

MEASURE APPLICATIONS PARTNERSHIP

Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2016

FINAL REPORT

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QUALITY FORUM

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CONTENTS

EXECUTIVE SUMMARY	2
INTRODUCTION AND PURPOSE	4
BACKGROUND ON MEDICAID	5
STATE EXPERIENCE COLLECTING AND REPORTING THE ADULT CORE SET	8
MAP REVIEW OF THE ADULT CORE SET	11
STRATEGIC ISSUES	16
OVERARCHING POLICY THEMES	20
CONCLUSION	22
APPENDIX A: MAP Background	25
APPENDIX B: Rosters for the MAP Medicaid Adult Task Force and MAP Coordinating Committee	28
APPENDIX C: MAP Measure Selection Criteria	30
APPENDIX D: Adult Core Set and MAP Recommendations	33
APPENDIX E: Additional Measures Considered	42
APPENDIX F: Public Comments	43

EXECUTIVE SUMMARY

Medicaid covers more than 80 million Americans and enables access to care for the nation's most vulnerable individuals, including low-income pregnant women and children, people with disabilities, and low income elderly.¹ In federal fiscal year (FFY) 2014, Medicaid covered a total of 44.3 million adults, including 27.1 million nonelderly adults, 6.3 million adults age 65 and over, and 10.9 million individuals who are blind/disabled.² Among the working-age adults enrolled in Medicaid, an estimated 57 percent are overweight, or have diabetes, hypertension, high cholesterol, or a combination of these conditions.^{3,4,5} Improving the health and the healthcare of these individuals is a national priority.

The National Quality Forum (NQF) convenes the Measure Applications Partnership (MAP), a public-private collaboration of healthcare stakeholders, to provide input to the U.S. Department of Health and Human Services (HHS) on the selection of measures for use in public reporting and performance-based payment programs. In this report, MAP provides its fourth set of annual recommendations to HHS to improve the Adult Core Set of measures for Medicaid, with a focus on addressing high-priority measurement gaps. The MAP's recommendations are guided by the MAP Measure Selection Criteria ([Appendix C](#)) and feedback from three years of state implementation. MAP also provides recommendations to HHS on measures in the Child Core Set of measures, as well as measures to assess the quality of healthcare for low-income Americans eligible for both Medicaid and Medicare.

MAP supports the continued use of all **28 measures** in the 2016 Adult Core Set to advance the health and healthcare of adult Medicaid

beneficiaries. In addition, MAP supports or conditionally supports the addition of six new measures to the Core Set (see Exhibit ES1). These six measures were considered a good fit for the Core Set and were selected out of a total of 14 measures discussed by the Adult Medicaid Task Force. Adding the selected measures over time will allow states time to build their data infrastructure as well as test the implementation of measures through pilot programs. The gradual addition of measures to the core set has allowed states to build measure reporting infrastructure as evidenced by the increase in the number of states voluntarily reporting on measures. Reporting of Adult Core Set measures increased to 34 states in federal fiscal year (FFY) 2014 from 30 states in FFY 2013.⁶ MAP acknowledges that—even though states are increasingly reporting on standardized measures that can be used to compare and benchmark state performance—many gap areas, including access to primary, specialty, and behavioral healthcare and care coordination, still lack appropriate or adequate metrics for measuring quality improvement.

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

NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use

NQF #0541: Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

NQF #2607: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

NQF #2605: Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence

NQF #2829: Elective Delivery (Conditional Support*)

NQF #1799: Medication Management for People with Asthma

*MAP has conditionally supported measures that are pending endorsement by NQF, undergoing a change by the measure steward, or have not received CMS confirmation of feasibility.

This report summarizes selected states' feedback on collecting and reporting on quality measures, including challenges faced by states in implementing the core set. The MAP Medicaid Adult Task Force and Medicaid Child Task Force members and invited state representatives together explored shared issues affecting the assessment of quality in Medicaid as well as successful, state-level adoption and use of Medicaid core set measures. Themes discussed included the characteristics and purpose of measures in the core sets, data availability and accessibility issues, opportunities for innovation, the impact of collaborative learning, and state participation. Embedded in these discussions were issues and opportunities related to data collection challenges, balancing different types of measurement, and overall quality improvement goals.

MAP advocates for measuring “what matters most” and addressing issues related to alignment, care coordination, and community linkage. The discussion of alignment was extended this

year to include policy aspects and implications of alignment, care coordination, and linkage with community supports and services. These concepts were discussed within the larger framework of healthcare and with respect to the recommendations and implications of the Institute of Medicine's *Vital Signs Core Metrics for Health and Health Care Progress report*.⁷ The Task Forces also addressed alignment from a practical perspective by recommending that measure NQF #1799: Medication Management for People with Asthma—already in the Child Core Set—be considered for the Adult Core Set as well.

MAP encourages HHS to continue to engage and support states in efforts to adopt and report on quality measures. This recommendation recognizes the considerable innovation underway to implement measures at the state level. Ultimately, any core set adoption and reporting activities need to balance the cost of implementation versus benefits gained at the local, state, and national levels to improve care for Medicaid enrollees. Resources must be devoted to allow for and foster continuous quality improvement at all levels. Finally, successful innovation, implementation, and reporting of both core sets will require adequate and consistent financial investments that mirror actual resource needs.

