunities. When measures are used across multiple programs simultaneously, it is especially important that they warrant the compounded incentives. Measures best suited for widespread use should be able to influence desirable health outcomes, as opposed to minute process steps.

The choice of measures for the Child and Adult Core Sets has specific consequences for CMS and for states. The CMS technical specifications manual for state-level reporting is released once annually. Following its release, states need time to program systems and plan for data collection. MAP members heard that this can involve negotiation with one or more contractors and potentially greater expense. For these and other reasons, states prefer to use measures that can satisfy multiple reporting requirements. Program experience to date demonstrates that it takes at least two years, and often longer, for a measure to experience significant uptake across states. CMS refrains from publishing performance data publicly until they have at least 25 states reporting on a given measure. As a result, the full utility of the measure is not realized until this threshold of participation is met.

Reproductive Health

One of Medicaid's core functions is to ensure that pregnant women and young children have access to health services that are vital for a healthy birth and lifelong wellness. Female reproductive healthcare continues from puberty to menopause, and the health outcomes of a woman and her child

or children are highly intertwined. As a result, MAP considered measurement of reproductive health across the lifespan and its implications for both the Child and Adult Core Sets.

The measure of chlamydia screening appears in both core sets, with different age groups reported in each one. The placement of other measures in the maternal and perinatal health area reflects that the Child Core Set was created prior to the Adult Core Set. As a general but imperfect rule of thumb, measures relating more to the mother's health appear in the Adult Core Set, and those that relate more to the infant's health are in the Child Core Set. MAP conducted extensive discussion to ensure that the division of measures in this manner was not artificially limiting quality measurement. Age ranges captured in both core sets should include all relevant populations impacted by the care being measured. For example, MAP advised that adult core set measures need to include all pregnancies, even if the Medicaid enrollee is a teenager outside of the age range that would otherwise be considered part of adult measurement.

Reproductive health is already the most frequently measured topic across the Child and Adult Core Sets, and MAP's 2015 recommendations would further expand it. Measures of contraceptive access and use gained strong, albeit conditional, support from MAP because of the robust and growing evidence that well-timed, intentional pregnancies are associated with better health outcomes for both the mother and the infant. Additionally, there is significant opportunity for improvement and cost effectiveness in this area. For example, 11 states have made specific policy changes to encourage placement of long-acting reversible contraception immediately postpartum, with the potential for others to follow.

Increasing State-Level Capacity for Quality Improvement

Peer-to-Peer Learning and Collaboration

State panelists' presentations of lessons learned from participation in reporting yielded strategic information that is potentially relevant to others. For example, "data not available" was the most frequently reported reason for not reporting the majority of measures. States cited budget constraints, lack of staff capacity, data sources that are not easily accessible, or information required for the measure is not routinely collected. However, states that have invested in building information infrastructure have overcome this barrier by creating a variety of data linkages. Leadership and political will are necessary precursors, as are savvy partnerships with the public health sector, academia, providers, and others in the delivery system. MAP encourages CMS to enhance states' abilities to communicate with each other through the technical assistance available in the reporting program.

Strategies to Understand and Address Disparities

MAP discussed the nature of health disparities within the Medicaid-enrolled population and observed several types: across states, across enrollee subpopulations including racial/ethnic groups and people with disabilities, and across diagnosis groups such as individuals with mental illness. Medicaid enrollees, by virtue of their low income, are already a group that experiences inequities in health and healthcare, and the other factors only compound the situation.

Stratification of measures by such factors of interest is one strategy that can be used to better understand and address disparities. For

example, MAP members suggested that states and CMS more deeply examine the performance of certain measures, such as screenings for breast and cervical cancer, to ensure care is equitable. Different strata could be created for other measures, as appropriate. Once made transparent, any disparities discovered are more easily understood and addressed with targeted action.

Appropriate Performance Benchmarks

States requested support from CMS and other partners in the measurement enterprise to better understand and set performance benchmarks for their measures. This is especially relevant for states implementing pay-for-performance models with contracted health plans. Benchmarks that are too high or too low fail to motivate quality improvement action. Incentives need to be designed to be achievable, but enough of a stretch to produce meaningful change. Furthermore, MAP members suggested that setting a reasonable benchmark in place of highly complex denominator exclusions—especially those that require medical record review to derive—would be a less burdensome way to implement a variety of measures.

MAP discussed that setting appropriate performance expectations is especially important for measures where 100 percent compliance is either unrealistic or potentially harmful. This is the case for the conditionally supported measures of contraceptive use, though it applies to other topics as well. The framing of how the measures should be interpreted is both important and sensitive to many stakeholder groups. It must be clear that by measuring rates of contraceptive use, the program would not be setting a universal expectation that all women should use contraceptives. Many women, in collaboration with their healthcare providers, choose to forego contraception for a variety of reasons. It is imperative that this choice be honored. However, many women who are interested in avoiding or delaying pregnancy lack access to effective family planning education and resources. To use another example, measurement of emergency department utilization would be expected to operate in much the same way. The expectation of the measure is not to reach zero percent; rather, it is to ensure that consumers are able to have routine health needs met in less costly and less acute environments before conditions are exacerbated to the point that urgent treatment is required.

Comments from hospitals, health plans, and other stakeholders were supportive of each of these strategic issues. They amplified MAP's discussion that encouraged use of measures derived from administrative and survey data, rather than chart review. Additionally, they strongly supported emphasis on behavioral and reproductive health, including synchronizing and aligning the Adult and Child Core Sets to provide a view of quality across an individual's lifespan.

CONCLUSION

As more adults enroll in Medicaid, the need for measures in the Medicaid Adult Core Set to drive quality improvement has become increasingly important. MAP's recommendations to HHS are intended to strengthen the program measure set to increase state participation in reporting and inform quality initiatives. In light of troublesome data collection and lack of actionability, MAP recommended a care transition measure for removal from the Adult Core Set. MAP supported all other current measures for continued use in the program. This year's recommendations for new measures focus on the high-impact areas of reproductive and behavioral health. A total of nine measures have been supported for phased addition to the program measure set over time.

As in previous years, MAP looked to the states' perspectives on the use of measures to inform its decisionmaking process. State representatives reinforced MAP's typical approach of recommending a parsimonious set of measures and thinking creatively about more efficient methods for data collection and analysis. As this voluntary reporting program continues to gain ground and more measures are reported by each state, the program measure set is expected to adapt to changing needs and priorities.

MAP also emphasized the importance of considering the overlap of the measures across the Child and Adult Core Sets, especially regarding high-impact conditions like reproductive and behavioral health. Aligned measures are expected to result in less burdensome data collection, and ultimately better rates of state reporting. MAP will continue to collaborate with CMS as infrastructure is enhanced to support states' efforts to gather, report, and analyze data that inform quality improvement initiatives.

ENDNOTES

1 Department of Health and Human Services (HHS). *2013 CMS Statistics*. Baltimore, MD: Centers for Medicare and Medicaid Services (CMS); 2013. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2013_final.pdf. Last accessed June 2014.

2 HHS. *Medicaid & CHIP: February 2015 Monthly Applications, Eligibility Determinations and Enrollment Report*. Baltimore, MD: Centers for Medicare and Medicaid Services (CMS); 2015. Available at http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-february-2015-application-eligibility-and-enrollment-data.pdf. Last accessed June 2015.

3 Kaiser Family Foundation (KFF). *Low-Income Adults Under Age 65-Many are Poor, Sick, and Uninsured [policy brief]*. Washington, DC: KFF; 2009.

4 Government Office on Accountability (GAO). *Medicaid Preventive Services: Concerted Efforts Needed to Ensure Beneficiaries Receive Services*. Washington, DC: GAO;2009.

5 Damler R. Medicaid expansion under the Affordable Care Act. *Health Watch*. 2013;73(October):31-34.

6 HHS. *2013 CMS Statistics*. Baltimore, MD: Centers for Medicare and Medicaid Services (CMS); 2013. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2013_final.pdf. Last accessed June 2014.

7 HHS. *Medicaid & CHIP: February 2015 Monthly Applications, Eligibility Determinations and Enrollment Report*. Baltimore, MD: Centers for Medicare and Medicaid Services (CMS); 2015. Available at http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-february-2015-application-eligibility-and-enrollment-data.pdf. Last accessed June 2015.

8 HHS. *2013 Annual Report on the Quality of Care for Children in Medicaid and CHIP*. Washington, DC: HHS; 2013. Available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-adult-sec-rept.pdf. Last accessed June 2015.

9 Centers for Medicare and Medicaid Services (CMS). Medicaid benefits website. Available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html. Last accessed August 2015.

10 Kaiser Commission on Medicaid and the Uninsured. *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence.* Washington, DC: Henry J. Kaiser Family Foundation; 2013.

11 Kaiser Commission on Medicaid and the Uninsured. *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence.* Washington, DC: Henry J. Kaiser Family Foundation; 2013.

