MEASURE APPLICATIONS PARTNERSHIP

Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015

FINAL REPORT

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NATIONAL QUALITY FORUM

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EXECUTIVE SUMMARY

Together, Medicaid and the Children's Health Insurance Program (CHIP) cover more than 45 million children, which is more than 1 in every 3, and half of all low-income children in the United States.[1,2] Medicaid plays a key role in child and maternal health, financing healthcare services for about 40 percent of all births, on average, across the country.[3] Improving the health and healthcare of children enrolled in Medicaid and CHIP is an important opportunity and a priority for our nation.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for the identification of a core set of healthcare quality measures for children enrolled in Medicaid and CHIP. The 2015 Child Core Set contains 24 measures representing the diverse health needs of the Medicaid and CHIP enrollee population, spanning many clinical topic areas. The measures are relevant to children ages 0-18 as well as pregnant women in order to encompass both prenatal and postpartum quality-of-care issues. CHIPRA also requires CMS to update the initial Core Set annually to ensure that the best available measures are being used. Changes to the Child 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 several years of state implementation, MAP is providing its latest round of annual recommendations to HHS for strengthening and revising measures in the Child Core Set and identifying high-priority measure gaps.

Not finding significant implementation difficulties, MAP supported all of the Federal Fiscal Year (FFY) 2015 Child Core Set measures for continued use. In addition, MAP recommends that CMS consider up to six measures for phased addition. MAP is aware that additional federal and state resources are required for each new measure; immediate addition of all measures supported by MAP is highly unlikely. Therefore, MAP rank ordered the measures it supports.

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 gaps identified will guide annual revisions to further strengthen the Child 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 CHILD CORE SET

Rank	Measure Name and NQF Number, if applicable
1/2 (tie)	NQF #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care
	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (not NQF-endorsed)
3	Effective Postpartum Contraception Access (not NQF-endorsed)
4	Use of Contraceptive Methods by Women Aged 15-20 Years (not NQF-endorsed)
5/6 (tie)	NQF #1360: Audiological Evaluation No Later Than 3 Months of Age
	NQF #2393: Pediatric All-Condition Readmission Measure

INTRODUCTION AND PURPOSE

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

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

Guided by the MAP Measure Selection Criteria (MSC) (Appendix C), MAP considered states' experiences as they continue to voluntarily implement the measures in the Child Core Set. 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 states 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 Child Core Set and its relationship to the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set).

This is MAP's second set of recommendations on the Child Core Set; it follows an Expedited Review performed in 2014. It evaluates the measures in CMS's Child 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 Child Core Set.

BACKGROUND ON MEDICAID AND THE CHILD CORE SET

Currently covering more than 45 million children, Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals.[4,5] CHIP provides coverage to children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. Both Medicaid and CHIP are financed through federal-state partnerships; each state designs and operates its own programs within federal guidelines.[6]

Medicaid and CHIP Benefits for Children and Pregnant Women

Together, Medicaid and CHIP cover more than 45 million children, which is more than 1 in every 3, and half of all low-income children in the United States.[7,8] Medicaid plays a key role in child and maternal health, financing healthcare services for about 40 percent of all births, on average, across the states.[9] The federal government sets minimum guidelines for Medicaid eligibility, but states can choose to expand coverage beyond the minimum threshold. Most states have elected to provide Medicaid to children with family incomes above the minimum of 100 percent of the Federal Poverty Level (FPL).[10] The FPL is determined by family size: it is $24,250 for a family of four in 2015.[11] As of April 2015, 28 states (including the District of Columbia) covered children in families with incomes at or above 250 percent FPL.[12] Additional background on Medicaid and CHIP structure and benefits for children and pregnant women was presented to MAP and is accessible in the report from the **2014 review**.[13]

Health Issues for Children in Medicaid and CHIP

Understanding the health-related needs of children in Medicaid and CHIP contributes to the selection of appropriate measures across the continuum of child health. While most children are healthy and the focus of their care is on strong development and prevention of disease, it is important to consider with equal attention the group of children with complex health needs. Medicaid covers approximately two-thirds of all children with complex health needs, accounting for approximately 6 percent of the total number of children with Medicaid. However, this 6 percent of enrollees incur nearly 40 percent of costs.[14]

Poor birth outcomes have a disproportionately strong impact in the Medicaid population, and MAP discussed in detail the downstream negative effects of births resulting from unintended and/or closely spaced pregnancies. Risks associated with these types of pregnancies include inadequate or delayed prenatal care, premature birth, and low birthweight, among others.[15] Medicaid covers more than half of hospital stays related to short gestation, low birth weight, or inadequate fetal growth.[16]

Increased access to high-quality care before and between pregnancies, also known as preconception and interconception care, can reduce the risk of pregnancy-related complications, including maternal and infant mortality.[17] Many stakeholders, including state Medicaid agencies, are working to improve the availability and uptake of effective contraceptive methods, including long-acting reversible contraceptives (LARCs).[18] MAP's focus on this issue mirrors that of the public health field. For example, the Healthy People 2020 campaign aims to reduce unintended pregnancy in the United States by 10 percent, from 49 percent of pregnancies to 44 percent of pregnancies.[19]

Children with behavioral health issues also deserve special attention in measurement due to their

complex health needs and the impact they have on Medicaid utilization and spending. MAP explored the issue of access to appropriate behavioral health services and the rising prescription of psychotropic medications for publicly insured children.[20] Behavioral health experts are especially concerned about the recent increase in prescribing of antipsychotic drugs, in part because of their very serious side effects, including rapid weight gain and the increased risk for the development of diabetes.[21] Studies have shown that on average, 6.2 percent of noninstitutionalized children with Medicaid took psychotropic medications during a calendar year, and 21 percent of those children took an antipsychotic medication.[22] It was separately estimated that antipsychotic use increased from 8.9 percent in 2002 to 11.8 percent in 2007 and that state-specific rates of prescribing increased in 45 states over the same time period.[23]

Background and Use of the Child Core Set

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for the identification of a core set of healthcare quality measures for children enrolled in Medicaid and CHIP. CMS and the Agency for Healthcare Research and Quality (AHRQ) jointly charged a group of experts with creating this core set of measures in 2009.[24] The measures contained within the core set are relevant to children ages 0-18 as well as pregnant women in order to encompass both prenatal and postpartum quality-of-care issues. Additionally, the Adult Core Set did not yet exist when the initial Child Core Set was published.

CMS's three-part goal for the Child Core Set is to increase the number of states reporting Core Set measures, increase the number of measures reported by each state, and increase the number of states using Core Set measures to drive quality improvement. States voluntarily submit data to CMS once annually. CMS then uses the Child Core Set data to obtain a snapshot of quality across Medicaid and CHIP and to inform policy and program decisions. Data from the Core Set are also presented in several publications each year, including the **annual child health quality report** and other analyses such as **chart packs**.[25,26]

Characteristics of the Current Child Core Set

CHIPRA also required CMS to update the initial Core Set annually beginning in January 2013. For the 2015 update, CMS issued changes that were informed by MAP's 2014 review and input. Following MAP's recommendation, CMS removed the measure Percentage of Eligibles That Received Dental Treatment Services and replaced it with the NQF-endorsed measure #2508 Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk. CMS also followed MAP's recommendation to add NQF #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment to augment the emphasis on behavioral health issues. Additionally, CMS has decided to pilot test the pediatric version of the Hospital Consumer Assessment of Healthcare Providers and Systems survey (Child HCAHPS) to determine how to aggregate the data for state-level reporting before full inclusion into the Core Set. Not including Child HCAHPS, the 2015 version of the Child Core Set contains a total of 24 measures (**Appendix D**).[27]

The 2015 Child Core Set measures are concentrated in the National Quality Strategy priority area of Healthy Living and Well-Being (Exhibit 1).

Viewed as an array of measure types, the set contains no structural measures, 21 process measures, 3 outcome measures, and 1 experience-of-care measure. Additionally, the Child Core Set is well aligned with other quality and reporting initiatives: nine of the measures are used in one or more federal programs, including the Medicaid Adult Core Set and the Health Insurance Marketplace Quality Rating System Measure Set.[28] Representing the diverse health needs of the Medicaid and CHIP population, the Child Core Set measures span many clinical topic areas (Exhibit 2).

EXHIBIT 1. MEASURES IN THE CHILD CORE SET BY NATIONAL QUALITY STRATEGY PRIORITY

National Quality Strategy Priority	Number of Measures (n = 24)
Patient Safety	1
Person- and Family-Centered Experience of Care	1
Effective Communication and Care Coordination	3
Prevention and Treatment of Chronic Disease	0
Healthy Living and Well-Being	17
Affordability	2

EXHIBIT 2. MEASURES IN THE CHILD CORE SET BY CLINICAL AREA

Clinical Areas	Number of Measures (n = 24)
Access to Care	1
Behavioral Health	3
Care of Acute and Chronic Conditions (e.g., Asthma, Obesity)	3
Experience of Care	1
Maternal and Perinatal Care	6
Oral Health	2
Preventive Care	8

STATE EXPERIENCE COLLECTING AND REPORTING THE CORE SET

MAP gathered feedback on the implementation of the Child Core Set from states that participated in reporting and the **2014 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP**.[29] Representatives from Medicaid agencies in Louisiana and Minnesota shared their implementation experiences, measure-specific challenges, and quality improvement successes related to reporting the Child Core Set. Additionally, they 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 measure-specific and strategic recommendations for the Child Core Set in support of CMS's three-part goal.