MAP received numerous public comments on the draft recommendations for the Adult Core Set. Comments were mostly supportive of measure recommendations put forth by MAP. In addition, comments also addressed many of the policy and strategic issues noted in the report including alignment of measures across programs, a parsimonious approach to recommending and selecting measures for core sets, data collection challenges related to infrastructure and interoperability of health information systems, and the voluntary nature of the core sets.

INTRODUCTION AND PURPOSE

The Measure Applications Partnership (MAP) is a public-private partnership of healthcare stakeholders convened by the National Quality Forum (NQF). In pursuit of the National Quality Strategy goals of improving the quality, affordability, and community impact of healthcare, MAP is convened and provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and value-based payment programs. Information and background on MAP is provided in [Appendix A](#). MAP has been charged with providing input on the selection of performance measures to assess and improve the quality of care delivered to adults who are enrolled in Medicaid.

The MAP Medicaid Adult Task Force advises the MAP Coordinating Committee on recommendations to HHS for strengthening the core set of healthcare quality measures for adults enrolled in Medicaid (Adult Core Set) as well as to identify high-priority measure gaps. The Task Force consists of MAP members from the MAP Coordinating Committee and MAP workgroups who have relevant interests and expertise ([Appendix B](#)).

Guided by the MAP Measure Selection Criteria (MSC) ([Appendix C](#)), the Task Force considered states' experiences with voluntarily collecting and reporting the Adult Core Set measures when making its recommendations. To inform the Task Force's review, the Centers for Medicare & Medicaid Services (CMS) provided summaries of the number of states reporting each measure,

deviations from the published measure specifications, the number and type of technical assistance requests submitted, and actions taken in response to questions and challenges.

This report summarizes selected states' feedback on collecting data and reporting measures as presented during the Task Force's deliberations. It also includes measure-specific recommendations to fill high-priority gaps ([Appendix D](#)). In addition, the Task Force identified several strategic and policy-related issues that are also contextually relevant to the Adult Core Set. The discussion of these policy and strategic issues addresses factors that affect the programmatic success of the Adult Core Set.

This is MAP's fourth set of recommendations on the Adult Core Set; it followed a review performed in 2015. The 2016 review evaluated the measures in CMS's 2015 Adult Core Set, but used data from the FFY2014 reporting cycle. MAP recommends changes that would take effect for the 2017 Adult Core Set. In the spirit of transparency, the recommendations have been vetted through for public comment ([Appendix F](#)). The annual process of re-evaluating measures through additions and removals in the core set allows for a better understanding of the evolving Medicaid landscape, the measures in use, and how states engage with the program. HHS uses the MAP and the Task Force findings, including the state perspectives, to inform the statutorily required annual updates to the Adult Core Set.

BACKGROUND ON MEDICAID

Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals. Medicaid is financed through a federal-state partnership in which each state designs and operates its own program within federal guidelines. Medicaid is a longstanding program that served 80.6 million individuals in 2014.⁸ This figure is expected to grow as more people are newly eligible for Medicaid under the low-income adult group established by the Affordable Care Act.⁹ Currently, 40 percent of newly insured Medicaid adults are male, and this group is younger than previously covered populations, with half of the newly insured between the ages of 19 and 34.¹⁰ Medicaid also provides coverage for low-income individuals with disabilities and those who are elderly, along with supplemental coverage for Medicare enrollees, also known as dual eligible beneficiaries.¹¹

Medicaid covers a broad range of services to meet the diverse needs of its enrollees. However, states determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain “mandatory” services through the Medicaid program (e.g., hospital care, laboratory services, and physician/nurse midwife/certified nurse practitioner services).¹² Many states also cover services that federal law designates as optional for adults, including prescription drugs, dental care, prosthetics, orthotics, supplies, and durable medical equipment. Notably, Medicaid also covers a broad spectrum of long-term services and supports (LTSS) not provided by Medicare or private payers. As a result, Medicaid is the most significant source of financing for nursing home and community-based long-term care.

Medicaid Adult Population

Given the expansion of Medicaid, many previously uninsured adults are now insured for the first time.¹³ As a result of this expansion, Medicaid

covers individuals with the highest medical and social needs, many of whom could not obtain commercial insurance in the past. These adults are both poorer and sicker than low-income adults with private health insurance. These adults are clinically vulnerable and have higher rates of both multiple chronic conditions and functional activity limitations than those of the same income levels with employer sponsored insurance or even those who are uninsured.¹⁴

The Medicaid population has a high prevalence of chronic conditions such as obesity, diabetes, hypertension, high cholesterol, or a combination of these conditions.¹⁵ Behavioral health conditions are prevalent and often complicate the course of other medical conditions.¹⁶ Racial and ethnic minority populations are disproportionately represented among Medicaid enrollees, warranting attention to data stratification and addressing health disparities.

MAP’s deliberations addressed the population-specific needs and considerations of the adult Medicaid population, and recommendations in this report are based on those needs and considerations. The goal of the Task Force as well as MAP is to put forward a parsimonious, yet inclusive set of the most important measures of quality.