12 KFF. *Low-Income Adults Under Age 65-Many are Poor, Sick, and Uninsured [policy brief]*. Washington, DC: KFF; 2009.

13 GAO. *Medicaid Preventive Services: Concerted Efforts Needed to Ensure Beneficiaries Receive Services*. Washington, DC: GAO; 2009.

14 Damler R. Medicaid expansion under the Affordable Care Act. *Health Watch*. 2013;73(October):31-34.

15 Goldman ML, Spaeth-Rublee B, Pincus HA. Quality indicators for physical and behavioral health care integration. *JAMA*. 2015;June 4 [epub ahead of print]. Available at http://jama.jamanetwork.com/article.aspx?articleid=2319350. Last accessed June 2015.

16 CMS. Adult health care quality measures website. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html. Last accessed June 2015.

17 HHS. *2014 Annual Report on the Quality of Health Care for Adults Enrolled in Medicaid*. Washington, DC: HHS; 2014.

18 HHS. *2014 Annual Report on the Quality of Health Care for Adults Enrolled in Medicaid*. Washington, DC: HHS; 2014.

19 Pharmacy Quality Alliance (PQA). PQA performance measure. use of opioids from multiple providers or at high dosage in persons without cancer website. Available at http://pqaalliance.org/measures/default.asp. Last accessed June 2015.

APPENDIX A:
MAP Background

Purpose

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

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

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

MAP's objectives are to:

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

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state

agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare. Foundational to the success of all of these efforts is a robust quality enterprise that includes:

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

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

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

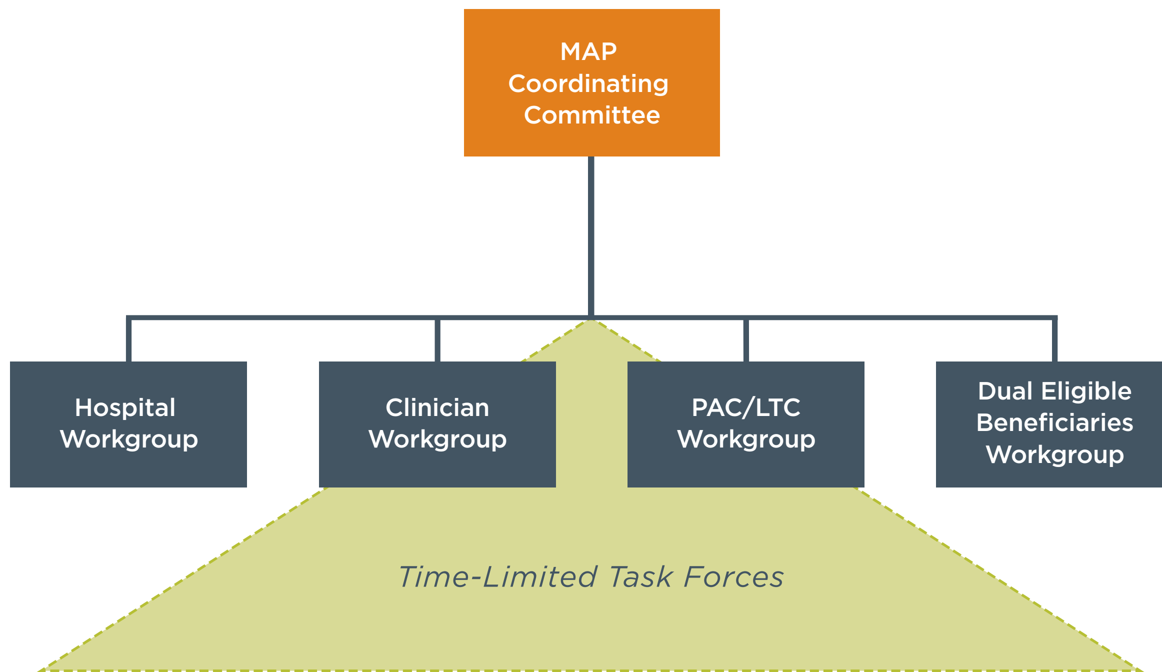
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for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

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

Structure

MAP operates through a two-tiered structure (see Exhibit A1). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces 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 developing "families of measures"—related measures that cross settings and populations—and a multiyear strategic plan 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 meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see **MAP 2015 Pre-Rulemaking Deliberations**).

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

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

ENDNOTE

1 Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014.2010: p.260. Available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Last accessed August 2015.

APPENDIX B:
Rosters for the MAP Medicaid Adult Task Force and MAP Coordinating Committee

Measure Applications Partnership Medicaid Adult Task Force

CHAIR (VOTING)
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
Academy of Managed Care Pharmacy	Marissa Schlaifer
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
American Academy of Nurse Practitioners	Sue Kendig, JD, WHNP-BC, FAANP
America's Health Insurance Plans	Kirstin Dawson
Humana, Inc.	George Andrews, MD, MBA, CPE, FACP
March of Dimes	Cynthia Pellegrini
National Association of Medicaid Directors	Daniel Lessler, MD, MHA, FACP
National Rural Health Association	Brock Slabach, MPH, FACHE

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Anne Cohen, MPH
Nancy Hanrahan, PhD, RN, FAAN
Marc Leib, MD, JD
Ann Marie Sullivan, MD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Centers for Medicare & Medicaid Services	Marsha Smith, MD, MPH, FAAP
Substance Abuse and Mental Health Services Administration (SAMHSA)	Lisa Patton, PhD

Measure Applications Partnership Coordinating Committee

CO-CHAIRS (VOTING)
Elizabeth McGlynn, PhD, MPP
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Lynda Flowers, JD, MSN, RN
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Shaun O'Brien
America's Health Insurance Plans	Aparna Higgins, MA

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
American Board of Medical Specialties	R. Barrett Noone, MD, FAcS
American College of Physicians	Amir Qaseem, MD, PhD, MHA
American College of Surgeons	Frank Opelka, MD, FACS
American HealthCare Association	David Gifford, MD, MPH
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Blue Cross and Blue Shield Association	Trent T. Haywood, MD, JD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip N. Kahn, III, MPH
Healthcare Financial Management Association	Richard Gundling, FHFMA, CMA
The Joint Commission	Mark R. Chassin, MD, FACP, MPP, MPH
The Leapfrog Group	Melissa Danforth
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Steve Wojcik
National Committee for Quality Assurance	Mary Barton, MD, MPP
National Partnership for Women and Families	Carol Sakala, PhD, MSPH
Network for Regional Healthcare Improvement	Elizabeth Mitchell
Pacific Business Group on Health	William E. Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher M. Dezii, RN, MBA,CPHQ

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Richard Kronick, PhD/Nancy J. Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MH, FACP
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD, FACP

NQF Project Staff

STAFF MEMBER	TITLE
Sarah Lash	Senior Director
Shaconna Gorham	Senior Project Manager
Zehra Shahab	Project Manager
Severa Chavez	Project Analyst

APPENDIX C:
MAP Measure Selection Criteria

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

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

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

APPENDIX D:
Adult Core Set and MAP Recommendations for Addition

In January 2012, HHS published a final notice in the *Federal Register* to announce the initial core set of healthcare quality measures for Medicaid-Eligible adults; annual updates including a 2015 version followed. Exhibit D1 below lists the measures included in the 2015 Core Set along with their current NQF endorsement number and status, including rates of state participation in 2013 reporting. In FFY 2015, states are voluntarily collecting the Medicaid Adult Core Set measures using the 2015 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 D2 lists the measures supported by MAP for potential addition to the Adult Core Set.