Louisiana

In the state of Louisiana, more than one million residents receive healthcare coverage through Medicaid, most of whom are children younger than 19.[30] Since June 2012 almost all children and pregnant women with Medicaid have been enrolled in a managed care benefit plan. On the whole, Louisiana's residents have below-average income, and the state consistently finds itself at or near the bottom of health rankings.[31]

During the first year of participation in the Children's Health Quality Measures reporting program, Louisiana submitted six measures in the Child Core Set to CMS. Believing that measurement processes can evolve and improve over time, state staff worked diligently to increase the number of measures reported each year. To do so, Louisiana built new capacities by partnering with public health agencies and other partners in the state. The agency also made significant strides in linking vital records and immunization registry information to their Medicaid data to enable the reporting of more measures. Louisiana was able to report an additional 10 additional measures in 2014.

Representatives from Louisiana identified several measure-specific challenges to reporting the Child Core Set. The chart review process is expensive and time-consuming; the state has worked through multiple strategies to determine the most

efficient ways of obtaining necessary medical records to support measurement. Measures based on administrative data are less burdensome. Additionally, the process of building trust in the provider network is slow but necessary; clinicians need tools and understandable data to drive improvement at the individual practice level.

Representatives from Louisiana also recommended to CMS and MAP that the Core Set include measures that address premature birth, as it influences a lifetime of health outcomes and is itself very costly. Specifically, the panelists urged more widespread access to progesterone for women at risk of a premature delivery. Representatives also suggested MAP consider measures of Attention Deficit Hyperactivity Disorder (ADHD), noting the geographic variation and potential overuse of drug treatment of ADHD they have observed in their state.

Minnesota

The state of Minnesota provides Medicaid-funded healthcare to more than 700,000 low-income Minnesotans each month. Three-fourths of the enrollees are children and families, pregnant women, and adults without children.[32] Both the state's CHIP and Medicaid programs use a managed care delivery system.

During the past three consecutive years of participation, Minnesota submitted five measures in the Child Core Set to CMS. To select and report these measures, state officials considered accountability, potential for quality improvement, population comparison, known health disparities, and development policy. Likewise, the state representative observed that making a concerted effort to improve quality on three to four measures at a time is all the state can realistically prioritize, though they could report additional measures.

Staff from Minnesota emphasized the need for vertical integration of measures and advised MAP and CMS to support measures that are meaningful to providers. The state and its delivery system partners have succeeded in reducing early elective delivery rates, in part because this quality improvement opportunity was perceived as actionable. Minnesota also identified three measure gaps in the Child Core Set: opiate exposure for neonates, behavioral health functional outcomes stemming from trauma-informed care, and care coordination/case management to address social determinants.

MAP REVIEW OF THE CHILD CORE SET

MAP reviewed the measures in the Child 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 several years 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: cost as represented by hospital readmissions, care coordination, measures in the inpatient care setting, maternal/perinatal care, and behavioral health. 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 children enrolled in Medicaid and CHIP. 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 has not yet endorsed measures in all relevant topic areas. For example, MAP reviewed measures newly developed under the auspices of the AHRQ-CMS Pediatric Quality Measures Program (PQMP). This grant program was established under CHIPRA to increase the portfolio of evidence-based, consensus-driven pediatric quality measures available to the field.[33] A small number of PQMP measures have completed endorsement review, and it is likely that many more will be submitted and reviewed for endorsement in the coming year. Monitoring the development of new measures will continue to be relevant for future annual reviews.

Measure-Specific Recommendations

Current Measures

Not finding any significant implementation problems with the current measure set, MAP supported all of the FFY 2015 Child Core Set for continued use. No measures were recommended for removal. In general, MAP considers removing a measure when the following factors are observed:

- Consistently high levels of performance (e.g., >95%), 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

Maintaining stability in the measure set will allow states to continue to gain experience reporting the measures, potentially increasing the number of states using the measures to drive quality improvement locally. MAP encourages continued focus on data fidelity and strategies to improve the completeness of data reported by states on an annual basis.

Public comment generated significant discussion regarding the current measure #1799: Medication Management for People with Asthma (MMA).

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 Child and Adult Core Sets.

Measures for Phased Addition to the Child Core Set

MAP recommends that CMS consider up to six measures for phased addition to the Child Core Set (Exhibit 3, below, and Appendix D). These measures passed the consensus threshold (>60 percent of voting members) to gain MAP's support or conditional support. MAP conditionally supported measures that are not currently NQF endorsed; MAP recommends that CMS add them to the programs once the measures are fully vetted through the NQF endorsement process and the detailed technical specifications are made publicly available. Overall, public comments indicated support for MAP's recommended additions to the measure set. A small number of commenters requested the 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.

The use of the recommended measures would strengthen the measure set by promoting measurement of a variety of high-priority quality issues, including maternity care and behavioral health. MAP is aware that additional federal and state resources are required for each new measure; immediate addition of all measures supported by MAP is highly unlikely. Therefore, MAP rank ordered the measures it supports.

EXHIBIT 3. MEASURES RECOMMENDED FOR PHASED ADDITION TO THE CHILD CORE SET

Ranking	Measure Number and Title	MAP Recommendation
1/2 (tie)	NQF #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care	Support
	Use of multiple concurrent antipsychotics in children and adolescents (*Not NQF-endorsed)*	Conditional Support, pending successful NQF endorsement
3	Effective Postpartum Contraception Access (*Not NQF-endorsed)*	Conditional Support, pending successful NQF endorsement
4	Use of Contraceptive Methods by Women Aged 15-20 Years (*Not NQF-endorsed)*	Conditional Support, pending successful NQF endorsement
5/6 (tie)	NQF #1360: Audiological Evaluation no later than 3 months of age (EHDI-3)	Support
	NQF #2393: Pediatric All-Condition Readmission Measure	Support

MAP conducted a lengthy discussion of possible maternal and perinatal care measures because of the central importance of reproductive health for female Medicaid enrollees and their children. These topics also generated a significant volume of public comment. 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, emphasizing three that relate to improving birth outcomes. MAP also recommended measures in other subject areas that are important for improving quality for children with Medicaid and CHIP. Discussion of those measures follows the maternal/perinatal measures.

NQF #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care

MAP previously recommended this measure during the 2014 review. This year MAP's prioritization placed the measure at the top of the list, tying with the measure of multiple concurrent antipsychotic medications. Measure #0477 captures the frequency at which low birth weight babies are delivered at hospitals that are not ideally equipped to care for them. Availability of a Level 3 neonatal intensive care unit (NICU) is associated with better outcomes for low birthweight infants.[34] Poor results on this measure would indicate missed opportunities to provide guidance for women with high-risk pregnancies and the need to better coordinate care regionally across facilities. Public comments emphasized that accurate designation of NICUs underpins the ability to use this measure effectively and suggested that more widespread use of the American Academy of Pediatrics' criteria is needed.

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 important aspect 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 Adult Core Set.

Use of Contraceptive Methods by Women Aged 15-20 Years (Not NQF-endorsed)

This measures the rate of contraceptive use among young women who could experience unintended pregnancy. It complements a related measure of a different age group (21-44) that MAP conditionally supported for the Adult 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.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Not NQF-endorsed)

Stakeholders have become increasingly concerned about rising rates of psychoactive medication use in the pediatric population and the risks associated with those classes of drugs. While psychotropic medications are an integral part of current evidence-based treatment for mental illness, studies have found high levels of potentially inappropriate psychotropic drug use by Medicaid enrollees places these individuals at increased risk for adverse health events and death, particularly for children.[35] A state representative presented compelling data about observed overuse of antipsychotic medication, with significant variation by race and geography. After reviewing several measures that evaluate different aspects of this problem, MAP conditionally supported the AHRQ-CMS CHIPRA National Collaborative for Innovation in Quality Measurement (NCINQ) measure of

the rate at which children and adolescents are prescribed multiple antipsychotic medications. MAP intended this measure to enhance the presence of mental and behavioral health in the program. Because the measure uses administrative data, has been tested at the state level, and is included in the HEDIS program, MAP members agreed that feasibility of reporting would be relatively high.

Public comment yielded numerous requests for reconsideration of measure #2337 Antipsychotic Use in Children Under 5 Years Old. Proponents cited the fact that there are no approved uses of antipsychotic medication in this age group yet rates are rising, thus risking serious side effects including rapid weight gain and potential for diabetes. MAP had previously discussed this measure as well as seven other measures on antipsychotic use. MAP ultimately favored the measure of multiple concurrent antipsychotics, citing that it is more broadly applicable. Measure #2337 was felt to be strong, but capacity to add measures to the Core Set is limited. Additionally, participants noted that cases in which this class of medication is prescribed to a young child tend to be highly complex and lacking clear clinical guidelines. State Medicaid stakeholders have collaborated on these quality improvement opportunities and may already be tracking rates of antipsychotic use in young children independent of the Child Core Set reporting program.

NQF #1360: Audiological Evaluation No Later Than 3 Months of Age (EHDI-3)

MAP supported the addition of NQF measure #1360 to increase prompt follow-up care for infants who do not pass an initial hearing screening performed in a hospital. After learning that 2012 performance data on this measure is only 69 percent, an opportunity to improve quality became obvious. MAP agrees that this measure is an important indicator of access. In terms of alignment, the measure is also a part of the electronic health record incentive program.