Medicaid Adult Core Set

The ACA called for the creation of a core set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid. HHS established the Adult Core Set to standardize the measurement of healthcare quality across state Medicaid programs, assist states in collecting and reporting on the measures, and facilitate use of the measures for quality improvement.¹⁷ HHS published the initial Adult Core Set of measures in January 2012 in partnership with a subcommittee

to the Agency for Healthcare Research and Quality's (AHRQ) National Advisory Council.¹⁸ It has been updated annually since that time, with recent iterations reflecting input from MAP.

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

The Adult Core Set is a voluntary program and a tool for assessing quality consistently within Medicaid. Prior to its creation and implementation, performance measurement varied greatly by state, this made meaningful comparisons across states impossible.

Statute requires CMS to release annual reports on behalf of the Secretary on the reporting of state-specific adult Medicaid quality information. CMS also issues reports to Congress on this subject every three years.

CMS has launched several initiatives in collaboration with states to increase reporting and use of specific measures in the core sets (i.e., Adult Core Set and Child Core Set) for improvement, for example:

- **Maternal and Infant Health Initiative.** Postpartum visits provide an opportunity to assess women's physical recovery from pregnancy and childbirth, and to address chronic health conditions, mental health status, and family planning. They also provide an opportunity for counseling on nutrition and breastfeeding and other preventive health issues. CMS's Maternal and Infant Health

Initiative aims to increase by 10 percentage points the rate of postpartum visits among women in Medicaid and CHIP in at least 20 states over a three-year period. Additionally, the Center for Medicaid and CHIP Services (CMCS) is collaborating with states to improve the rate and content of postpartum visits, and increase the use of effective methods of contraception in Medicaid and CHIP. For FFY 2014, a median of 58 percent of women delivering a live birth had a postpartum care visit on or between 21 and 56 days after delivery (n = 34 states).

Characteristics of the Current Adult Core Set

The 2016 version of the Adult Core Set contains 28 measures that are a mix of process, outcome, and experience-of-care measures (Exhibit 1 and [Appendix D](#)). There has been an increase in uptake of measure reporting by states, particularly for measures that states perceive as straightforward to collect. For example, the most frequently submitted measures are generally claims-based and aligned with other quality programs and reporting initiatives, such as the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures. Of the 28 measures, 23 are used in one or more other federal programs.

The measures in the Adult Core Set cover all six of the National Quality Strategy (NQS) priorities (Exhibit 2). Additionally, the Adult Core Set measures span many clinical conditions to represent the diverse health needs of Medicaid enrollees (Exhibit 3). Measures are not exclusive to each alignment category and can span across more than one category.

EXHIBIT 1. CHARACTERISTICS OF MEASURES IN THE 2016 ADULT CORE SET

Medicaid Adult Core Set Characteristics		# of Measures
NQF Endorsement Status	Endorsed	25
	Not endorsed	3
Measure Type	Structure	0
	Process	21
	Outcome	6
	Person and family experience of care	1
Data Collection Method	Administrative claims	21
	Electronic clinical data	18
	eMeasure available	8
	Survey data	3
Alignment	In use in one or more federal programs	23
	In the Child Core Set	3

EXHIBIT 2. MEASURES IN THE 2016 ADULT CORE SET BY NQS PRIORITY

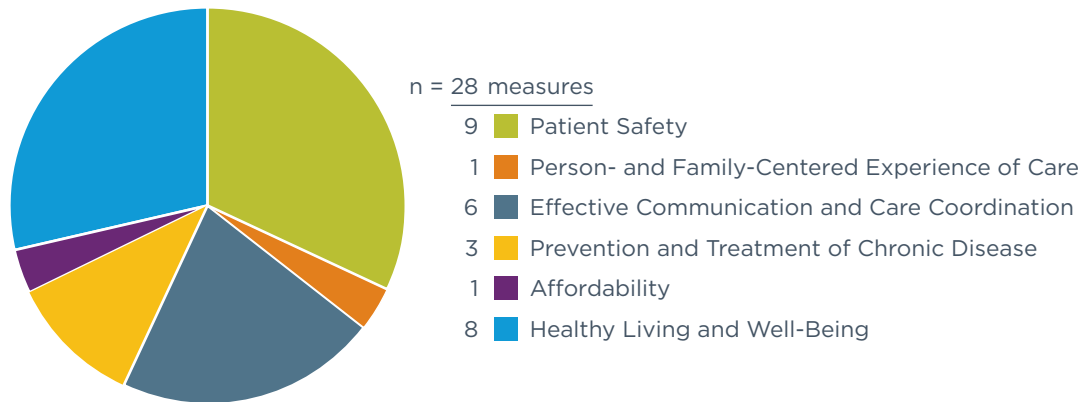
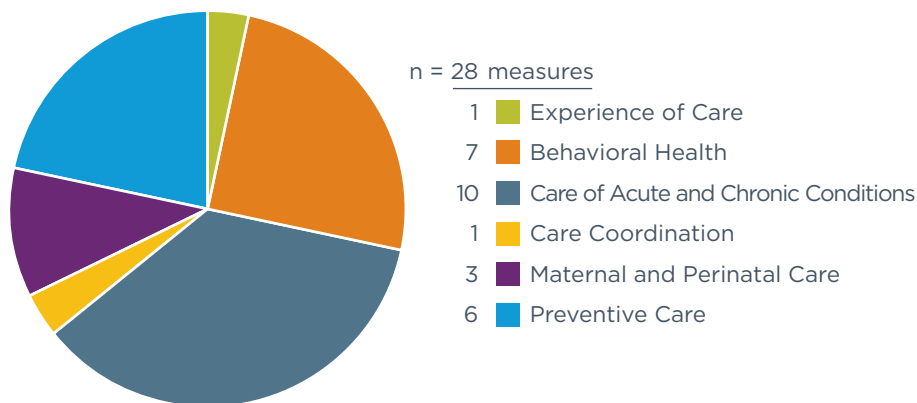