EXHIBIT D1. CURRENT ADULT CORE SET FOR FFY 2015

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0004 Endorsed **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment** Measure Steward: National Committee for Quality Assurance (NCQA)	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	18 states reported FFY 2013 Alignment: Meaningful Use Stage 2 – Eligible Professionals (MU-EP), PQRS, HEDIS, Health Insurance Marketplace Quality Rating System (HIX-QRS), Physician Value-Based Payment Modifier	Support for continued use in the program
0006 Endorsed **CAHPS Health Plan Survey - Adult Questionnaire** Measure Steward: NCQA	30-question core survey of adult health plan members that assesses the quality of care and services they receive.	16 states reported FFY 2013 Alignment: Medicare Shared Savings Program (MSSP), HEDIS, HIX-QRS	Support for continued use in the program
0018 Endorsed **Controlling High Blood Pressure** Measure Steward: NCQA	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	15 states reported FFY 2013 Alignment: MU-EP, MSSP, PQRS, HEDIS, HIX-QRS, Physician Compare, Physician Value-Based Payment Modifier	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0027 Endorsed **Medical Assistance With Smoking and Tobacco Use Cessation** Measure Steward: NCQA	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.	15 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program
0032 Endorsed **Cervical Cancer Screening** Measure Steward: NCQA	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	28 states reported FFY 2013 Alignment: MU-EP, PQRS, HEDIS, HIX-QRS, Physician Value-Based Payment Modifier	Support for continued use in the program
0033 Endorsed **Chlamydia Screening in Women [ages 21-24 only]** Measure Steward: 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.	26 stated reported FFY 2013 Alignment: MU-EP, PQRS, HEDIS, HIX-QRS, Physician Value-Based Payment Modifier, Medicaid Child Core Set (ages 16-20)	Support for continued use in the program
0039 Endorsed **Flu Vaccinations for Adults Ages 18 and Over** Measure Steward: NCQA	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.	12 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0057 Endorsed **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing** Measure Steward: NCQA	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	30 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program
0059 Endorsed **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)** Measure Steward: NCQA	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	0 states reported FY 2013 (New for 2015) Alignment: MU-EP, PQRS, MSSP, Physician Compare, Physician Value-Based Payment Modifier	Support for continued use in the program
0105 Endorsed **Antidepressant Medication Management (AMM)** Measure Steward: NCQA	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	25 states reported FFY 2013 Alignment: MU-EP, PQRS, HEDIS, Physician Value-Based Payment Modifier, HIX-QRS	Support for continued use in the program
0272 Endorsed **Diabetes Short-Term Complications Admissions Rate (PQI 1)** Measure Steward: Agency for Healthcare Research and Quality (AHRQ)	The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	24 states reported FFY 2013 Alignment: N/A	Support for continued use in the program
0275 Endorsed **Chronic obstructive pulmonary disease (PQI 5)** Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	24 states reported FFY 2013 Alignment: MSSP	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0277 Endorsed **Heart Failure Admission Rate (PQI 8)** Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	24 states reported FFY 2013 Alignment: MSSP	Support for continued use in the program
0283 Endorsed **Asthma in Younger Adults Admission Rate (PQI 15)** Measure Steward: AHRQ	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.	24 states reported FFY 2013 Alignment: N/A	Support for continued use in the program
0418 Endorsed **Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan** Measure Steward: Centers for Medicare and Medicaid Services (CMS)	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.	5 states reported FFY 2013 Alignment: MU-EP, MSSP, PQRS, Physician Compare, Physician Value-Based Payment Modifier	Support for continued use in the program
0469 Endorsed **PC-01 Elective Delivery** Measure Steward: The Joint Commission	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)	14 states reported FFY 2013 Alignment: Meaningful Use Stage 2 -Hospitals and CAHs	Support for continued use in the program
0476 Endorsed **PC-03 Antenatal Steroids** Measure Steward: The Joint Commission	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	5 states reported FFY 2013 Alignment: N/A	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0576 Endorsed **Follow-Up After Hospitalization for Mental Illness** Measure Steward: NCQA	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	27 states reported FFY 2013 Alignment: Medicaid Child Core Set, HEDIS, HIX-QRS	Support for continued use in the program
0648 Endorsed **Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)** Measure Steward: AMA-convened Physician Consortium for Performance Improvement (AMA-PCPI)	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	4 states reported FFY 2013 Alignment: N/A	MAP recommends the removal of this measure from the program. Measure requires data exchange with facilities and discharge processes are not felt to be appropriate for state-level accountability. Additionally, only 4 states have reported on this measure for both FFY 2013 and FFY 2014.
1517 Endorsed **Prenatal & Postpartum Care [postpartum care rate only]** Measure Steward: NCQA	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	29 states reported FFY 2013 Alignment: Medicaid Child Core Set, HEDIS, HIX-QRS	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
1768 Endorsed **Plan All-Cause Readmissions** Measure Steward: NCQA	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/ Denominator) 5. Total Variance Note: For commercial, only members 18-64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	18 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program In 2014 MAP recommended the development and application of a risk-adjustment model for the Medicaid population.
2082 Endorsed **HIV Viral Load Suppression** Measure Steward: HRSA	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. A medical visit is any visit in an outpatient/ ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.	17 states reported FFY 2013 Alignment: PQRS, Physician Value-Based Payment Modifier	Support for continued use in the program
2371 Endorsed **Annual Monitoring for Patients on Persistent Medications** Measure Steward: NCQA	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the four rates separately and as a total rate : Rates for each: Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), Digoxin, diuretics, or anticonvulsants Total rate (the sum of the four numerators divided by the sum of the four denominators)	23 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
2372 Breast Cancer Screening Measure Steward: NCQA	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	27 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program.
Not NQF-endorsed **Adult Body Mass Index Assessment** Measure Steward: NCQA	The percentage of Medicaid Enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	16 states reported FFY 2013 Alignment: HEDIS	Support for continued use in the program
Not NQF-endorsed **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)** Measure Steward: NCQA	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).	16 states reported FFY 2013 Alignment: HEDIS	Support for continued use in the program

EXHIBIT D2. MEASURES SUPPORTED BY MAP FOR PHASED ADDITION TO THE ADULT CORE SET

Measures in the table are listed in the order in which MAP prioritized them for inclusion.

Measure & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
Not NQF-endorsed **Use of Contraceptive Methods by Women Aged 21-44 Years** Measure Steward: Centers for Disease Control and Prevention/ Office of Population Affairs	The percentage of women aged 21-44 years who are at risk of unintended pregnancy and who: 1) Adopt or continue use of the most effective or moderately effective FDA-approved methods of contraception. 2) Adopt or continue use of a long-acting reversible method of contraception (LARC). The first measure is an intermediate outcome measure, and it is desirable to have a high proportion of women at risk of unintended pregnancy using most or moderately effective contraceptive methods. The second measure is an access measure, and the focus is on making sure that some minimal proportion of women have access to LARC methods.	N/A	Conditional Support, pending successful NQF endorsement. Enhances maternal/perinatal measures and would reduce the risk of unplanned pregnancy and pregnancy-related complications by increasing access to high-quality care before and between pregnancies.
2602 Controlling High Blood Pressure for People with Serious Mental Illness Measure Steward: NCQA	The percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.	N/A	Support Addresses behavioral health gap area with a focus on an intermediate clinical outcome that is important for managing co-occurring chronic conditions such as cardiovascular disease and diabetes.
1927 Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications Measure Steward: NCQA	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.	N/A	Support Addresses behavioral health gap area in the Core Set and focuses on the identification of cardiovascular disease, a leading cause of morbidity and mortality in this population.

Measure & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Measure Steward: NCQA	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Alignment: HEDIS	Support Addresses behavioral health gap area in the Core Set and focuses on the identification of cardiovascular disease, a leading cause of morbidity and mortality in this population.
Not NQF-endorsed **Effective Postpartum Contraception Access** Measure Steward: TBD	The percentage 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 utilization of postpartum contraception. Part A: Highly effective postpartum contraception access. The percentage of women who received contraceptives such as implants, intrauterine devices or systems (IUD/IUS), or female sterilization within 99 days after birthing. Part B: Moderately effective postpartum contraception access. The percentage of women who received contraceptives such as injectables, oral pills, patch, or ring within 99 days after birthing.	N/A	Conditional Support, pending successful NQF endorsement Enhances maternal/perintatal measures and intended to reduce the risk of unplanned pregnancy and pregnancy-related complications by increasing access to high-quality care between pregnancies.
Not NQF-endorsed **Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer: Multiple-provider, high dosage** Measure Steward: Pharmacy Quality Alliance	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.	N/A	Conditional Support, pending successful NQF endorsement Addresses behavioral health gap and provides an opportunity to intervene in substance abuse pattern. Opioid overuse and addiction is more common in some minority groups, including Native Americans.
Not NQF-endorsed **Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer: Multiple prescribers and multiple pharmacies** Measure Steward: Pharmacy Quality Alliance	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.	N/A	Conditional Support, pending successful NQF endorsement Addresses behavioral health gap and provides an opportunity to intervene in substance abuse pattern. Opioid overuse and addiction is more common in some minority groups, including Native Americans.

Measure & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
1799 Medication Management for People with Asthma (MMA) Measure Steward: NCQA	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.	Alignment: HEDIS, Medicaid Child Core Set, HIX-QRS	Conditional Support, pending update from NQF annual review Aligns with the Child Core Set and addresses a high-impact condition in the Medicaid Adult population.
Not NQF-endorsed **Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer: Opioid High Dosage** Measure Steward: Pharmacy Quality Alliance	The proportion (XX out of 1,000) of individuals without cancer receiving a daily dosage of opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	N/A	Conditional Support, pending successful NQF endorsement Addresses behavioral health gap and provides an opportunity to intervene in substance abuse pattern. Opioid overuse and addiction is more common in some minority groups, including Native Americans.

APPENDIX E: Public Comments Received

General Comments on the Report

American Academy of Otolaryngology - Head and Neck Surgery

Caitlin Drumheller

The American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) recommends the consideration of two NQF-endorsed measures for acute otitis externa (AOE) for inclusion in the 2015 Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid. Available AOE measures owned and stewarded by the AAO-HNS include: NQF #0653: Topical Therapy, and NQF #0654: Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use. These measures satisfy the NQS domains of effective clinical care, and efficiency and cost reduction. Both measures are currently in use in the PQRS program, and capture processes directly related to improved patient outcomes.