NQF #2393: Pediatric All-Condition Readmission Measure

With support from the PQMP, the Center of Excellence for Pediatric Quality Measurement developed a case-mix-adjusted rate of hospital readmissions occurring within 30 days. MAP supported this measure to enhance measurement of potentially avoidable costs to Medicaid. MAP members also felt that the addition of this measure to the Child Core Set could improve discharge planning, coordination across settings, and integration with community services and supports. This measure is harmonized with #1768 Plan All-Cause Readmission Rate, which is included in the Adult Core Set. The pediatric version includes all conditions and covers patients discharged from general acute-care hospitals, including children's hospitals.

Remaining High Priority Gaps

Many important priorities for quality measurement and improvement do not yet have metrics available to address them. MAP discusses and documents these gaps in current measures to communicate its vision for the future of measurement to the developer community. Additionally, the list of measure gaps will be a starting point for future discussions and will guide annual revisions to further strengthen the Child Core Set. The Core Set includes measures related to some of the topics below, but MAP did not perceive them as comprehensive. MAP first identified other gap areas during MAP's 2014 review. An asterisk (*) denotes newly identified gap areas.

Child Core Set Measure Gaps

- Care coordination
  - Home- and community-based care
  - Social services coordination
  - Cross-sector measures that would foster joint accountability with the education and criminal justice systems*

- Screening for abuse and neglect
- Injuries and trauma
- Mental health
  - Access to outpatient and ambulatory mental health services
  - ED use for behavioral health
  - Behavioral health functional outcomes that stem from trauma-informed care*
- Overuse/medically unnecessary care
  - Appropriate use of CT scans
- Durable medical equipment (DME)
- Cost measures
  - Targeting people with chronic needs
  - Families' out-of-pocket spending
- Sickle-cell disease*
- Patient-reported outcome measures*
- Dental care access for children with disabilities – could stratify current measures*

Public commenters supported MAP's assessment of high priority measure gaps for Medicaid and CHIP enrollees. In response to the gap in measures for appropriate use of CT scans, a representative from The Joint Commission noted that their organization has become increasingly interested in this safety issue and may pursue measure development. Public commenters suggested the addition of several more measure gaps, including optimal vaccine care practices and emphasizing more measures for children with disabilities. 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 other programs relevant to Medicaid use measures in the Adult and Child Core Sets, 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, it reduces comparability and potentially adds burden and 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. CMS releases the technical specifications manual for state-level reporting 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 the oral health measures in the Child Core Set by stratifying results for children with special healthcare needs. High-quality, appropriate dental care for children with disabilities and/or behavioral health challenges is a well-documented area needing improvement. Different strata could be created for other measures, as appropriate. A public comment suggested that children in foster care may also warrant specific attention within measurement. 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 were mostly supportive of MAP's strategic recommendations. One commenter suggested that MAP further acknowledge alternate viewpoints in the reproductive health discussion to mitigate the resistance MAP and/or CMS might face with the adoption of contraceptive use measures. Comments also amplified MAP's discussion that encouraged use of measures derived from administrative and survey data, rather than chart review. Additionally, commenters appreciated MAP's emphasis on synchronizing the Child Core Set and Adult Core Set to ensure a comprehensive view of quality across an individual's lifespan.

CONCLUSION

With more than a third of the nation's children receiving healthcare through Medicaid and CHIP, it is crucial for the program to deliver high-quality healthcare. MAP's recommendations to HHS are intended to strengthen the program measure set and support CMS's goals for states' participation in the Child Core Set reporting program. MAP members found the information offered by state representatives about their implementation experiences to be highly valuable in grounding the deliberations.

To maintain stability in the measure set, MAP supports all measures in the current Child Core Set for continued use, encouraging continued focus on state-driven quality improvement projects and data accuracy and completeness. To address critical measure gap areas identified during the review, MAP recommends that CMS consider up to six measures for phased addition to the Child Core Set. MAP also refined and expanded its list of gap areas for future action.

MAP also emphasized the importance of considering the relationship of the measures across the Child and Adult Core Sets, especially regarding high-impact areas like perinatal care and behavioral health. Aligned measures will 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 informs quality improvement initiatives.

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APPENDIX A:
MAP Background

Purpose

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

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

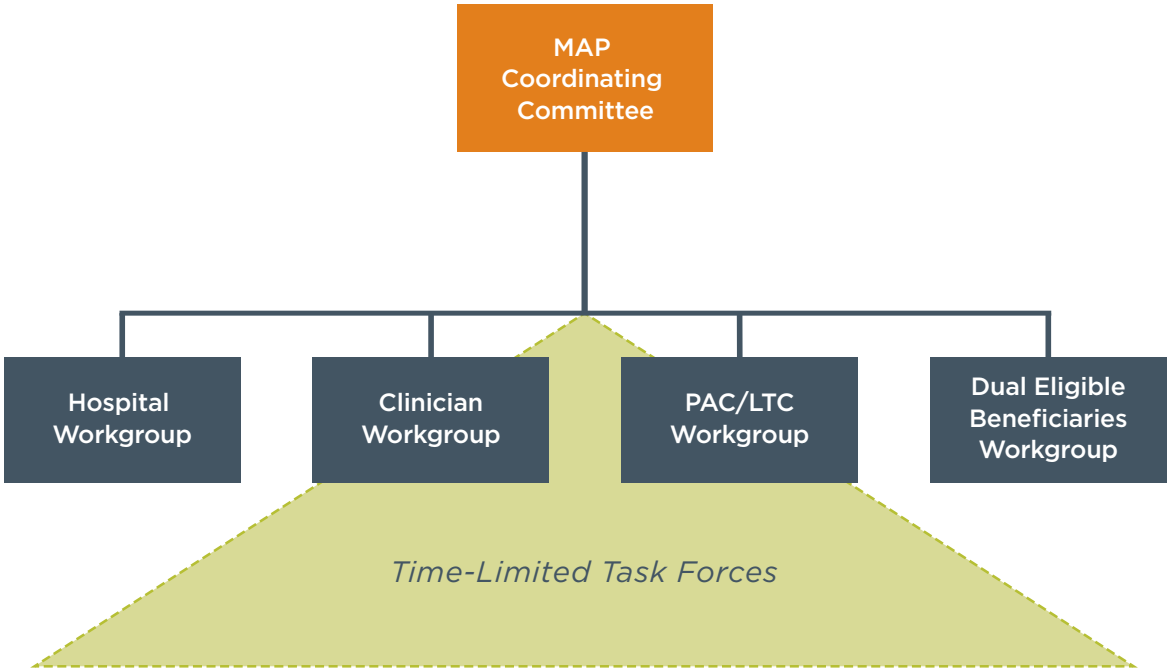
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for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

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

Measure Applications Partnership Medicaid Child Task Force

CHAIRS (VOTING)
Foster Gesten, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
Aetna	Sandra White, MD, MBA
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
American Academy of Pediatrics	Terry Adirim, MD, MPH, FAAP
American Nurses Association	Susan Lacey, RN, PhD, FAAN
American's Essential Hospitals	Denise Cunill, MD, FAAP
Blue Cross and Blue Shield Association	Carole Flamm, MD, MPH
Children's Hospital Association	Andrea Benin, MD
Kaiser Permanente	Jeff Convissar, MD
March of Dimes	Cynthia Pellegrini
National Partnership for Women and Families	Carol Sakala, PhD, MSPH

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Luther Clark, MD
Anne Cohen, MPH
Marc Leib, MD, JD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	Denise Dougherty, PhD
Health Resources and Services Administration	Ashley Hirai, PhD
Office of the National Coordinator for Health IT	Kevin Larsen, MD, FACP

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
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 MEMBERS	TITLE
Sarah Lash	Senior Director
Shaconna Gorham	Senior Project Manager
Nadine Allen	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:
Current Child Core Set and MAP Recommendations for Addition

In February 2011, HHS published the initial core set of quality measures for children enrolled in Medicaid and CHIP. The authorizing legislation also requires HHS to publish annual changes to the Child Core Set beginning in January 2013. Exhibit D1 below lists the measures included in the 2015 version of the Child Core Set along with their current NQF endorsement number and status, including rates of state participation in 2013 reporting. Not finding any significant implementation problems, MAP recommended that all measures currently in the Child Core Set continue to be used. In FFY 2015, states will be voluntarily collecting the Child 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 Child Core Set.