EXHIBIT 3. MEASURES IN THE 2016 ADULT CORE SET BY CLINICAL AREA



STATE EXPERIENCE COLLECTING AND REPORTING THE ADULT CORE SET

In an effort to provide well-informed and appropriate recommendations, MAP deliberations are preceded by presentations from states where Medicaid agency representatives provide an overview of their state Medicaid program as well as address their experience with collecting and reporting on the Adult Core Set. During this year's deliberations, Medicaid agency representatives from California and Oregon shared their challenges as well as successes in implementing measures from the core set. These states received the Adult Medicaid Quality Grant¹⁹ and the Children's Health Insurance Program Reauthorization Act (CHIPRA)²⁰ grants, designed to support states' efforts to improve quality as well as capacity to implement the core set measures. Both state presentations addressed new initiatives and opportunities provided by these funding vehicles. Presentations also included policy issues salient to programmatic success in adopting and reporting of the Adult Core Set at the state level, and were supplemented with data on all Adult and Child Core Set measures reported by all states.

California

California's Medicaid program, better known as Medi-Cal, serves more than 13 million beneficiaries, and almost 90 percent are in managed care. The California Department of Health Care Services (DHCS or Department) contracts with 23 full-scope Medi-Cal managed care health plans (MCPs) and three specialty health plans (SHPs) to provide healthcare services to Medi-Cal enrollees in all 58 California counties.

California's representative presented information on core set reporting, data collection related issues, and opportunities for innovation and evolution. The Medicaid agency, Medi-Cal, participated in the Adult Medicaid Quality Grant

initiative and used funds to test and evaluate the Adult Core Set measures as well as implement quality improvement concepts within the agency. In 2015, the state reported on 16 of the 26 measures (11 based on administrative data, four from hybrid and administrative data, and one hybrid-only measure). Hybrid measures use both administrative data sources and medical record data to determine numerator compliance. The majority of measures selected for reporting by the state are driven by administrative data; however, the cohort of measures implemented by Medi-Cal included some of the measures with the lowest reporting across states, such as HIV Viral Load Suppression (HVL) and Antenatal Steroids (PCO3).

Other measurement related efforts to improve health outcomes and align across payers include four major initiatives, namely Whole-Person Care Pilots, Health Homes, Coordinated Care Initiative, and Public Hospital Redesign and Incentives in Medi-Cal (PRIME).²¹ California faced some challenges during the implementation of measure collection and reporting in these programs. These challenges included the dual eligible status of Medicaid beneficiaries since they are not readily identifiable at point of care, encounter data reported by managed care plans versus data available from fee-for-service (FFS), missing laboratory results data, missing clinical data, lack of provider data, and lack of longitudinal data on beneficiaries. The measures in these programs are a mix of NQF-endorsed measures and Adult Core Set measures. Of those measures reported by the state and in these programs, 20 percent of all measures reported are defined as innovative metrics. The innovative measures are used to gather data and address gap areas in Medicaid core sets, specifically patient safety, abnormal results follow-up, and opioid use.²² However, the state representative noted that NQF-endorsed

measures and HEDIS measures are preferred because of benchmarks and predetermined thresholds of performance.

The measure gaps and measurement difficulties experienced by California reflect themes that have consistently appeared in the 2014 and 2015 Medicaid reports on the Adult Core Set. Coordination between physical and behavioral health providers, along with the lack of seamless data transmission and sharing between them, is a barrier. In such cases, the data exist, but the sharing them requires extensive inter-organizational agreements which can be resource intensive and burdensome. Another barrier is the lack of baseline data for new enrollees without prior coverage. Given these challenges, California is focusing on the alignment of care services, care coordination, linkages with community, and increasing healthcare equity as a means of addressing whole-person care.

California's representative suggested using pilot tests when adopting measure sets in programs. Policy determinations based on pilot tests address issues related to large enrollments in Medicaid with the recent increase in access to coverage, changing focus of care to a whole-person perspective, as well as the role of innovation in Medicaid. These issues and others are further explored in the Strategic Issues and Policy Themes sections of this report, where experiences shared are distilled into actionable, practical considerations for the core set as well as for the Medicaid program overall.