2013 PQRS data indicate that over 85,000 providers were eligible to report these measures; a number that includes primary care and emergency medicine physicians, as well as specialist clinicians treating conditions of the head, neck, ears, nose, and throat.

Acute otitis externa is one of the most common infections encountered by clinicians, and data from ambulatory care centers and emergency departments indicate that in 2007 there were roughly 2.4 million visits for AOE, affecting 1 in 123 persons in the United States. Despite their limited utility, many patients with AOE inappropriately receive systemic antimicrobial therapy, risking significant adverse effects from oral antibiotic use, including rashes, vomiting, diarrhea, allergic reactions, altered nasopharyngeal flora, and development of bacterial resistance. Topical preparations should be used to treat AOE, as they are active against the most common bacterial pathogens in AOE and have demonstrated efficacy in the treatment of AOE.

American College of Obstetricians and Gynecologists

Sean Currigan

The American College of Obstetricians and Gynecologists, the nation's leading group of professionals providing health care for women representing more than 58,000 physicians and educational affiliate members and over 90% of America's board-certified obstetrician-gynecologists, strongly supports the inclusion and widespread implementation of the contraception composite and postpartum contraception access measures across all age groups in the Adult Medicaid and Children's Health Insurance Program Reauthorization Act Core Sets.

We applaud the National Quality Forum's efficient overlap of the Adult Medicaid and Child Measurement Application Panels' discussions of measures affecting women's health care including both perinatal and well-woman clinical topics.

ACOG strongly supports each MAP's majority vote to recommend inclusion of the contraceptive composite and postpartum contraceptive access measures in the voluntary Adult Medicaid and CHIPRA Core Measure Sets conditionally on endorsement of the measures by a standing NQF consensus development panel. We note that neither MAP was afforded the opportunity to vote for any of these measures without the condition of endorsement. We understand the oversight as these may have been the first measures that did not achieve NQF endorsement prior to MAP consideration. We also note that start date of the next standing consensus development panel addressing perinatal and reproductive health is unknown.

ACOG is also actively seeking to include these measures in the voluntary OBGYN core measure set for commercial health plans, in a project led by America's Health Insurance Plans, the Centers for Medicare and Medicaid Services, and the National

Quality Forum. ACOG has also nominated these measures for consideration within the AHIP/CMS/NQF development of the Accountable Care Organization/Patient Centered Medical Home measure set.

America's Health Insurance Plans

Carmella Bocchino

We support the effort to include reproductive health, chronic disease, mental illness, and substance abuse into this report. Furthermore, we appreciate the alignment with and recommendation of NCQA HEDIS measures.

We also recommend that measures track quality improvement and quality of care in the most efficient and accurate manner. Medical record review is unduly burdensome and vital statistics data are often not available, may not be timely and may be incorrect. These barriers result in a lack of complete and reliable data, which is necessary for effective interventions such as with the elective delivery or antenatal steroid measures. We encourage the use of clinical registries to capture reliable and accurate data for use in quality measurement so long as appropriate third party audit protocols for the data are in place.

We also recommend that certain measures be broken into sub-measures to provide a more detailed and effective measure of quality. For example, #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)measure could be broken into sub-measures which would provide more detail as to the existence of gaps in the transition record. This measure not only requires the timely transition record (within 24 hour of discharge) but also requires multiple data elements in the transition record: advance planning, medication list, reasons for inpatient, etc. When all these data elements are bundled in one numerator, it becomes difficult to have clarity into all the aspects of the measure.

AWHONN

Kerri Wade

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) represents the interests of 350,000 nurses across the country working to promote the health of women and newborns.

AWHONN strongly supports the inclusion and widespread implementation of the contraception composite and postpartum contraception access measures across all age groups in the Adult Medicaid and Children's Health Insurance Program Reauthorization Act Core Sets. We applaud the National Quality Forum's efficient overlap of the Adult Medicaid and Child Measurement Application Panels' discussions of measures affecting women's health care including both perinatal and well-woman clinical topics.

AWHONN strongly supports each MAP's majority vote to recommend inclusion of the contraceptive composite and postpartum contraceptive access measures in the voluntary Adult Medicaid and CHIPRA Core Measure Sets conditionally on endorsement of the measures by a standing NQF consensus development panel. We note that neither MAP was afforded the opportunity to vote for any of these measures without the condition of endorsement. We understand the oversight as these may have been the first measures that did not achieve NQF endorsement prior to MAP consideration. We also note that start date of the next standing consensus development panel addressing perinatal and reproductive health is unknown.

Florida Hospital

John Hood

I am writing on behalf of Adventist Health System (AHS) to share our comments on the National Quality Forum (NQF) Measure Applications Partnership's (MAP) report on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid. AHS includes 44 hospital campuses located across 10 states and comprises more than 8,000 licensed beds. Our organization provides inpatient, outpatient and emergency room care for four million patient visits each year.

AHS strongly agrees with MAP's assessment of the key issues facing the Medicaid Adult population. We believe that quality measurement for this population is important because more adults are enrolling in Medicaid yet resources in many states remain constrained.

We believe MAP has correctly identified that reproductive health and behavioral health are important areas of focus for the Medicaid Adult population. However, we are concerned that several of the measures MAP has recommended for phased addition to the Medicaid Adult Core Measure Set are not endorsed by the NQF. While we applaud MAP's underlying rationale for support, we caution against premature support for measures that have not been fully evaluated and endorsed by the NQF.

We think MAP's emphasis on alignment is particularly important. AHS believes that quality measurement programs must reach a balance between alignment that reduces the administrative burden of data collection and comprehensiveness that ensures quality improvement efforts are not being unduly focused on one area of need to the disadvantage of other critical areas.

Finally, we support MAP's efforts to collaborate with the Centers for Medicare and Medicaid Services (CMS) to grow and support quality infrastructure and diffuse quality measurement best practices at the state-level.

AHS appreciates the opportunity to comment on MAP's draft recommendations to the Department of Health and Human Services (HHS) on the Medicaid Adult Core Set of quality measures. We think that MAP has accurately identified highly impactful measures and has prioritized gaps where meaningful quality measures are needed. We have included additional thoughts about specific items included in this report in our comments on measure specific recommendations and gaps as well as our 3) Comments on MAP's Strategic Recommendations.

PPFA

Carolyn Cox

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") are pleased to submit these comments in response to two draft reports for public comment regarding core set of health care quality measures for adults and children enrolled in Medicaid. We appreciate the opportunity to provide feedback on the draft recommendations and have submitted the same comments to MAP's Child Task Force.

We strongly support MAP's recommendations to include additional quality measures on contraception access in the Adult Medicaid and Children's Health Insurance Program (CHIP) Core Sets. We urge MAP to adopt and support these recommendations regardless of whether NQF endorses the measures. Medicaid plays a critical role for women and their families. The vast majority of women enrolled in Medicaid are of reproductive age (18-44), and across all ages, the majority of Medicaid enrollees are female. In addition, nearly half of U.S. births are funded by the Medicaid program. Including contraceptive quality measures into the core sets for women ages 21-44, teens ages 15-20, and postpartum women will complement the other existing reproductive health-related quality measures (e.g., Chlamydia screenings), ensure future Medicaid payment reforms reflect the majority of the Medicaid population, and improve access to the care women need.

As noted in the draft report, contraceptive access and use improves the ability to have planned pregnancies, which are associated with better health outcomes for women and their children. However, birth control adherence requires each woman having the opportunity to select the method of contraception that best meets her needs, including her medical history, age, and lifestyle. We appreciate the draft measures are defined to include use of moderately and highly effective contraceptive methods so that neither a woman nor a provider is inadvertently pressured toward a specific contraceptive method. Patients should be provided with accurate information and counseling about all of their options, but ultimately, each woman must make the decision about whether to use contraception and which family planning method to employ.

We thank MAP for its dedication to improve access to quality care, and we look forward to working with MAP and NQF in this important work.

Comments on MAP's Measure Specific Recommendations and Gaps

Academy of Managed Care Pharmacy

Susan Oh

Academy of Managed Care Pharmacy (AMCP) supports the inclusion of 'use of opioids at high dosage in persons without cancer' PQA measure.

AMCP conditionally supports the below opioid measures if a specific meaningful time period is identified as part of the measure.

Use of Opioids from multiple providers in persons without cancer – for example, the PQA measure of 4 prescribers AND 4 pharmacies over a time frame of 12 months could identify false positives.

Use of Opioids at high dosage and from multiple providers in persons without cancer.