EXHIBIT D1. CHILD CORE SET OF MEASURES FOR FFY 2015 REPORTING

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
0024 Endorsed **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)** Measure Steward: National Committee for Quality Assurance (NCQA)	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: • Body mass index (BMI) percentile documentation • Counseling for nutrition • Counseling for physical activity	25 states reported FY 2013 Alignment: HEDIS, Meaningful Use Stage 2 – Eligible Professionals (MU-EP), Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier, Health Insurance Exchange–Quality Rating System (HIX-QRS)
0033 Endorsed **Chlamydia Screening in Women (CHL)** 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.	37 states reported FY 2013 Alignment: HEDIS, Medicaid Adult Core Set, MU-EP, PQRS, Physician Value-Based Payment Modifier, HIX-QRS
0038 Endorsed **Childhood Immunization Status (CIS)** Measure Steward: NCQA	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B(HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	34 states reported FY 2013 Alignment: HEDIS, MU-EP, PQRS, HRSA program(s), Physician Value-Based Payment Modifier

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
0108 Endorsed **Follow-Up Care for Children Prescribed ADHD Medication (ADD)** Measure Steward: NCQA	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. • Initiation Phase. The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. • Continuation and Maintenance (C&M) Phase. The percentage of members 6-12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	31 states reported FY 2013 Alignment: HEDIS, MU-EP, PQRS, Physician Value-Based Payment Modifier
0139 Endorsed **National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure** Measure Steward: Centers for Disease Control and Prevention (CDC)	Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • Other inpatient locations. (Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.	41 states reported FY 2013 Alignment: Hospital Acquired Condition Reduction Program, Hospital Compare, Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, Long-Term Care Hospital Quality Reporting, PPS-Exempt Cancer Hospital Quality Reporting
0471 Endorsed **PC-02 Cesarean Section** Measure Steward: Joint Commission	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	17 states reported FY 2013 Alignment: N/A

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
0576 Endorsed **Follow-Up After Hospitalization for Mental Illness (FUH)** Measure Steward: NCQA	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the patient received follow-up within 30 days of discharge • The percentage of discharges for which the patient received follow-up within 7 days of discharge.	28 states reported FY 2013 Alignment: HEDIS, Medicaid Adult Core Set, Inpatient Psychiatric Hospital Quality Reporting, HIX-QRS
1365 Endorsed **Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment** Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	0 states reported FY 2013 (New for 2015) Alignment: MU-EP; Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier
1382 Endorsed **Percentage of Low Birthweight Births** Measure Steward: CDC	The percentage of births with birth weight <2,500 grams	21 states reported FY 2013 Alignment: Health Resources and Services Administration/Maternal and Child Health Bureau Title V Maternal and Child Health Program
1391 Endorsed **Frequency of Ongoing Prenatal Care (FPC)** Measure Steward: NCQA	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: • <21 percent of expected visits • 21 percent–40 percent of expected visits • 41 percent–60 percent of expected visits • 61 percent–80 percent of expected visits • > or =81 percent of expected visits	27 states reported FY 2013 Alignment: HEDIS

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
1392 Endorsed **Well-Child Visits in the First 15 Months of Life (W15)** Measure Steward: NCQA	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported: • No well-child visits • One well-child visit • Two well-child visits • Three well-child visits • Four well-child visits • Five well-child visits • Six or more well-child visits	44 states reported FY 2013 Alignment: HEDIS
1407 Endorsed **Immunizations for Adolescents (IMA)** Measure Steward: NCQA	The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.	31 states reported FY 2013 Alignment: HEDIS
1448 Endorsed **Developmental Screening in the First Three Years of Life** Measure Steward: Oregon Health & Science University	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.	20 states reported FY 2013 Alignment: N/A
1516 Endorsed **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)** Measure Steward: NCQA	Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	47 states reported FY 2013 Alignment: HEDIS, HIX-QRS
1517 Endorsed **Prenatal & Postpartum Care (PPC)*** Measure Steward: National Committee for Quality Assurance *Child Core Set includes "Timeliness of Prenatal Care" rate only. "Postpartum Care" rate is evaluated in Medicaid Adult Core Set.	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	27 states reported FY 2013 Alignment: HEDIS, Medicaid Adult Core Set, HIX-QRS

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
1799 Endorsed **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.	23 states reported FY 2013 Alignment: HEDIS
1959 Endorsed **Human Papillomavirus Vaccine for Female Adolescents (HPV)** Measure Steward: NCQA	Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	23 states reported FY 2013 Alignment: HEDIS
2508 Endorsed **Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk** Measure Steward: American Dental Association on behalf of the Dental Quality Alliance	Percentage of enrolled children in the age category of 6-9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year.	0 states reported FY 2013 (New for 2015) Alignment: N/A
Not NQF-endorsed **Maternity Care: Behavioral Health Risk Assessment** Measure Steward: AMA-PCPI/NCQA/ACOG	Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: screening for depression, alcohol use, tobacco use, drug use, and intimate partner violence screening	2 states reported FY 2013 Alignment: N/A

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
Not NQF-endorsed **Children and Adolescents' Access to Primary Care Practitioners** Measure Steward: NCQA	The percentage of children 12 months – 19 years of age who had a visit with a primary care practitioner. Four separate percentages are reported: Children 12 through 24 months and children 25 months through 6 years who had a visit with a primary care practitioner during the measurement year; Children 7 through 11 years and adolescents 12 through 19 years who had a visit with a primary care practitioner during the measurement year or the year prior to the measurement year.	45 states reported FY 2013 Alignment: HEDIS
Not NQF-endorsed **Adolescent Well-Care Visits** Measure Steward: NCQA	The percentage of enrolled adolescents 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.	43 states reported FY 2013 Alignment: HEDIS, HIX-QRS
Not NQF-endorsed **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0, Child Version** Measure Steward: NCQA	This measure provides information on parents' experience with their child's health care for population of children with chronic conditions. Results include same ratings, composites, and individual question summary rates as reported for the CAHPS Health Plan Survey 4.0H, Child Version. Three CCC composites summarize satisfaction with basic components of care essential treatment, management and support of children with chronic conditions. 1. Access to Specialized Services; 2. Family Centered Care: Personal Doctor Who Knows Child; 3. Coordination of Care for CCC. Question summary rates also reported individually for summarizing the following two concepts: 1. Access to Prescription Medicines; 2. Family Centered Care: Getting Needed Information. Five composite scores summarize responses in key areas: 1. Customer Service; 2. Getting Care Quickly: 3. Getting Needed Care: 4. How Well Doctors Communicate; 5. Shared Decision Making.	41 states reported FY 2013 Alignment: HEDIS, HIX-QRS
Not NQF-endorsed **Percentage of Eligible Children Who Received Preventive Dental Services** Measure Steward: Centers for Medicare & Medicaid Services	The percentage of individuals ages one to twenty years old eligible for Medicaid or CHIP Medicaid Expansion programs (that is, individuals eligible to receive EPSDT services) who received preventive dental services.	49 states reported FY 2013 Alignment: N/A
Not NQF-endorsed **Ambulatory Care: Emergency Department Visits** Measure Steward: NCQA	The rate of emergency department visits per 1,000 member months among children up to age 19.	32 states reported FY 2013 Alignment: HEDIS

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

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

Measure Number and NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
0477 Endorsed **Under 1500g infant Not Delivered at Appropriate Level of Care** Measure Steward: California Maternal Quality Care Collaborative	The number per 1,000 livebirths of <1500g infants delivered at hospitals not appropriate for that size infant.	N/A	Support addition of this measure to the program. Enhances perinatal measures and would improve regional care coordination for high-risk pregnancies.
Not NQF-endorsed **Use of Multiple Concurrent Antipsychotics in Children and Adolescents** Measure Steward: AHRQ-CMS CHIPRA National Collaborative for Innovation in Quality Measurement (NCINQ)	The percentage of children 0 to 20 years of age on any antipsychotic medication for longer than 90 days during the measurement year who were on two or more concurrent antipsychotic medications for longer than 90 days.	HEDIS	Conditionally support addition of this measure to the program pending successful NQF endorsement. Addresses the challenges in tracking and measuring behavioral health issues in children.
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	Conditionally support addition of this measure to the program pending NQF endorsement. Enhances perinatal measures and would reduce the risk of pregnancy-related complications by increasing access to high-quality care before and between pregnancies.

Measure Number and NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
Not NQF-endorsed **Use of Contraceptive Methods by Women Aged 15-20 Years** Measure Steward: Centers for Disease Control and Prevention/ Office of Population Affairs	The percentage of women aged 15-20 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	Conditionally support addition of this measure to the program pending NQF endorsement. Enhances perinatal measures and would reduce unplanned pregnancies as well as the risk of pregnancy-related complications by increasing access to high-quality care before and between pregnancies.
1360 Endorsed **Audiological Evaluation no later than 3 months of age (EHDI-3)** Measure Steward: Centers for Disease Control and Prevention	This measure assesses the percentage of newborns who did not pass hearing screening and go on to have an audiological evaluation no later than 3 months of age.	N/A	Support addition of this measure to the program. Ensures that children enrolled in Medicaid receive follow-up care for an important developmental risk factor.
2393 Endorsed **Pediatric All-Condition Readmission Measure** Measure Steward: Center of Excellence for Pediatric Quality Measurement	This measure calculates case-mix-adjusted readmission rates, defined as the percentage of admissions followed by 1 or more readmissions within 30 days, for patients less than 18 years old. The measure covers patients discharged from general acute care hospitals, including children's hospitals.	N/A	Support addition of this measure to the program. Addresses important opportunity for quality improvement and additional cost associated with hospital readmission.

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 three NQF-endorsed measures for otitis media with effusion (OME) for inclusion in the 2015 Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP. Available OME measures owned and stewarded by the AAO-HNS include: NQF #0655: Antihistamines or Decongestants – Avoidance of Inappropriate Use; NQF #0656: Systemic Antimicrobials – Avoidance of Inappropriate Use; and NQF #0657: Systemic Corticosteroids: Avoidance of Inappropriate Use. These measures satisfy the NQS priority of affordable care.