Oregon

Oregon's presentation focused on policy and on how the value and effect of measurement differ based on perspective. As a recipient of a Children's Health Insurance Program Reauthorization Act (CHIPRA)²³ grant for a three-state demonstration project that required inter- and intra-state implementation of the entire Child Core Set, Oregon's experiences are applicable across the

Adult and Child Core Sets.

All measures in the Child Core Set were reported by Oregon and the other two states (West Virginia and Alaska) in the demonstration project. For the MAP deliberations, Oregon's representative highlighted analysis and results for the Weight Assessment and Counseling measure, which captures the percentage of children who have evidence of BMI percentile documentation in their medical record, noting that results lack face validity. The Oregon representative noted that states need to assess measure results critically based on the intent of the measure, because measure calculations can sometimes be inaccurate where measure results do not reflect disparities at the population level. The presenter noted that the magnitude of inaccuracies in measure calculations are multiplied when measure results are aggregated and used to implement population based public health initiatives. The presenter emphasized that analysis of data as well as interpretation of results requires consideration of factors such as diversity, disparity, and health equity. Stratification of data is helpful in analyzing and in identifying differences due to disability and disparities. Therefore, Oregon stratifies all measures in use at the state level. However, analyzing trends based on administrative and hybrid data is challenging because stratification results in very small sample sizes.

The Oregon representative further stated and the Task Force members agreed that when measures are produced and implemented, the measurement results impact policy and programs, even though they may not be capturing the true population characteristics of interest. The Weight Assessment and Counseling measure, presented by Oregon, was used to exemplify this point. In light of a perceived disconnect between measure intent and measurement result, the presenter emphasized the need for feedback loops that allow for continuous quality improvement as well as political will and support at the state level to succeed in addressing population health needs while reporting on individual measures.

The presenter noted that the flexibility to modify measures in the core set is necessary for quality improvement and successful reporting. For example, implementation of CMS core set measures requires modification of specifications from the technical specifications provided, especially since measures are not developed for multiple systems of care or for multiple levels of aggregation.

Oregon's representative recommended that Medicaid population characteristics such as housing, behavioral issues, and co-morbid health issues be considered when using data collected through measurement, especially since the most vulnerable cohorts may be missing due to population instability and transiency. For example, when looking at measures related to behaviors such as smoking, and alcohol and drug use, data segmenting by age is not always helpful, since any of these behaviors can start within a wide age range and co-relate to other behavioral and or medical conditions.

The presenter emphasized that all measurement should be "actionable," such that providers can

use the data and provide follow-up services, and that compelling and meaningful outcomes are sometimes best presented through patient feedback and participation.

The presenter noted that the implications as well as the perceived applicability of data vary by perspective. Patients or the local, state, or federal governments will have different points of view. Perception is the basis of judging value versus effort, especially since a lack of value leads to the perception of burden. For successful implementation of the core set and measures in general, the value of a measure should be assessed from multiple perspectives in order to understand how the value/effort balance shifts and how to design and implement measures so as to increase the perception of value and decrease the perception of burden. To this point, MAP agreed that the need to report on measures should not lose sight of the intent of measurement, mainly improving the quality of healthcare and health improvement.

These issues and others are further explored in the Strategic Issues and Policy Themes sections.

MAP REVIEW OF THE ADULT CORE SET

MAP reviewed the measures in the Adult Core Set to provide recommendations to strengthen the measure set in support of CMS's goals for the program. Guided by MAP's Measure Selection Criteria (MSC) ([Appendix C](#)) and feedback from the most recent year of state implementation, MAP carefully evaluated current measures in the core set. The MSC are not absolute rules; rather, they provide general guidance for selecting measures that would contribute to a balanced measure set. The MSC recommend that the measure set should address the National Quality Strategy's three aims, respond 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 not in the core set and identify those with the best potential to fill gaps in the set. Using the measure gap areas identified in the 2015 review as a starting place, NQF staff compiled and presented measures in the following topic areas: access, asthma, behavioral health/substance use, engagement and activation of care, health-related quality of life, home and community-based services, maternal/perinatal care, and workforce. Task Force members identified measures for potential inclusion in the Adult Core Set as well. Consequently, MAP discussed a small number of measures that staff and individual Task Force members judged to be a good fit for the core set largely based on the measure specifications, the MSC, and the feasibility of implementing them for statewide quality improvement. All MAP Task Force members also had the opportunity to put forth other available measures for discussion and consideration during the in-person meeting.

MAP examined NQF-endorsed measures and other measures in the development pipeline. MAP generally favored measures that can be implemented at the state level, promote parsimony and alignment, and address prevalent

or high-impact health conditions for adults enrolled in Medicaid. NQF-endorsed measures, when chosen, were selected because they have been successfully evaluated through a separate consensus-based process for evidence, opportunity for improvement, and scientific acceptability of measure properties. Following discussion of each measure, MAP voted to determine if there was sufficient support from Task Force members to consider the measure for addition to the core set. The measures that MAP reviewed and voted on but did not ultimately support for use in the program at this time are listed in [Appendix E](#).