American Academy of Allergy, Asthma and Immunology

Shazia Ali

The American Academy of Allergy Asthma and Immunology (AAAAI) does not support inclusion of NQF measure #1799: Medication Management for People with Asthma (MMA), in the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid. Most significantly, the MMA measure has not been shown to be associated with improved health outcomes and no clinically significant difference in hospitalizations, emergency department visits, or rescue inhaler dispensing has been demonstrated in compliant and non-compliant patients (Yoon et al. 2015). The AAAAI fully supports implementing quality measures that help achieve the goals of asthma control and encourages the committee to consider replacing this MMA measure with NQF Measure #1800, Asthma Medication Ratio (AMR), a measure that has been shown to be associated with improved asthma outcomes in diverse populations (Schatz, et al., 2006; Yong and Werner, 2009).

Due to the MMA measure format, timing becomes an unintended component of the measure. When compared, patients with similar controller dispensing were considered MMA-compliant or MMA-noncompliant depending solely on the timing of medication dispensing, and both groups were found to have similar asthma outcomes (Yoon, et al. 2015). Additionally, national asthma guidelines recommend adjusting asthma medication through a step-up or step-down approach (NHLBI/NAEPP 2007), but the MMA measure risks potentially penalizing the appropriate step-down of well-controlled asthma patients to lower doses of controller medication (Yoon, et al. 2015).

In contrast, the AMR measure has been shown to be associated with improved asthma utilization and patient-reported outcomes in many studies (e.g. Schatz, et al, 2006, Yong and Werner, 2009). When studied, patients compliant with this measure reported significantly better quality of life, asthma control and symptom severity compared to patients who were not compliant with the AMR measure (Schatz 2006). Additionally, patients with high AMRs were less likely to experience asthma hospitalizations or emergency department visits (Schatz 2006). Furthermore, when asthma exacerbations were studied in the Medicaid population, beneficiaries meeting the AMR measure were 23% less likely to experience asthma exacerbations (Yong and Werner 2009).

According to the CDC, asthma is a common chronic illness that affects 18.9 million American adults and 7.1 million children and results in direct and indirect health care costs estimated at $19.7 billion annually. The AAAAI stresses the importance of identifying measures to improve the quality of asthma care, lower costs and improve outcomes. While the AAAAI does not support the MMA measure, we hope the committee will consider inclusion of the AMR measure in the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid. We thank you for your consideration.

A list of references is available upon request.

American College of Obstetricians and Gynecologists

Sean Currigan

ACOG, the nation's leading group of professionals providing health care for women, strongly supports the inclusion of the contraception composite and postpartum contraception measures in the Adult Medicaid Set.

These measures require no medical chart review and can be done in administrative claims data. The testing data from national Title X and CA shows variation across settings. ACOG can facilitate presentation of the testing data.

We understand the sensitivity around coercion that these measures require which is why they are specified with a larger denominator at a population health level. ACOG is working within EHRs to create data elements specific to pregnancy intention and sexual activity that would support future refinement and the development of new measures. There are no other nationally specified and pilot-tested performance measures within the family planning space. Waiting for electronic clinical quality measures that are ready for national implementation will require a minimum of 4 years because the structured data elements do not exist.

We do not seek 100% on any of these measures. Women must be given the opportunity to make a choice that fits their lifestyle and values. Women should be given all of their options and should be educated and counseled on the most effective options available. Please note The Joint Commission-stewarded PC-05: Exclusive Breastmilk Feeding in the Hospital is a NQF-endorsed measure being used for accreditation in birthing facilities with more than 1100 births (soon to be 300 births in 2016) and also has anecdotal concerns for coercion. The goal for exclusive breastmilk feeding in the hospital is not 100%, TJC and ACOG believe the benchmark is closer to 70%. ACOG fully supports this measure until we are able to systematically capture patient experience of breastfeeding support. http://www.jointcommission.org/annualreport.aspx

In April 2015, the IOM released Vital Signs: Core Metrics for Health and Health Care Progress, a report examining measures that will yield the clearest understanding and focus on better health in the US. The IOM Committee on Core Metrics for Better Health at Lower Cost identified unintended pregnancy (teen or otherwise) as one of 15 core national measures. The Committee advises that the National Quality Forum "consider how they can orient their work to reinforce the aims and purposes of the core measure set." Contraceptive use is a related priority measure and also addresses health inequities across racial and ethnic minorities. http://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Vital_Signs/VitalSigns_Recs.pdf

These measures align with the National Quality Strategy Triple Aim addressing better care, population health, and cost-effectiveness.

In the United States, almost half of all pregnancies are unintended and one-third of all pregnancies are conceived within 18 months of a previous birth (Healthy People 2020). The United States continues to have the highest teen birth rate in the developed world, twice the rate of Canada and one and a half times the rate of the United Kingdom (Martin et al, 2013).

In 2001, 49% of births were unintended and 21% of women gave birth within 24 months of a previous birth (CDC MMWR, 2009). In 2006, the rate of unintended pregnancies remained at 49%, accounting for some 3.2 million pregnancies. Among women aged 19 years and younger, more than 4 out of 5 pregnancies were unintended. Between 2001 and 2006, the proportion of pregnancies that were unintended declined from 89% to 79% among teens aged 15–17 years but increased from 79% to 83% among women aged 18 and 19 years and from 59% to 64% among women aged 20–24 years (Finer and Zolna, 2011). In women ages 20-29 during 2008, 69% of almost two million pregnancies were unplanned (Special Tabulations from The National Campaign, 2012).

The US DHHS has included family planning goals in Health People 2020 in the hopes of improving pregnancy planning and birth spacing as well as preventing unintended pregnancy. Its objectives include increasing the proportion of females at risk of unintended pregnancy or their partners who used contraception at most recent sexual intercourse, reducing the proportion of females experiencing pregnancy despite use of a reversible contraceptive method and reducing the proportion of pregnancies conceived within 18 months of a previous birth (Healthy People 2020). In order to more effectively reach these goals, it will be important to increase access to more effective and longer acting reversible forms of contraception for those who wish to delay or avoid pregnancy.

any public health and reproductive health experts, including the American College of Obstetricians and

Gynecologists (ACOG) recommend that LARC be used as a first-line option for all women. And while LARC use in the U.S. has increased significantly from 2.4% in 2002 to 8.5% in 2009, usage remains relatively low compared to other, less effective, forms of birth control (Finer et al, 2012). Most of the increase occurred among women with at least one child, particularly in women younger than 30 years old. Use of LARC in parous women increased from 8% in 2007 to 17% in 2009. The increase in LARC use is primarily driven by increased use of IUD's and is accompanied by a small and not statistically significant decrease in rates of sterilization.

Of note, the use of LARC is lower in the U.S. than in British (11%), French (23%), Norwegian (27%) and Chinese (41%) users. The majority of LARCs in these countries are also IUDs (Finer et al, 2012).

In 2008, 48% of all births in the U.S. were paid for by public insurance through Medicaid, CHIP and IHS. 1.7 million of those births were a result of unintended pregnancies – both unwanted and mistimed – and it is estimated that public insurance programs paid for 65% of these births along with 36% of births resulting from intended pregnancies. A Guttmacher Institute report estimates that government expenditures on births resulting from unintended pregnancies totaled $12.5 billion in 2008 (Sonfield and Kost, 2013). With the expansion of Medicaid in many states beginning in 2014 with the Affordable Care Act, these public costs will likely rise.

Government expenditures for family planning services are also substantial and it has been estimated that publicly funded services helped avert $12.7 billion in costs by preventing unintended pregnancies in 2010. (Sonfield and Kost, 2013). Contraceptive use saves nearly $19 billion in direct medical costs every year (Trussell, 2007). In FY 2010, public expenditures for family planning services totaled $2.37, including counseling, education and provision of contraceptives. Medicaid covered 75% of the total cost with state and Title X funding covering the remaining cost. In 2010, there were about 181,000 abortion procedures for low-income women, costing $68 million. The states covered the vast majority of these procedures and the federal government, which restricts funding to cases of life endangerment, rape and incest, contributed to the cost of 331 procedures (Sonfield and Gold, 2012).

A 2013 study constructed an economic model to estimate all direct costs of unintended pregnancies to third party payers as well as the proportion of that cost attributed to imperfect contraceptive adherence. These costs included births, induced abortions, miscarriages, and ectopic pregnancies. Annual medical costs attributed to unintended pregnancies were estimated at $4.6 billion and 53% of these costs were attributed to imperfect use of contraception. The study also estimates that if just 10% of women aged 20-29 switched to from oral contraceptives to LARCs, the total cost would be reduced by $288 million per year (Trussell et al, 2013).

There are persistent and, in some cases, worsening disparities in unintended pregnancy rates among subgroups with minority and low-income white women more likely to have short birth intervals as a result of unintended pregnancy than white or middle-class women (Zhu et al, 2001). Women with the lowest levels of education, black and Hispanic women, and poor and low-income women had significantly higher rates of unintended pregnancies. In 2006, 43% of unintended pregnancies ended in abortion, a decline from 47% in 2001. The proportion of unintended pregnancies ending in abortion decreased from 2001 to 2006 across all racial/ethnic groups. Black women were most likely to end an unintended pregnancy with abortion. However, black and Hispanic women were more than twice as likely to have an unintended birth (Finer and Zolna, 2011).