An estimated 2.2 million episodes of OME occur annual in the United States, and roughly 90 per cent of children have OME before school age, most often between the ages of 6 months and 4 years. By the age of 2, more than 60 percent of children will experience OME.

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 alignment and stratification of current measures when possible and prioritizing current measures to help reduce the number of measures in programs. Additionally, if measures are included that require medical record review, then technical specifications for the denominator/numerator

components of medical record review should be more clearly defined.

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.

Family Voices NJ

Lauren Agoratus

In general we support the pediatric measures. However, we noticed that there was only one pediatric measure regarding children with disabilities, which was dental care. As 1 in 5 childrne have special health care needs, we would expect more pediatric measures proposed related to children with disabilities.

Futures Without Violence

Lena Orourke

Futures Without Violence thanks the National Quality Forum (NQF) for the opportunity to comment on the draft report "Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015". This set of voluntary state reporting measures provide critical data on key quality indicators on the delivery of services for children and we strongly support the continued adoption of these measures by states, and the development of the additional measures to address gaps in the core data set.

Although not all children are equally affected, the empirical literature increasingly documents that traumatic exposures are an independent risk factor for poor child health and development. When children are exposed to violence and abuse, they become fearful and repeatedly mount the "fight or flight" response. Although this stress response system is adaptive in the short-term, repeatedly activating it can lead to significant and pathological changes in brain architecture and in hormonal responses. In turn, these changes compromise children's health. Abused children and children exposed to intimate partner violence have increased risk of developing asthma and of becoming obese; they also are at elevated risk for delayed language and social development including impaired memory processing and problem solving. Furthermore, the Adverse Childhood Experience study demonstrated that childhood exposure to trauma led to increased risk-taking behaviors and higher rates of multiple diseases in adulthood.

Both the IOM and USPSTF have both recognized the importance of screening for DV/IPV as a preventive service. As part of their recommended services for women, IOM recommends "screening and counseling for interpersonal and domestic violence which involves eliciting information from women and adolescents about current and past exposures to violence and abuse in a culturally informed and supportive manner to address current health concerns about safety and other current or future health problems". The USPSTF recommends that doctors and other health care providers screen women of childbearing age for IPV and refer those

who report such violence to specialty services that address IPV.

Similarly, the MAP has previously included an important measure in the Child Common Core Measures designed to provide data on the percentage of pregnant women who are screened for exposure to intimate partner violence. Futures Without Violence has strongly supported this measure and is glad that the MAP recommends no changes to this measure. Unfortunately, according to this report, only two states have reported data on this measure. We hope that in the future more states will collect and report these data.

Mason Consulting LLC

Dave Mason

On behalf of more than 8,000 pediatric nurse practitioners (PNPs) and other advanced practice nurses committed to providing optimal health care to children, the National Association of Pediatric Nurse Practitioners (NAPNAP) is pleased to offer comments on the National Quality Forum (NQF) Measure Applications Partnership (MAP) Medicaid Child Task Force report, "Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015."

PNPs are licensed advanced practice registered nurses (APRNs) who have enhanced education in pediatric nursing and health care using evidence based practice guidelines. Dedicated to improving children's health, they practice in primary care, specialty, and acute care settings, and they have been providing quality health care to children and families for more than 40 years.

In general, NAPNAP supports the report's conclusion and recommendations. We are concerned about the emphasis placed on measures evaluating birth and contraception at the expense of advancing specific pediatric measures, given the gaps the Task Force and MAP recognize. We are troubled by the potential lack of funding needed to implement these measures and fill in critical gaps. Finally, we restate our concern that providers of care be clearly identified and accountable for meeting or failing to meet these measures.

NAPNAP and its members are committed to promoting and improving the quality of health care to meet the special needs of infants, children, and adolescents, working closely with NQF and the Agency for Healthcare Research and Quality. The association is also dedicated to identifying and providing opportunities for the implementation, dissemination, and evaluation of research-based care by PNPs.

While we deeply appreciate the opportunity to review and provide comments on this draft report, NAPNAP believes the experience and perspective provided by qualified PNPs is an essential asset to ensuring that MAP is able to develop evidence-based recommendations to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Failing to include the viewpoint of PNPs would diminish the clinical and academic perspective on which MAP's recommendations are based. NAPNAP looks forward to working with you to nominate qualified PNPs to serve as members of NQF partnerships, task forces and advisory groups.

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 Medicaid Adult 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.

U Mass Medical School

Louise Bannister

MassHealth, as a CHIPRA Quality Demonstration grantee, supports CMS' continued focus on child health quality and voluntary reporting on the Child Core Set. Information that MAP collected from States on their experience with using the Core Set demonstrates that States are reasonably able to focus on a handful of measures at a time. With voluntary reporting, states are able to dedicate resources to measurement and improvement efforts on the measures that are most relevant to, or most in need of improvement, the state.

MassHealth agrees with MAP's observations that the Child Core Set focuses well on several important domains of child health care quality (preventive, perinatal, and behavioral health, and care of acute and chronic conditions), but does not measure the full scope of care important to the health of children. We appreciate the MAP's recommendations to add new measures focusing on specific areas of particular import to children, namely interconception care, contraception, and a more in-depth focus on care for children with behavioral health care needs. These new measures will allow states to determine their performance on, and opportunities for improvement in, measures that support improvements in health, health care, and cost for Medicaid and CHIP enrolled children. In order to continue to control for the overall number of measures contained in the Child Core Set, and to support consistency in the measure set over time, to allow states to gain experience in collecting and reporting on the measures in the Core Set, MassHealth agrees that new measures should be added to the Child Core Set in a phased-in manner.

We appreciate the focus on aligning the Child Core Set with other measure sets, including the Adult Core Set. Such alignment efforts are important for managing the full scope of efforts required to comply with reporting on multiple measure sets, and minimizing the potential for duplication of data collection and reporting. We strongly encourage additional alignment of the Child Core Set with the HEDIS measure set, and encourage CMS and MAP to prioritize adding new measures which are part of the HEDIS measure set. Many states' Medicaid programs, including MassHealth, contract with NCQA-accredited Managed Care Organizations (MCOs). As these MCOs collect and report on HEDIS measures, aligning CMS and HEDIS measures sets creates administrative efficiencies, and allows states to dedicate less resources to data collection, and more to improving performance. To support the continued alignment of the Child Set with the HEDIS set, we recommend that the measure "Use of Multiple Concurrent Antipsychotics in Children and Adolescents" be prioritized for addition to the Core Set. Although not NQF-endorsed, this measure's inclusion in the HEDIS set is noted by the MAP as making it likely to be feasible for reporting.

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 multiple concurrent antipsychotics in children and adolescents' measure.

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 Health Care Quality Measures for Children Enrolled in Medicaid and CHIP. 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 Health Care Quality Measures for Children Enrolled in Medicaid and CHIP. We thank you for your consideration.

A list of references is available upon request.

American Academy of Pediatrics

Lisa Krams

AAP comments on measures recommended for phased inclusion:

Both measures recommended for phased addition related to contraceptive access are subject to variation based on factors not controllable by practitioners, e.g. culture, religious beliefs. MAP noted "potential ethical implications" and "strong agreement that the target rate...would be well below 100%." The fact that the adjustment factors might be difficult to discern from medical records or claims data would make these measures not just difficult to compute, but also could be misinterpreted by the public. While the AAP supports contraception access

for adolescents, as currently written the AAP does not support these measures.

"Use of multiple concurrent antipsychotics in children and adolescents": AAP is concerned about overuse of antipsychotic medications for children/adolescents, and recognizes that overuse is a problem in some regions and populations. Depending on the operational definition, AAP would consider supporting the inclusion of a metric to address this.

"Audiological Evaluation No Later Than 3 Months of Age (EHDI-3)" (NQF 1360): AAP supports the addition of this measure

"Pediatric All-Condition Readmission Measure" (NQF 2393): AAP supports the addition of this measure

AAP comments on gaps:

AAP agrees with the identification of care coordination as a current gap area for quality measurement, and advocates for the endorsement and inclusion of objective care coordination measures. This is a high priority for the AAP as payment and practice models for primary care services evolve.

Objective measures related to mental health are a high priority for the AAP. Care coordination requires a high degree of interaction with behavioral health services, so patient access to and utilization of these services impacts care coordination measures.

Overuse/medically unnecessary care is currently under the purview of payers. However, carefully crafted measures for providers could potentially be helpful. Overuse of CT scans is often measured by payers, and sometimes requires prior authorization, so overuse of CT scans may not be a priority starting point. Issues such as antibiotic use for hospitalized patients may have more impact.

Use of durable medical equipment (DME) is typically measured by payers as a cost item for providers. AAP's support of additional measures related to this would depend on the operational definitions of those measures. This would not necessarily be a high priority from the AAP's perspective.

Other gap areas identified in this report lack the specificity necessary for the AAP to make concrete recommendations. However, the AAP recognizes the potential for a positive impact on child health of clinically relevant, rigorously developed measures for child abuse/neglect, screening, trauma, sickle cell disease, and other topics outlined in the gap analysis.

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 and widespread implementation of the contraception composite and postpartum contraception measures in the CHIPRA Core 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." 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.

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.