NQF-endorsed measures are not available for all relevant gap areas identified for the Adult Core Set. Understanding this, MAP did not restrict its review to endorsed measures. Task Force members participating in the process helped to bring measures in the development and endorsement pipeline—such as AHRQ-CMS Pediatric Quality Measures Program (PQMP) measures—forward for consideration. For example, MAP examined measures related to maternal/perinatal care that have not yet been reviewed for endorsement. Monitoring the development of new measures will remain essential for future annual reviews.

Measure-Specific Recommendations

Current Measures and Recommendation for Removal

MAP noted that states' participation in voluntarily reporting the Adult Core Set is strong, though there is much room for improvement in both the total number of states submitting measurement data and the number of states reporting each measure. Because the Adult Core Set is newer, participation is expected to be lower than for the Child Core Set, but ideally will increase each year.

MAP was comfortable supporting all measures for continued use. This decision was based on considerations such as allowing sufficient time for states to build their data and information technology infrastructure. Maintaining stability in the measure set will allow states to continue to gain experience reporting the measures, potentially increasing the number of states submitting quality information to CMS and using the measures locally to drive quality improvement.

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

- Consistently high levels of performance (e.g., >95 percent), indicating little opportunity for additional gains in quality
- Multiple years of very few states reporting a measure, indicating that it is not feasible or a priority topic for improvement
- Change in clinical evidence and/or guidelines that have made the measure obsolete
- Actionable information not yielded by the measure for the state Medicaid program or its network of providers
- Availability of a superior measure on the same topic, warranting a substitution

Measures for Addition to the Adult Core Set

MAP and the Medicaid Adult Task Force jointly suggested that CMS consider the following six measures for addition to the Adult Core Set (Exhibit 4, below, and [Appendix D](#)). These measures gained support or conditional support for addition by receiving more than 60 percent approval by voting Task Force members. Measures that are not currently NQF-endorsed are supported conditionally; MAP and the Medicaid Adult Task Force recommended that CMS add them to the programs once endorsement review is complete and the detailed technical specifications are made publicly available.

MAP and the Adult Medicaid Task Force are aware that additional federal and state resources are required for each new measure, and therefore the immediate addition of all six recommended measures supported by MAP to the Adult Core Set is highly unlikely. Given the burden of additional measurement requirements, MAP recommended measures that address gap areas such as behavioral health, preventive care and screening, medication adherence, and asthma.

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

Measure name and NQF number

NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use

NQF #0541: Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

NQF #2607: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

NQF #2605: Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence

NQF #2829: Elective Delivery (Conditionally Support)*

NQF #1799: Medication Management for People with Asthma

* MAP has conditionally supported measures that are pending endorsement by NQF, a change by the measure steward, CMS confirmation of feasibility, etc.

The use of recommended measures would strengthen the measure set by promoting measurement of a variety of high-priority quality issues, including maternal/perinatal care, chronic disease management for people with serious mental illness, medication adherence, asthma, and follow-up post screening for alcohol use. Further explanation and rationale regarding MAP's support for these measures is presented below. Overall, public comments supported MAP's recommended additions to the measure set. A small number

of commenters requested the addition of contraceptive care measures; these were reviewed but failed to gain greater than 60 percent of MAP's support.

NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use

The Adult Medicaid Task Force recommended the inclusion of this measure as a way to capture data on those who receive treatment following screening for behavioral health issues. The measure addresses the behavioral health gap area. Additionally, this measure fosters the principles of care coordination through screening and follow-up counseling, especially since effectiveness of screening presupposes follow-up services such as counseling would be provided. MAP discussed the measure's ability to "cut across the broad swath" of the Medicaid population, and have an impact on care management for a lot of conditions. This measure assesses the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within the last 24 months of the measurement year using a systematic screening method and who received brief counseling if identified as being at risk from unhealthy alcohol use.

NQF #0541: Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

This measure assesses the percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80 percent or greater during the measurement year for three medication categories (computed separately): renin angiotensin system (RAS) antagonists, diabetes medications, and statins. This measure addresses patient adherence by evaluating the supply of chronic medication available to the patient over time. MAP agreed that this is important because successful treatment of chronic conditions requires consistent medication management and patient adherence to taking prescribed medications. The measure is currently undergoing annual update through NQF's maintenance review process. The majority of commenters supported the inclusion

of this medication adherence measure, noting that the measure aligns with other quality programs (e.g., Medicare STARS, the Health Insurance Marketplace Quality Rating System) and will provide health plans and states with valuable quality improvement related information.

NQF #2607: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

MAP favored this measure as a complement to NQF #0059, Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%), which is already in the core set. MAP agreed that this measure addresses chronic disease management for people with serious mental illness, and assesses integration of medical and behavioral services by reinforcing shared accountability and linkage of medical and behavioral healthcare services. MAP noted that this measure allows for capturing and addressing any disparities in the treatment of individuals with serious mental illness compared to the general population. This measure was initially discussed during the 2015 review. This measure assesses the percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0 percent (indicating poor control). The measure captures an intermediate outcome through an out-of-range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage.