Though racial/ethnic discrepancies in use of LARC was seen in 2002 and continued through 2007, they were largely gone by 2009. 2009 data also did not show significant differences by income level. However, LARC use was found to be higher among women on Medicaid and women offered no-cost contraception, suggesting that if the high up-front cost of LARC is no longer a barrier, more women would use LARC (Finer et al, 2012).

America's Health Insurance Plans

Carmella Bocchino

Harmonization between these measures and those recommended in the dual eligible report is encouraged to the extent that is possible. We agree with the gap areas proposed by the Taskforce.

We suggest that the MAP consider measures

or measure updates that are aligned with more comprehensive coverage of ages and insurance statuses (e.g. Medicare, Medicaid, and Commercial). For example, measure #0033 Chlamydia Screening should be applicable to both male and females and to age groups beyond 16-24.

We also continue to suggest the MAP recommend measures that focus on outcomes of care such as those recently included in the Physician Quality Reporting System program.

For use-rate measures such as Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multi-provider, High Dosage we suggest that more clarity be provided around definitions regarding terms such as “multiple” or “high dosage” and note the challenges that may exist due to benefit carve-outs. Furthermore, these measures often have data collection issues related to chart abstraction.

Implementation challenges exist with contraception measures and it is important to consider that most of the women that become eligible for Medicaid through pregnancy and delivery while on Medicaid may lose eligibility within 90 days of delivery.

AWHONN

Kerri Wade

AWHONN, representing the interests of 350,000 nurses across the country working to promote the health of women and newborns strongly supports the inclusion of the contraception composite and postpartum contraception measures in the Adult Medicaid Set.

We understand the sensitivity around the perception of coercion that these measures require. Thus is is critical that they are specified with a larger denominator at a population health level.

We do not seek 100% compliance on any of these measures. Women must be given the opportunity to make a choice that fits their lifestyle and values. Women should be given all of their options and should be educated and counseled on the most effective options available.

Please note The Joint Commission-stewarded PC-05: Exclusive Breastmilk Feeding in the Hospital is a NQF-endorsed measure being used for accreditation in birthing facilities with more than 1,100 births (soon to be 300 births in 2016) and also has anecdotal concerns for coercion. The goal for exclusive breastmilk feeding in the hospital is not 100%, TJC and AWHONN believe the benchmark is closer to 70%. AWHONN fully supports this measure until we are able to systematically capture patient experience of breastfeeding support. http://www.jointcommission.org/annualreport.aspx

In April 2015, the IOM released Vital Signs: Core Metrics for Health and Health Care Progress, a report examining measures that will yield the clearest understanding and focus on better health in the US. The IOM Committee on Core Metrics for Better Health at Lower Cost identified unintended pregnancy (teen or otherwise) as one of 15 core national measures. The Committee advises that the National Quality Forum “consider how they can orient their work to reinforce the aims and purposes of the core measure set.” Contaceptive use is a related priority measure and also addresses health inequities across racial and ethnic minorities. http://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Vital_Signs/VitalSigns_Recs.pdf

These measures align with the National Quality Strategy Triple Aim addressing better care, population health, and cost-effectiveness.

BlueCross BlueShield Association

Kerri Fei

Use of Contraceptive Methods by Women Aged 21-44 YearsWhile Plans agree that women’s reproductive health is a high priority area and understanding that MAP is conditionally supporting this measure pending NQF endorsement, it may be premature to consider this measure for inclusion in the Adult Core Set. As the specifications provided are not clear as to how “risk for unintended pregnancy” is defined, it appears that Plans will not be able to rely on administrative claims for data collection/reporting as identification of the denominator will require medical record data. This requires time for implementation as well as additional cost. Additionally, even with setting an expected performance threshold below 100%, the potential for unintended consequences with this measure (e.g., potential pressure into using a certain contraceptive method) remains a concern. This measure may

have limitations as an improvement measure and is not in and of itself and outcome. Given the high rates of change in eligibility status in the Medicaid population, it is unclear that the majority of women could be followed long term. Mostly likely, they can only be followed up to 60 days post-partum as that is when the majority of benefits end. We would like to see additional testing information regarding implementation and performance as well as for the measure to obtain NQF-endorsement prior to consideration for inclusion in the Adult Core Set.

NQF #2602: Controlling High Blood Pressure for People with Serious Mental Illness

Plans support behavioral health measures as an important priority, however the current measure included in the Adult Core Set (NQF #0018: Controlling High Blood Pressure) could be stratified to evaluate at this population. It does not necessarily require a new measure.

Effective Postpartum Contraception Access

As mentioned previously, women's reproductive health measures are a priority for Plans. We are unsure as to why the measure requires looking out up to 99 days for contraception use, when most Medicaid benefits end for women at 60 days post-partum. Please clarify the specifications prior to considering for inclusion in the Adult Core Set.

Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multi-Provider, High Dosage

Use of Opioids from Multiple Providers at High Dosage in Persons without Cancer: Multiple Prescribers and Multiple Pharmacies

Use of Opioids from Multiple Providers at High Dosage in Persons without Cancer: High Dosage

Overutilization of opioids is a priority area for some Plans. Would like to see that the measure specifications are clear and provide definitions of terms such as "multiple" and "high dosage". Additionally, medical appropriateness criteria that can be used for instances where opioid use outside of a cancer diagnosis is warranted? Support inclusion of this measure in the Adult Core Set pending clarification of specifications and NQF endorsement.

NQF #1799: Medication Management for People With Asthma

This measure is widely used and accepted by Plans. Given Plan experience with this measure and in order to align with how the measure is used for NCQA Health Plan Accreditation for Medicaid service line products, it is recommended that the 75% rate be utilized.

CVS Health

Marissa Schlaifer

Recommendations

CVS Health is pleased to provide comments in response on the draft report. CVS Health supports the task force's recommendation of the removal of measure #0648 due to reports of low feasibility and lack of reporting by states.

CVS Health would like to recommend reprioritizing measure #1799 'Medication Management for People with Asthma' as a top three priority. The task force conditionally supported measure #1799 pending completion of the measure's annual update. MAP initially recommended this measure during its 2014 review, but CMS has not yet added it to the Adult Core Set.

According to the CDC:

Asthma: affects 25.7 million people, including 7.0 million children under 18,

Is a significant health and economic burden to patients, their families, and society

In 2010, 1.8 million people visited an emergency department for asthma-related care and 439,000 people were hospitalized because of asthma and

People with lower annual household income are more likely to have asthma.[1]

CVS Health recommends that MAP continues to recommend the Medication Adherance for people with Asthma measure be considered for phased addition.

Prescription medications have been shown to lower overall medical costs through reduced hospitalization, emergency room utilization and outpatient visits, while medication therapy management programs and pharmacy counseling play an important role in optimizing prescription adherence to improve quality outcomes for individuals with chronic conditions.

CVS Health recommends adding "The Proportion of Days Covered (PDC) – three rates" measure for

inclusion into the Medicaid core adult set. Proportion of Days Covered (PDC) is the PQA-recommended metric for estimation of medication adherence for patients using chronic medications. This metric is also endorsed by the National Quality Forum (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 the Medicaid population and is aligns with other programs managed by CMS. CVS Health generally supports the remaining the task force recommendation.

These comments are submitted on behalf of CVS health and are independent of my role as a member of the MAP Coordinating Committee and Medicaid Adult Core Set task force. If you have any questions, please feel free to contact me at (202) 772-3538 or marissa.schlaifer@cvshealth.com.

[1]Centers for Disease Control and Prevention: http://www.cdc.gov/asthma/asthmadata.htm

Florida Hospital

John Hood

In the report, MAP recommends that CMS remove the Care Transition — Timely Transmission of Transition Record measure (NQF #0648) from the Adult Core Set. AHS disagrees with this recommendation. We believe that this is an important measure given the nature of health care delivery model reform efforts that seek to achieve greater coordination of health care services. As the U.S. health care delivery system transitions to a payment system that emphasizes value over volume it will be increasingly important that providers deliver timely and well-informed care. The ability to do this will hinge on the availability of adequate information. We think that it is critical for providers to receive patients' transition records within 24 hours of discharge if they are to ensure that services are provided in a timely and well-coordinated fashion across the continuum of care. In addition, Alternative Payment Models (APMs), such as Medicare's Bundle Payments for Care Improvement (BCPI) program and Medicare Shared Savings Program (MSSP), require that providers work to together to boost quality and efficiency. Delays in the transmission of important patient information, such as transition records, impede efforts to reduce overutilization and emphasize well-informed care. While these APMs do not necessarily apply to the Medicaid beneficiary population, the overall goal of improving the coordination of care is highly relevant. AHS believes that health care outcomes and overall costs can be improved if transitions of care are better coordinated. For this reason, we encourage MAP to continue to recommend that the Care Transition — Timely Transmission of Transition Record, measure remain in the Adult Core Set. We believe that care coordination is a high priority for the Adult Medicaid beneficiary population.