Many 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

We support the recommendations and gap areas highlighted within the report as well as the emphasis on addressing the needs of children with disabilities, dental care, mental health, and contraceptives. However, sub-stratification may be inadvisable as high dental quality care should be a goal for all for children. We also would support the MAP's consideration of breast feeding, early elective delivery, and cesarean section measures.

Furthermore, children in foster care or state custody present with special needs, and unique challenges with timing of care. In addition, challenges exist with care coordination in this population. As such, quality of care for child populations in foster care should be considered a gap area for future MAP consideration. A robust infrastructure for information flow across providers and health plans will also be needed for this population.

We also support the use of measures that are not limited to children, such as #0139 National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome measure.

We continue to urge the MAP to reconsider inclusion of measures that require EHR abstraction such as Contraceptive Use by Women's aged 14-20 and measures that are not part of HEDIS, such as Low Birth Weight Infant Not Delivered at the Appropriate Level of Care.

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 and widespread implementation of the contraception composite and postpartum contraception measures in the CHIPRA Core 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." 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.

BlueCross BlueShield Association

Kerri Fei

Use of Contraceptive Methods by Women Aged 15-20 Years

While 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 Child Core Set.

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 Child Core Set.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents

While relevant to a small sub-population, Plans note that overuse of antipsychotics in adolescents is a growing area of concern. As the measure is included in HEDIS and based in administrative specifications, it is relatively easy to collect and report. Support inclusion of this measure in the Child Core Set pending NQF endorsement.

NQF #1360: Audiological Evaluation No Later Than 3 Months of Age

Plans agree that audiological evaluations in children are vitally important. More often than not, these evaluations occur at a well-child visit and are not

billed separately. Therefore, Plans would not be able to collect this measure via administrative data. Chart review would be required.

NQF#2393: Pediatric All-Condition Readmission Measure

Plans support the inclusion of this measure in the Child Core Set and note that monitoring pediatric readmissions provides an opportunity to improve outcomes and reduce avoidable costs. The alignment with NQF #1768 is noted an appreciated

Children's Hospital Association

Ruth Riggs

The Children's Hospital Association applauds the Medicaid MAP continued efforts reviewing the measures in the Child Core Set and provide recommendations to strengthen the measure set in support of CMS' goals for the program. We further appreciate the MAP identifying measure gap areas in the 2014 report.

Because of the importance of a gap analysis and the framework used to inform gaps, we encourage NQF, under the guidance of the MAP, to conduct a more thorough, systematic, and structured child health measure gap analysis. This analysis should include specific challenges for state's, as well as providers. The current gap analysis is a great starting point, and maps the measures into National Quality Strategy Priority and clinical areas, providing the reader with a count of measures from the core set within each.

The gap analysis should be a pathway forward, and, thereby, include a measure framework specific to children health care needs and use. The analysis should go beyond a count of measures; it would be more useful if it also assesses how well we are measuring these domains. Using a framework and gap analysis consistently in this manner is critical to understanding not just how many measures are in the core set (and to which domain they belong), but to our understanding whether we are adequately measuring priority and key domains for this population. This helps inform the pipeline, as well as efforts for more parsimony.

We support the decision to require NQF endorsement for the Use of Multiple Concurrent Antipsychotics in Children and Adolescents and the Effective Postpartum Contraception Access.

Based on the materials made available, it did not appear that the measure specifications were adequately detailed for consistent and reliable implementation. Putting the measures through the endorsement process will ensure that the specifications are in sufficient detail.

We understand the need to balance state resources and data limitations, but encourage the MAP to make recommendations that further replace low bar measures with those that will drive us toward better care, better child and family/caregiver outcomes, and smarter spending. A thorough gap analysis would better inform this charge.

We encourage NQF to include a gap analysis report as part of the new Pediatric Measure project.

Commonwealth of PA

Michele Robison

The Commonwealth of Pennsylvania highly recommends the 'use of multiple concurrent antipsychotics in children and adolescents' measure be included if NFQ endorses.

FDA

Mary Ghods

I support the inclusion of NQF-endorsed measure (#2337), Antipsychotic Use in Children Under 5 Years Old that measures the percentage of children under age 5 using antipsychotic medications during the measurement period.

Futures Without Violence

Lena Orourke

Futures Without Violence supports the measures that the MAP has documented in order to communicate its vision for the future. This vision clearly outlines the important relationship between trauma, care coordination, abuse and violence. In particular, the following measures will provide important quality data and will help improve care for women and children who are exposed to violence and abuse:

Care Coordination and Social Services Coordination; Cross sector measures that would foster joint accountability with education/criminal justice· Injuries

and trauma; and Behavioral health outcomes that stem from trauma-informed care.

The MAP also lists "Screening for Abuse and Neglect" as a goal for future work. As the MAP moves forward on this recommendation, Futures Without Violence supports measures that increase universal education on exposure to violence and the impact on health, as well as where to seek help if needed.

We encourage the MAP to move towards including valid measure for these factors as soon as possible.

FUTURES thanks NQF for the opportunity to comment on this important report and we look forward to future efforts to improve access to high quality health care and services for children and mothers who have experience violence and abuse.

GA Dept of Community Health

Janice Carson

Regarding the Child Core Set:

NQF #0477 - Will the specifications for this measure dictate that the AAP's criteria for designation of NICUs be utilized by all states as a matter of consistency? Will the measure specify how the NICUs are to be designated as Level 3 - will they be allowed to self designate? How will the measure take into consideration deliveries in areas where a level 3 NICU may not be accessible. This could skew the results.

NQF not endorsed Effective Postpartum Contraception Access - Is this measure specifically looking at immediate postpartum LARC utilization? If a significant percentage of women don't return for their post partum visit, this measure would essentially only track the number of women who had an immediate postpartum LARC insertion or women who were prescribed a contraceptive method and they filled the prescription prior to 60 days postpartum when their Medicaid coverage ended..

NQF not endorsed Use of Contraceptive Methods by Women Aged 15 - 20 - this measure may be controversial for states with strong views about contraceptive use in women under the age of 18.

NQF #1360 Audiological Evaluation no later than 3 months of Age - will need to review the specifications for this measure before final comments. The implication is that practitioners are able to pull data from the electronic health record for this measure but state Medicaid programs do not have access to the majority of their Medicaid enrolled providers' EHRs and would have to resort to medical record reviews to obtain this data.

GlaxoSmithKline

Christopher Cook

GSK commends MAP for their recent draft report continuing to support the inclusion of the NQF #1799 Medication Management for People with Asthma (MMA) in the Childhood 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.

HEALTH MANAGEMENT ASSOCIATES

Jodi Bitterman

As the project manager of the Florida-Illinois CHIPRA Quality Demonstration Grant, I'm submitting the following comment:

The report specifically notes in regard to the Use of Contraceptive Methods by Women Aged 15-20 Years measure that the target rate would be well below 100%. It is important to establish at the outset what benchmarks are desirable. Without a valid benchmark, it is unclear how the metric is measuring quality. Measures than cannot clearly point to quality improvement opportunities are a waste of limited state resources. With all measures, we recommend determining reasonable benchmarks at the outset.

As the project manager of the Florida-Illinois CHIPRA Quality Demonstration Grant, I'm submitting the following comments:

While the report recommends a "phased addition" of 6 new measures, it does not specifically recommend a timetable by which this phased introduction should occur. A specific timetable would better allow us to determine whether adding new measures would be feasible. While incorporating a lot of new measures at once may not be feasible due to limited resources, a phased introduction can also produce its own challenges. In Florida, Child Core Set measures are reported by MCOs and aggregated for a statewide rate. This reporting structure requires that measures are added to contracts, which is not an annual process.

Full specifications would be needed to determine the feasibility of reporting the new measures. Some factors that could render a measure immediately unfeasible could include the utilization of coding sets that a state does not collect (e.g., LOINC), or the utilization of a method that the state is unable to use (EHR or medical record). A clear understanding of the measurement specifications for proposed measures would better inform states, and thus their recommendation, on whether reporting is feasible. Likewise, adequate time is needed, after introduction, to program a new measure. In the course of the CHIPRA project, states would often have to "guess" to anticipate which measures would be included and/or retired. CMS Informational Bulletins may be helpful, but are often not getting down to state-level staff. The state, or MCOs depending on who is responsible for reporting a given measure, need time to program new measures into their systems and have them reviewed by their HEDIS auditors. Thus, there is a time lag between when Child Core Set changes are announced and when they can first be reported. Sufficient time is needed between the introduction of new measures and when they can be reported.

The addition of new measures, in alignment with CMS' stated three-part goal for the Child Core Set that includes increasing the number of measures reported by each state, implies that the Core Set will continually expand and costs of reporting will accordingly escalate. However, the increasing size of the core set may not be sustainable for states. Reporting is a resource-intensive activity. Even previously reported measures are not a no-cost proposition as the specifications must be updated in each year. In Illinois, the majority of core set measures are reported to CMS and a core set of measures is in use in managed care contracts. However, new measures, despite addition to the CMS Child Core Set, will not be added without a federal mandate that these measures must be reported.

Healthfirst

Abby Maitra

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 for stakeholders to be able to fully comment, technical specifications for this measure be publicly available. We are concerned that this is another measure that would require medical record review that 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.

Use of Contraceptive Methods by Women Aged 15-20 Years:

Hea lthfirst 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. We expect that cultural norms around sex, pregnancy, sex education and contraception among this younger demographic to vary and rates will be effected by regional differences.