NQF #2605: Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence

This measure was initially discussed by MAP in 2015 but not recommended and re-visited again during the current MAP Medicaid 2016 discussions. Updates made to the measure helped influence MAP's decision to recommend it. This measure has been included in the HEDIS 2017 measure set. Therefore, Medicaid, Medicare, and commercial plans will start reporting it using 2016

calendar data. Also, this measure addresses the gap areas of access and follow-up of care. This measure assesses the percentage of discharged patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year and who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within seven to 30 days of discharge.

NQF #2829: Elective Delivery

This measure assesses patients with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed. It is an electronic clinical quality measure (eMeasure) format of NQF measure #0469 PC-01 Elective Delivery, already a measure on the adult core set. MAP noted that many state governments are looking at elective delivery and wanted to provide states with more eMeasures in the Adult Core Set. Because this is an eMeasure, addition of this measure would provide greater choice with regard to measure formats. This measure is conditionally supported pending NQF endorsement. The 2015-2016 Perinatal and Reproductive Health Standing Committee is also considering this measure. The measure was recommended for endorsement by the 2015-2016 Perinatal and Reproductive Health Standing Committee and has been released for public and member comment.

NQF #1799: Medication Management for People with Asthma

This measure assesses adherence to long-term asthma controller medications in patients with persistent asthma. The measure assesses the percentage of patients 5 to 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. MAP initially

recommended this measure during its 2014 review and then again during the 2015 review, but CMS has not yet added it to the Adult Core Set. During its 2015 review, MAP received comments that alternative asthma medication measures, like NQF #1800: Asthma Medication Ration (AMR) and NQF #0548 Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT), may be more appropriate for inclusion in the core set. As requested by the MAP Coordinating Committee, the MAP Adult Task Force members examined both alternative measures during its 2016 review. Once again, MAP recommended measure #1799 to address medication management for the adults in the Medicaid population who have asthma. Since this measure is already part of the Child Core Set, MAP highlighted the importance of alignment between the two core sets. After completing maintenance review in the Pulmonary and Critical Care 2015-2016 project, this measure lost NQF endorsement. A few comments supported this measure, noting potential alignment between the Adult and Child Core Sets.

Remaining High-Priority Gaps

The Task Force also recommended that the Adult Core Set be strengthened by adding measures in key areas to address identified gaps in the current measure set. Gap areas were identified from state feedback, review of state reporting, and data on prevalent conditions affecting the adult Medicaid population. Although the Adult Core Set includes some measures pertaining to some of these topics, the Task Force did not perceive the measure set as sufficiently comprehensive. Several of the gaps identified during this review were also identified during MAP's 2015 deliberations. An asterisk (*) denotes newly identified gap areas. This list of measure gaps will be a starting point for future discussions and will guide MAP's input on strengthening the Adult Core Set.

Adult Core Set Measure Gaps

- Access to primary, specialty, and behavioral healthcare
 - Access to care by a behavioral health professional
- Behavioral health and integration with primary care*
- Beneficiary-reported outcomes
 - Health-related quality of life
- Care coordination
 - Integration of medical and psychosocial services
 - Primary care and behavioral health integration
- Cultural competency of providers
- Efficiency
 - Inappropriate emergency department utilization
- Long-term supports and services
 - Home and community-based services
- Maternal/Reproductive health
 - Inter-conception care to address risk factors

- Poor birth outcomes (e.g., premature birth)
- Postpartum complications
- Support with breastfeeding after hospitalization
- Promotion of wellness
- Treatment outcomes for behavioral health conditions and substance use disorders
 - Psychiatric re-hospitalization
 - Follow-up
 - Clinical improvement
- Workforce
- New chronic opiate use (45 days)
- Polypharmacy
- Engagement and activation in healthcare
- Trauma-informed care

Public commenters supported MAP’s assessment of high-priority gap areas for the Medicaid adult populations. One commenter suggested consideration of measures that focus on outcomes and that lead to value-based performance, urging MAP to consider measures that assess prevention and social determinants of health.

STRATEGIC ISSUES

As healthcare payments move from volume to value, the quantification and assessment of value becomes an integral part of that process. One of the most prevalent ways to assess value of care quality, even if indirectly, is through the use of quality metrics and performance measurement. The Medicaid Adult Task Force and the Medicaid Child Task Force members and state panelists held joint deliberations to explore shared issues of strategic importance that affect the assessment of value in Medicaid. The themes discussed included the characteristics and purpose of measures in the core sets, data, innovation, and state participation. Embedded in these discussions were issues and opportunities related to data collection challenges, balancing different types of measurement, and overall quality improvement.

Comments from health plans, specialty providers, consumer advocates, and other stakeholders were supportive of these strategic issues. They highlighted and further elaborated on topics such as data challenges related to data collection and reporting infrastructure, and interoperability of electronic health records. Commenters also addressed the issue of burden relative to the type of measure, i.e., a measure based on a hybrid of medical records and administrative data versus a measure based on claims data. Commenters also reflected on how relative stability in the measures included in the core set limits burden that would otherwise result from more frequent changes in the composition of the core set.

Measure Characteristics

The joint discussions started with an analysis of the characteristics and purpose of measures available for reporting as well as the opportunities for quality improvement provided by their individual attributes. Determination of measure characteristics, as in how a measure is described and implemented, is based on the use and

purpose of the measure. The members of both Task Forces further suggested that measures could be categorized as analytic, improvement, and/or accountability measures. These are not mutually exclusive categories.