While AHS agrees with the measures MAP has recommended for phased addition to the Adult Core Set, we caution MAP against "conditional support." We believe that support should be binary. We think that MAP should either "support" or "not support" measures. We find that CMS often takes conditional support to mean full support and uses this as an argument in favor of implementing measures into programs, including highly impactful payment programs, prior to completion of the NQF endorsement process. The NQF endorsement process requires measures to undergo rigorous evaluation. Often, measure weaknesses are identified and corrected as a result of this process. We believe MAP can note in the report that it is interested in a particular measure and feels that it has the potential to be useful. However, we urge MAP to refrain from issuing any support based on conditions.

MAP should state clearly in the report that it is not supporting the measure because it has not been evaluated or endorsed by the NQF.

AHS supports MAP's assessment of high priority measure gaps for the adult Medicaid population. We think the newly identified gap areas identified by the report are highly relevant. In particular, we believe that beneficiary reported measures of health-related quality of life will enable informed assessment of state programs designed to improve population health. We also support the prioritization of measures related to psychiatric re-hospitalization, new chronic opiate use, polypharmacy, trauma-informed care and engagement and activation in health care.

GlaxoSmithKline

Christopher Cook

GSK commends MAP for recognizing the need to support improvements in asthma care by supporting the phase-in of NQF #1799 Medication Management for People with Asthma (MMA) into the Adult Medicaid Core Set. While we see value in the adoption of NQF #1799 to harmonize with the Childhood Medicaid Core Set we respectfully suggest MAP support adoption of NQF#1800 Asthma Medication Ratio (AMR) in addition to or as a replacement to their recommendation for NQF #1799.

Achieving and maintaining control of asthma is a challenge for patients and physicians. Lack of control is not only costly, it can also be lethal. In 2010, hospital inpatient costs due to asthma totaled $1.9 billion, [1] and uncontrolled patients cost approximately $4,400 more in direct costs per year than their counterparts who have well controlled asthma. [2] According to the CDC, in 2009 there were 2.1 million emergency room visits and nine deaths per day due to asthma. [3]

Unlike NQF#1799, NQF #1800 achieves the dual purpose of identifying patients who are not adequately persistent in their use of controller medication AND identifying patients who are high utilizers of rescue medications. While NQF#1799 promotes asthma control by assessing controller adherence, the measure lacks a component to evaluate the patient use of rescue medications or short-acting beta agonists (SABAs). Overuse of SABAs is associated with increased risk of hospitalization and is a marker for poor control and disease severity. [4] NQF #1800 in contrast takes into consideration the burden of asthma on the patient by assessing the relative use of SABA to that of controllers. Studies suggest that a higher ratio for NQF #1800, is a predictor of better patient outcomes (e.g., decreased emergency department visits, hospitalizations and exacerbations). [5], [6], [7], [8], [9] For these reasons, we believe NQF #1800 is a better measure of assessing quality of care for asthma patients. As CMS programs continue the quality measure harmonization efforts, we believe alignment to better measures of care remains an equal priority.

[1] AHRQ Statistical Brief #151, March 2013. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb151.jsp.

[2] Sullivan PW, et al. J Asthma. 2014;51(7):769-778.

[3] Moorman JE, et al. Vital Health Stat 3. 2012(35):1-67

[4] Shireman, et.al. Ann Pharmacother 2002;36:557-64.

[5] Schatz M, et al. Chest 2006; 130:43–50.

[6] Schatz M, et al. Ann Allerg Asthma Immunol. 2008;101(3):235-239.

[7] Broder MS, et al. Am J Manag Care. 2010;16(3):170-178.

[8] Schatz, M, et al. Am J Manag Care. 2010;16(5):327-333.

[9] Stanford, R, et al. Am J Manag Care. 2013;19(1):60-67.

Healthfirst

Abby Maitra

General Comment: We suggest that minimizing the administrative burden on states and plans be explicitly considered when contemplating new additions to the MAP Family of Measures (FOM) for Medicaid Adult Beneficiaries. Measures which require medical record review are particularly challenging and involve resources, time and effort for data collection and evaluation.

Use of Contraceptive Methods by Women Aged 21-44 Years

Healthfirst supports emphasis on the importance of reproductive health as a significant issue relevant to the adult Medicaid population. However, we are concerned that this measure will require medical record review. Further, data collection would be complex, involving numerous health care settings in which contraceptive methods could be dispensed. For these reasons, the full set of encounter data may not be fully captured, impacting measure performance. For instance, it will be difficult to obtain utilization information about women who are using moderate or highly effective contraception methods received from health care settings (e.g., Planned Parenthood) which are outside of a plan's network.

Healthfirst has reservations concerning the methodology which would be required to make this an unbiased reliable performance measure.

At minimum, this measure would need to be risk adjusted to account for factors known to affect contraceptive use among women, including level of education, race, and income. These factors could be determined at the plan level. However, there are many other factors impinging on contraceptive use among women ranging from social norms, embarrassment over discussing or obtaining birth control, worry about side effects, condom use, perceived risk of pregnancy, cultural and religious beliefs and values, and relative influence of partners, peers and family. These factors may not reliably be determined at the plan level. Because of these numerous factors which affect contraceptive use, we are concerned that risk adjustment would be imperfect. Furthermore, there is considerable variation in public funding for contraceptive methods which impacts access to and utilization rates. These factors are also difficult to capture within a risk-adjustment methodology.

Finally, we are in strong agreement that a low target rate for this measure would need to be established, given all the factors that influence contraception usage and adherence, and that the measure be reviewed by NQF for endorsement.

Effective Postpartum Contraception Access

Healthfirst supports emphasis on family planning and spacing of births to provide both health and social benefits to mothers and their children. We suggest that technical specifications for this measure be publicly available, in order for stakeholders to be able to fully comment on the proposed performance measure. We are concerned that another measure that would require medical record review may potentially be added to the FOM, posing a burden to plans to collect and evaluate data. We are in strong agreement that the measure be reviewed by NQF for endorsement before being considered for inclusion in the FOM.

Controlling High Blood Pressure for People with Serious Mental Illness

Controlling blood pressure is a highly desirable clinical outcome. However, Healthfirst does not support a separate measure to examine blood pressure with people with serious mental illness. Instead, we suggest that that the measure be restricted to individuals diagnosed with schizophrenia. In this way, the measure will parallel the HEDIS measure “Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia”.

Further, we recommend that this not be a separate performance measure. Instead, we suggest that it be a stratified performance measure, in which blood pressure rates for members with schizophrenia would be blended into a combined rate for all members. We feel that this this methodology would be more desirable, in that the overall performance measure would be adjusted to reflect the volume and proportion of members with schizophrenia; this would not the be the case if the performance measure were separate. Additionally, this measure will require medical record review which is burdensome to plans, involving resources, time and effort for data collection and evaluation.

Opioids Utilization:

There are patients using greater than 120mg MED for a medically necessary diagnosis as confirmed by their provider and are using a reasonable amount of prescribers and pharmacies (less than 3). Under the current specifications, these patients would remain in the denominator indefinitely. Healthfirst urges that these members should be excluded from the measure.

Michigan Department of Health and Human Services

Meta Kreiner

The Quality Improvement and Program Development Section of the Bureau of Medicaid Care Management and Quality Assurance, Michigan Department of Health and Human Services has reviewed the draft report entitled “Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2015”. We think the report represents a positive direction for the Adult Core Set and that the new measures identified in Exhibit 4 fill gaps in the current set and promote measurement in high-priority areas for quality assurance and quality improvement. We support all of the measures that are recommended for phased addition to the Adult Core Set and think the attention to behavioral health and reproductive health is well placed. We also support sustained attention to the importance of addressing health disparities.

When considering new measures, we would like to highlight the importance of a greater balance of measures that use administrative claims or survey data. As was mentioned in regards to other state experiences with the Adult Core Set, measures that require extensive chart audit are less feasible for Michigan. We are very supportive of the exploration of using survey data in conjunction with administrative data, such as in the "Use of Contraceptive Methods by Women Aged 21-44 Years" measure, to estimate data which would otherwise need to be collected through medical record review. Similarly, guidance and technical assistance from CMS and partner agencies to assist with setting reasonable benchmarks in place of complex denominator exclusions that require medical record review would be of great value. Other identified challenges with the Adult Core Set that Michigan has also experienced include issues with data for services that are reimbursed as a bundle, the need for greater clarity regarding Medicaid-specific inclusion/exclusion criteria, the importance of developing Medicaid-specific risk adjustment, and the alignment of measure specifications across programs.