Pediatric All-Condition Readmission Measure: Healthfirst does not support this measure to be added into the FOM, as the rates of pediatric admissions are significantly less than adult admission rates. Managed care plans are devoting extensive resources, money and infrastructure to ensure that care within the adult population is well coordinated and readmissions are prevented. We believe the pediatric readmission measure should be phased-in at a later time, in order to focus resources on reducing the adult all-cause readmission rate. We also recommend that (pediatric) admissions due to sequelae of the birth event be excluded from the measure.

Kaiser Permanente

Jeff Convissar

The contraceptive measures are important ones and are being promoted nationally. The IOM has set reduction of adolescent pregnancy as a core quality measure. It is a measure Kaiser Permanente can use.

Mason Consulting LLC

Dave Mason

On behalf of more than 8,000 pediatric nurse practitioners (PNPs) and other advanced practice nurses committed to providing optimal health care to children, the National Association of Pediatric Nurse Practitioners (NAPNAP) is pleased to offer comments on the National Quality Forum (NQF) Measure Applications Partnership (MAP) Medicaid Child Task Force report, "Measure Applications

Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015."

PNPs are licensed advanced practice registered nurses (APRNs) who have enhanced education in pediatric nursing and health care using evidence based practice guidelines. Dedicated to improving children's health, they practice in primary care, specialty, and acute care settings, and they have been providing quality health care to children and families for more than 40 years.

NAPNAP acknowledges the benefits of consistency between adult and pediatric core measure. However, adoption of "NQF #2993: Pediatric All-Condition Readmission Measure" raises concerns that have also been recognized with implementation of the similar adult measure regarding the measure's lack of a methodology to exclude unpreventable readmissions or readmissions unrelated to the index admission, the lack of testing to support the absence of such exclusions and concerns about the adequacy of the measure's risk adjustment methodology, which should incorporate additional factors. We would encourage future measures that account for the preventability of readmissions.

We agree with the Task Force that many important priorities for quality measurement and improvement do not yet have adequate metrics, and we generally agree with the gaps outlined in the report. We would emphasize the lack of measures for mental health screening and care, referral to necessary developmental or supportive therapies before a child enters school. We also believe it is important to focus on pediatric-specific acute care outcome measures, not measures that largely duplicate those for adult care but consider the unique health care needs of hospitalized children. NAPNAP is also troubled by the lack of measures to address the treatment of chronic illnesses in children, care coordination and to measure patient and family engagement.

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With regard to measure-specific recommendations, NAPNAP joins MAP in supporting the continued use of all of the 2015 Child Core Set measures and the consideration of additional measures to address gaps in the current Core Set.

However, NAPNAP believes that "NQF #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care," which tied as MAP's highest priority measure, is proposed to measure a missed opportunity to provide guidance and coordinate regional care across facilities. We believe that associating the location of a high-risk neonate delivery with the provision of guidance and coordination of care related to the delivery lacks validity as a measure of guidance and care coordination on behalf of the care providers. The measure, as proposed, can truly measure only where such deliveries occur. It does not have the depth to measure anticipatory guidance or care coordination. To make those assessments, we believe other better measures should be used.

National Partnership for Women & Families

Carol Sakala

The National Partnership for Women & Families strongly supports inclusion of Use of Contraceptive Methods by Women Aged 15-20 Years in the core child set. Developed by CDC but not yet considered for endorsement by NQF, this access measure 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 bel be well below 100% nationwide.

The National Partnership for Women & Families supports inclusion of Effective Postpartum Contraception Access in the Medicaid child core set. It would report the percentage of young 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 Under 1500 Infant Not Delivered at Appropriate Level of Care in the Medicaid child core set. This measure would encourage providers to ensure that the smallest babies are born in facilities that are well-equipped to care for them, versus the less safe option of transporting the newborn after the birth. It would also educate women with high-risk pregnancies on the importance of giving birth, to the maximum extent possible, at a facility that is prepared to care for a very tiny newborn. Its adoption should also help galvanize state and regional cooperation to assure these women will be able to access such facilities. Lower income women, in particular, face significant barriers, such as the lack of transportation, to assure they can get to the appropriate facility when they go into labor. Adoption of this measure can be instrumental in motivating the creation of systems that assure their needs will be met. As this measure fosters regional coordination, it is an excellent candidate for the Medicaid child core set and, indeed, the Task Force ranked it first among recommended additions to this set.

NCQA

Paul Cotton

Thank you for the opportunity to submit comments on the draft "Measure Application Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP 2015" report. NCQA generally agrees with the report overall, which will help to advance work in improving the quality of care for this imporant population.

We especially support the recommendation for CMS to consider the measure on "Use of Multiple Concurrent Antipsychotics in Children and Adolescents" as a top priority for addition to the core set. While not yet NQF-endorsed, this measure has cleared NCQA's similarly rigorous process that includes thorough review of supporting evidence, multi-stakeholder consensus vai several NCQA advisory committees and public comment. It addresses an imporant clinical issue with significant impact on the cost, quality and experience of care. It also is part of our comprehensive and widely used HEDIS measure set and thus promotes alignment across payers.

We encourage you to also consider recommending additional mesaures that address the important issue of antipsychotic medications. These include:

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. This measure assesses whether safer and potentially more cost-effective psychosocial treatment was tried as first-line treatment before prescribing higher risk and costlier antipsychotics.

Metabolic Monitoring for Children and Adolescents on Antipsychotics. This measure assesses whether children, once on these powerful drugs, are monitored for their potentially serious metabolic complication side effects.

These are both administrative mesaures that are reported with minimal burden and that address critically important areas of care. They have been through NCQA's rigorous process for developing and vetting new measures. They also are part of our comprehensive and widely used HEDIS measure set and thus promote alignment across payers.

Finally, we support the draft report's suggestion for stratification of measure results by race, ethnicity

and other relevant factors to better understand disparities. States generally have data needed for stratification. Stratification also is a more constructive approach than risk adjusting measures for socioeconomic factors as it highlights, rather than masks, disparities in care. This allows us to track improvements in reducing disparities over time, which is a key goal we all share for the core set.

Pharmacy Quality Alliance

Woody Eisenberg

PQA is pleased to comment on the recent NQF draft report: Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015. Specifically, PQA suggests that MAP supports inclusion of NQF-endorsed measure (#2337), Antipsychotic Use in Children Under 5 Years Old that measures the percentage of children under age 5 using antipsychotic medications during the measurement period.

Children with behavioral health issues deserve special attention in measurement due to their complex health needs and the impact they have on Medicaid utilization and spending. Behavioral health experts are especially concerned about the recent increase in prescribing of antipsychotic drugs, for which there are no FDA-approved indications in children under age 5 years and because of their very serious side effects including rapid weight gain and the increased risk for the development of diabetes. Studies have shown that on average, 6.2 percent of non-institutionalized children with Medicaid took psychotropic medications during a calendar year, and 21 percent of those children took an antipsychotic medication. It was separately estimated that antipsychotic use increased from 8.9 percent in 2002 to 11.8 percent in 2007 and that state-specific rates of prescribing increased in 45 states over the same time period.

RGH Health Consulting

Bob Hussey

On behalf of Wolters Kluwer, I am writing to provide comments on the recently issued draft report entitled Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015. We appreciate the opportunity to comment.

As way of background, Wolters Kluwer (WK) is a leading global provider of information, business intelligence and point-of-care solutions for the healthcare industry. Key brands include ProVation® Medical, UpToDate®, Medi-Span®, Lexicomp®, Facts & Comparisons®, Pharmacy OneSource®, Health Language and Medicom (China). Wolters Kluwer had annual revenues in 2014 of $4.9 billion.

Our comments focus on the NQF-endorsed measure #2337, Antipsychotic Use in Children Under 5 Years Old, which captures the number of children under age 5 using antipsychotic medication. We support the use of this measure in the Core Set of Healthcare Quality Measures for Children enrolled in Medicaid and CHIP. We understand that there has been a recent increase in prescribing of antipsychotic drugs for children under age 5, despite the lack of FDA-approved indications. The use of such medications in children that young can result in serious side effects, including rapid weight gain and increased risk of diabetes. Children with behavioral issues have complex health needs that should be closely monitored using such measures as NQF #2337, and we strongly urge its inclusion in the final draft of the MAP recommendations.

Thank you for the opportunity to comment.

St. Louis College of Pharmacy

Clark Kebodeaux

I support the inclusion of NQF-endorsed measure (#2337), Antipsychotic Use in Children Under 5 Years Old that measures the percentage of children under age 5 using antipsychotic medications during the measurement period.

Comments on MAP's Strategic Recommendations

American Academy of Pediatrics

Lisa Krams

The AAP anticipates that the MIPS/APM method of reimbursement that Medicare has set in motion will address many of the issues in the alignment discussion. Although not currently directed at pediatrics, we expect that these approaches will spread to private and Medicaid payers to become germane for pediatrics.

The point that overemphasized alignment could create perseveration on specific measures is correct, but ultimately fails to address the exigency that providers respond to payers' incentives, and if a particular measure set becomes generally accepted by payers, providers will concentrate efforts in those areas. In a way, that focus is helpful, because providers typically don't have the resources to "boil the ocean", but inevitably some issues will be neglected. The AAP will continue to push the important childhood concerns to the public and to payers so that the "orphan" problems aren't ignored.

The document notes that states are burdened as new measures become a priority with CMS, but it ignores the same issues for providers. Providers also must get their vendors to make IT system changes to capture new data or modify the collection of existing data, requiring time and funding. The document should reflect the burden on providers for changes in measures, as well as the problems faced by the states.

The points made in the reproductive health discussion are well-taken, but the text ignores the marked cultural and religious variation regarding the use of contraception in some regions and among some constituencies in the US. MAP needs to include some alternate viewpoints in the discussion to mitigate some of the resistance it will likely face as these measures are developed.

The problems associated with disparities in care based on socioeconomic factors are being studied by CMS and are the subject of some Medicare Advantage metrics and incentives. The use of these factors for understanding disparities in other populations, e.g. Medicaid and commercial pediatric populations, would greatly benefit child health care. The AAP strongly supports the recommendation that rational subgrouping by socioeconomic or clinical factors should be implemented for many measures of access to and outcomes of care.

Benchmarks are helpful, and the observation that unrealistically high or low benchmarks are not useful is accurate. However, one way for an organization to deal with these issues is to benchmark internally between business units or use trends to set benchmark performance. In some instances, external benchmark data are not available, and so using internal benchmarks or trends to set goals can provide a useful alternative.

America's Health Insurance Plans

Carmella Bocchino

We agree with MAP's strategic recommendations and support the concept of synchronizing the Child Core set and Adult Core set to ensure a comprehensive view of quality across an individual's lifespan. An additional important issue for consideration is optimal vaccination care practices as many providers move away from providing vaccines due to strict audit policies associated with vaccine safety.

Children's Hospital Association

Ruth Riggs

Because of the important role the MAP plays in providing input to CMS, the Children's Hospital Association encourages the MAP to clearly delineate and state the MAP recommendation for each strategic consideration.

HEALTH MANAGEMENT ASSOCIATES

Jodi Bitterman

While we appreciate the introduction of new measures to the core set, much can be done to improve the current measure set and its utility. One significant issue with current reporting is the comparability across states. States often use different reporting methods (e.g., administrative, state-level data in Illinois and medical record review MCO-level data in Florida), report measures for

partial populations (e.g., all publicly funded persons vs. those enrolled in managed care only) or with altered specifications. These changes potentially prevent comparability across states. In its first issue brief, CMS used the Core Set to discuss "higher" and "lower" performing states. CMS should ensure comparability before making these types of comparisons.

We also appreciate CMS' efforts to balance measures that are feasible to report with measures that are aligned with state goals. We urge that this balance is continually kept in mind, both in terms of the number and types of measures that are included in the Core Set. Reporting vast amounts of data that the states are not able to use to make actionable improvements – either because of the lack of improvement evidence in that area or due to the sheer volume of opportunities – will do little to improve child health. We recommend that CMS balance measures with actionable improvement suggestions.

Mason Consulting LLC

Dave Mason

On behalf of more than 8,000 pediatric nurse practitioners (PNPs) and other advanced practice nurses committed to providing optimal health care to children, the National Association of Pediatric Nurse Practitioners (NAPNAP) is pleased to offer comments on the National Quality Forum (NQF) Measure Applications Partnership (MAP) Medicaid Child Task Force report, "Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015."

PNPs are licensed advanced practice registered nurses (APRNs) who have enhanced education in pediatric nursing and health care using evidence based practice guidelines. Dedicated to improving children's health, they practice in primary care, specialty, and acute care settings, and they have been providing quality health care to children and families for more than 40 years.

NAPNAP generally agrees with the strategic issues raised by the Task Force and offers a few specific comments with recommendations.

With regard to alignment of reporting programs, we also note that many states are falling short in the timely, consistent reporting of existing measures. While we acknowledge the value of appropriate alignment as a way to make the most of scarce resources, we would underscore the Task Force's comment regarding the "distinctly different health and medical needs of the pediatric and adult population." We urge MAP to consider recommending that CMS and Congress provide meaningful incentives to states to improve the reporting of quality measures.

We support the report's recommendations that CMS enhance states' abilities to communicate through technical assistance in the reporting program and that performance benchmarks be designed to be reasonable but ambitious enough to produce meaningful improvement.

PNPs are also concerned that current measures fail to adequately identify the health care professional who is actually delivering care to patients and is directly accountable for compliance with a given measure. Identifying the provider of care is an essential element in the accountability for measure compliance. We urge MAP to consider including in its recommendations requirements to ensure that providers of care are identified and accountable for measure compliance.

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 Child 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 measure is flawed or unimportant. These and other measures could be reconsidered during a future review of the Child Core Set.

Measure Number	Measure Title	Measure Steward
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	National Committee for Quality Assurance
0138	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	Centers for Disease Control and Prevention
0344	Accidental Puncture or Laceration Rate (PDI 1)	Agency for Healthcare Research and Quality
0470	Incidence of Episiotomy	Christiana Care Health System
0478	Neonatal Blood Stream Infection Rate (NQI #3)	Agency for Healthcare Research and Quality
0480	PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice	Joint Commission
0716	Healthy Term Newborn	California Maternal Quality Care Collaborative
1335	Children Who Have Dental Decay or Cavities	The Child and Adolescent Health Measurement Initiative
1659	Influenza Immunization	Centers for Medicare & Medicaid Services
2414	Pediatric Lower Respiratory Infection Readmission Measure	Center of Excellence for Pediatric Quality Measurement
2337	Antipsychotic Use in Children Under 5 Years Old	Pharmacy Quality Alliance
2509	Sealants in 10 – 14 years	American Dental Association on behalf of the Dental Quality Alliance
n/a	Use of first-line psychosocial care for children and adolescents on antipsychotics	AHRQ-CMS CHIPRA National Collaborative for Innovation in Quality Measurement (NCINQ)
n/a	Followup visit for children and adolescents on antipsychotics	NCINQ
n/a	Metabolic screening for children and adolescents newly on antipsychotics	NCINQ
n/a	Metabolic monitoring for children and adolescents on antipsychotics	NCINQ
n/a	Safe and judicious antipsychotic use in children and adolescents	NCINQ

Measure Number	Measure Title	Measure Steward
n/a	Use of antipsychotic medications in very young children	NCINQ
n/a	Reporting on supplemental CAHPS data regarding availability of treatment or counseling services for children on Medicaid for whom the family sought treatment or counseling for an emotional , developmental, or behavioral problem	AHRQ-CMS CHIPRA Quality Measurement, Evaluation, Testing, Review, and Implementation Consortium (Q-METRIC)
n/a	Transition from pediatric-focused to adult-focused health care	AHRQ-CMS CHIPRA Center of Excellence for Pediatric Quality Measurement (CEPQM)
n/a	Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-focused Health Care	CEPQM
n/a	Pediatric Medical Complexity Algorithm Family Experiences with Coordination of Care (FECC)	AHRQ-CMS CHIPRA Center of Excellence on Quality of Care Measures for Children with Complex Needs (COE4CCN)
n/a	Mental Health Followup Measures I: Timeliness of followup visits following hospital discharge of children with a primary mental health diagnosis	AHRQ-CMS CHIPRA Collaboration for Advancing Pediatric Quality Measures (CAPQUAM)
n/a	Accurate ADHD diagnosis	AHRQ-CMS CHIPRA Pediatric Measurement Center of Excellence (PMCoE)
n/a	Behavior Therapy as First-Line Treatment for Preschool-Aged Children	PMCOE
n/a	Pediatric global health	AHRQ-CMS CHIPRA Children's Hospital of Philadelphia (CHOP)
n/a	Perinatal I: Timely temperature for all low birthweight neonates	CAPQuaM
n/a	Perinatal II: Timely temperatures upon arrival in Level 2 or higher nurseries for LBW neonates	CAPQuaM
n/a	Perinatal III: Distribution of temperatures for LBW admitted to Level 2 or higher nurseries in first 24 hours of life	CAPQuaM
n/a	Perinatal IV: Thermal condition for LBW neonates admitted to Level 2 or higher nurseries in first 24 hours of life	CAPQuaM
n/a	Assessing the availability of the preconception component of high-risk obstetrical services by estimating the use of teratogenic medications before and during pregnancy	CAPQuaM
n/a	High-risk deliveries at facilities with 24/7 in-house physician capable of safely managing labor and delivery, and performing a cesarean section, including an emergent cesarean section	CAPQuaM

Measure Number	Measure Title	Measure Steward
n/a	High-risk deliveries at facilities with 24/7 in-house physician coverage dedicated to the obstetrical service by a qualified anesthesiologist	CAPQuaM
n/a	High-risk deliveries at facilities with 24/7 in-house blood banking/transfusion services available	CAPQuaM
n/a	High-risk deliveries at facilities with Level 3 or higher NICU services	CAPQuaM
n/a	Availability of OPD maternal fetal medicine and specialty care for women with high-risk pregnancies	CAPQuaM
n/a	Availability of multidisciplinary OPD care for women with high-risk pregnancies	CAPQuaM
n/a	Obstetric trauma (3rd or 4th degree lacerations): rate per 1,000 vaginal deliveries without instrument assistance.	Agency for Healthcare Research and Quality
n/a	Severe Maternal Morbidity	Centers for Disease Control and Prevention

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