National Partnership for Women & Families

Carol Sakala

The National Partnership for Women & Families supports inclusion of Effective Postpartum Contraception Access in the Medicaid adult core set. It would report the percentage of women covered by Medicaid who gave birth during the year and who had access to postpartum contraception within 99 days after giving birth. An important feature of this measure is the ability to examine contraceptive access by increments of time from the birth. It would have two parts: one reporting on use of a highly effective method, the second a moderately effective one. Clinical research has well documented the health benefit to both mother and baby of avoiding closely-spaced pregnancies. Especially for communities where a pattern of closely spaced births exists, the adoption of this measure would be a valuable tool in identifying the extent to which lack of contraception access is a crucial factor.

The National Partnership for Women & Families strongly supports inclusion of Use of mContraceptive Methods by Women Aged 21-44 Years in the Medicaid adult core set. This access measure, developed by CDC but not yet considered for endorsement by NQF, it has two parts. The first part would measure the utilization of one of the most or moderately effective FDA-approved methods of contraception by women enrolled in the state's Medicaid program. The second part would narrow the numerator definition and report the number of these women specifically using a Long Acting Reversible Contraception method. Its adoption will permit women and women's health advocates to identify program successes and opportunities for improvement. Given the diversity of the Medicaid population across the states, it is important to recognize any target rate would be well below 100% nationwide.

We applaud the MAP's recognition of the importance of this indicator by voting it as the #1 priority for inclusion in the adult set.

Pharmacy Quality Alliance

Woody Eisenberg

PQA (Pharmacy Quality Alliance) supports the MAP's conditional support of three related measures recently developed by PQA that address potential misuse/abuse of opioid analgesics:

1. Use of Opioids at High Dosage in Persons Without Cancer
2. Use of Opioids from Multiple Providers in Persons Without Cancer
3. Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer.

Medicaid offers healthcare coverage to many of the individuals with the highest medical and social needs. Behavioral health conditions are prevalent and often complicate the course of other medical conditions. State Medicaid programs have described to the MAP that early intervention for people who are prescribed opioid medications is important to prevent addiction and a pathway to illegal heroin use.

There is no FDA-approved maximum dosage for any opioid. However, the Washington State Agency Medical Directors Group has suggested 120 morphine equivalent dosage (MED) as a dosage level that should not be exceeded without special consideration. Additionally, 120mg MED is used by

the CMS Part D opioid monitoring program to alert health plans for potentially inappropriate doses of opioids. Other studies suggest that high opioid dosage increases the risk of overdoses, fractures and death. Further, people who see multiple prescribers or use multiple pharmacies are more likely to die of drug overdoses. Data from the California Prescription Drug Monitoring Program indicates that people with higher daily dosages are more likely to see multiple prescribers or go to multiple pharmacies.

The data suggest that efforts to prevent opioid overdose deaths should focus on strategies that target (1) high-dose opioid users as well as (2) persons who seek care from multiple prescribers and pharmacies. The data also suggests that these criteria can be considered separately, as measures related to prescribed opioids for appropriate clinical uses versus inappropriate uses. Thus, we support three measures: one for each set of criteria and one that is the intersection of both sets of criteria. This approach will also assist health plans in managing the number of patients who meet the measure criteria and planning their respective interventions, so that a balance of identification and intervention can be determined.

Comments on MAP's Strategic Recommendations

America's Health Insurance Plans

Carmella Bocchino

We agree with the recommendations as stated. Furthermore, reproductive and behavioral health are important issues to the adult Medicaid populations and we support the emphasis on these areas within the strategic recommendations. Lastly, we support the concept of synchronizing the Child Core set and Adult Core set to provide a clearer view of quality across an individual's lifespan.

Florida Hospital

John Hood

AHS commends MAP for its assessment of the Medicaid Adult Core set. We believe that MAP has correctly identified several of the strategic issues facing quality measurement for this beneficiary population.

We agree that alignment of measures across the health system is of critical importance. This is especially true, "in the context of resource-constrained" state Medicaid programs. We also agree that caution must be exercised when selecting measures. An over-emphasis on alignment can lead to an overly narrow measure set. Such a measure set could cause outsized quality improvement efforts in one area while another important area receives inadequate attention.

AHS agrees with MAP's recommendation that CMS help states enhance their ability to communicate and share best practices or other quality measurement resources.

AHS strongly supports MAP's recommendation that measures be stratified by factors of interest in order to identify disparities. We believe this will enable greater multivariate analysis of measures to identify disparities and other confounding factors that are influencing the health of the Medicaid beneficiary population. As MAP has noted, due to their low income, this population is a group that experiences inequities in health. The extent to which these inequities are due to disparities in health care or other disparities such as income, nutrition, education, transportation or environmental health is not fully understood. Stratification of these measures will enable further research into this area. One finding may be that providers with overall quality scores that are lower than average may in fact be performing better than the norm within certain low income population subsets. Highlighting the performance of these providers may help identify best practices.

AHS commends MAP for suggesting that states should ensure performance benchmarks are appropriate and achievable. Reasonable benchmarks can safeguard against overly burdensome measures while still encouraging meaningful improvement. In addition, we believe it is critically important to ensure appropriate performance benchmarks are used for measures where 100 percent compliance is unrealistic or potentially harmful. For instance, emergency department utilization measures should be carefully calibrated in order to reduce inappropriate utilization while also avoiding incentivizes that could encourage behavior that may discourage necessary utilization.

In the draft report, MAP encourages CMS to enhance states' abilities to communicate with each other via reporting program technical assistance processes. We think this, and similar strategies, may enable states to overcome budgetary and other resource constraints that limit the ability to collect measure data. CMS should identify similar strategies to address resource constraints and provide greater economies of scale across the Medicaid program.

U Mass Medical School

Louise Bannister

MassHealth appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) report and supports the continued collection and reporting of the Adult Core Set by State Medicaid programs.

The MAP report thoroughly describes the process by which current and new measures are assessed and identifies clear criteria for the addition of new and retirement of existing measures. MassHealth particularly appreciates the inclusion of prior state experience with measure collection and reporting as a key criterion when considering a retirement of a measure. MassHealth notes that there is only one measure recommended for retirement: #0648 Care Transition – Timely Transmission of Transition Record. While we recognize the challenges in collecting this measure, MassHealth would like to reiterate the importance of communication among and between providers in achieving better care and recommends that this be an area of consideration for future measures.

The Map report identifies "maintaining stability" as a key consideration in defining the Adult Core Set for 2015. Maintaining stability of the measure set will allow MassHealth and other states to continue to refine its processes as well as expand on currently existing improvement projects initiated as part of the Adult Medicaid Quality Grant. Moreover, the 'growing pains' experienced during the first several years of the program will decline as states become more proficient with measure specifications. MassHealth also appreciates efforts to align the Adult Core measures with measures contained in other measure sets used by CMS, including the Child Core Measures Set. MassHealth recommends that this alignment be consistent not only across measure sets but also measure specifications, especially with the HEDIS specifications as many states spend significant time and effort collecting and reporting HEDIS data. MassHealth noted several instances in which the Adult Core Set specifications differed with regard to populations. For example, the breast cancer screening measure in Exhibit D-1, shows an "outdated" age range of 40-69 for the population measure and is not consistent with the HEDIS 2014 revised age range of 50-74 years of age. Additionally, we strongly encourage CMS and MAP to prioritize adding new measures which are part of the HEDIS measure set.

MassHealth agrees with MAP's observation that gaps in the current Adult Core Set exist and additional measures are needed to address those gaps especially with regard to high priority, quality issues, such as reproductive health, chronic disease management for people with serious mental illness, and the prevention of Substance Abuse. The proposed list of new measures is lengthy (n=9) however, the phased in implementation approach will allow states to ensure the acquisition of adequate resources prior to measurement.

APPENDIX F:
Additional Measures Considered

MAP considered several measures that did not pass the consensus threshold (>60 percent of voting members) to gain MAP's support or conditional support for use in the Adult Core Set. MAP needed to limit the number of measures it supported for the sake of parsimony and practicality; lack of support for one of these measures does not indicate that the measures are flawed or unimportant. These and other measures could be reconsidered during a future review of the Adult Core Set.

NQF Measure Number	Measure Title	Measure Steward
0480	PC-05 Exclusive Breast Milk Feeding	The Joint Commission
0647	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	AMA-convened Physician Consortium for Performance Improvement
1927	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	National Committee for Quality Assurance (NCQA)
1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA
2599	Alcohol Screening and Follow-up for People with Serious Mental Illness	NCQA
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA
2601	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	NCQA
2603	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing	NCQA
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	NCQA
2608	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA
n/a	Adults' access to preventive/ambulatory health services: percentage of members 20 years and older who had an ambulatory or preventive care visit.	NCQA

© 2015 National Quality Forum
ISBN 978-0-9828420-6-5

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