- Analytic measures are descriptive and are characterized by a lack of clear benchmarks backed by empirical data. Therefore, the measures are used to explore variations and address questions related to the results that may be affected by artifacts of data collection.²⁴
- Improvement measures are intended primarily for quality improvement. These measures are used to improve care quality through monitoring and data analysis. MAP noted that these measures hold the most promise as tools for quality improvement within Medicaid.²⁵
- Accountability measures are used to hold providers and organizations accountable for care quality. With these measures, payment is linked to reporting and performance benchmarks. The purpose of these measures is to promote transparency through mandated reporting of measure results. As such, there is a higher standard applied with regard to scientific acceptability.

Mandatory Versus Voluntary Reporting

In discussing these measure characteristics, Task Force members explored the implications and benefits of the voluntary nature of reporting in the Medicaid program. A majority of the discussants agreed that voluntary reporting allows for innovation as well as provides flexibility needed to address quality at the state level, and public comments echoed this sentiment. Flexibility is especially important since the core sets are

relatively new, and states are at various stages of developing the infrastructure needed for measure adoption and reporting. However, a minority of members argued that requiring reporting of core sets through a mandate can be an impetus for states to prioritize resources for data reporting and quality improvement infrastructure development. Some Task Force members noted that mandates can also impede quality improvement by changing the focus from improving quality to fulfilling the reporting requirement.

Data Collection Burden

This discussion around reporting introduced issues related to resource availability and data collection burden for hybrid and medical record measures. Measures requiring abstraction of medical record data—either alone or in conjunction with use of administrative data—are the most burdensome. The high level of effort or cost can thus drive the decision not to report on the measures. States attribute their decision not to report on certain measures—or attribute low reporting rates—to the requirement that medical records or a hybrid of medical records and administrative data be reviewed.²⁶ In furthering this discussion, the Task Force members and the state panelists acknowledged both the burden as well as the value of outcome and hybrid measures, especially in comparison to claims based process measures. As a way forward, the group emphasized the need for balancing of measure types in the core sets. This need for balance was reaffirmed in public comments. The group agreed that the relative nascence of the core sets, along with the amount of resources needed to build infrastructure, makes a strong case for allowing the Medicaid Adult and Child Core Sets to mature over the next few years. Factors that will facilitate this maturation include data considerations, innovation, and support for states.

Data Specificity

The Task Force discussed the ease of collecting claims-based data versus conducting medical record reviews and or collecting hybrid measure data (i.e., data from both administrative claims and medical records). Administrative data generally lack clinical granularity and other features of care delivery not related to the core function of billing and financial accountability. This has important implications for whether clinicians accept quality improvement efforts and find them useful. The group noted that bundling of services, for example, can limit the specificity of conclusions, where payment is provided for a service bundle and therefore individual codes may not be submitted for those services. Task Force members agreed that requiring physicians to provide individual codes for the bundled services would require additional effort, and thereby diminish the value of bundling from the provider’s perspective. In this regard, the movement toward “value based payments” and “global payments” may run counter to a desire for greater specificity in coding procedures, services, and interventions in order to enhance the utility of billing data.

Data Availability/Accessibility

Task Force members agreed that any consideration of data needs to address the expansion of coverage and the recent growth of the Medicaid population. It is well accepted that longitudinal data allow for analyzing changes in quality over time. However, a lack of data on newly insured Medicaid enrollees—who are entering the Medicaid system through coverage expansions—affects baseline determinations of overall care as well as health quality, which in turn affect the ability to capture changes in health or care for these individuals. Another data-related consideration is the lack of seamless sharing of behavioral and physical health information. This barrier can result from local, state, and federal regulatory requirements, where resource intensive

processes of obtaining inter-organizational data sharing agreements hinder data integration and sharing. The Task Force noted that organizations are often reluctant to share data across different settings of care. However, this issue of inaccessibility is multifaceted and includes technology limitations, mainly interoperability, and data mining considerations along with regulation-based barriers.

Ownership of data leads to fragmented data repositories. The need for data sharing agreements adds another layer of burden to an already strained healthcare system. The Task Force noted that in our medically focused system, data sharing is structured and includes firewalls based on varied clinical parameters, thereby creating artificial barriers to access. Task Force members discussed the implications of not sharing data, and noted that a path forward has to allow for bi-directional flow of information between different organizations, providers, and care settings such as medical and behavioral care.

The Task Force noted that future success will require adequate information technology infrastructure to capture specific data and make that data available. However, in some cases when data are unavailable, flexibility is needed to substitute measures and capture necessary care-related information. The Task Force acknowledged that data issues will always exist, along with resource allocation issues. As a result, evolution of the use of the core set, along with participation in data collection, will rely heavily on innovation both at the federal and state levels. MAP encouraged the Medicaid Adult and Child Core Set programs to continue to foster this innovation through grants and other supports.

The Task Force members also acknowledged the potential value of emerging health technology as a means of capturing data and reporting on measures using the data, through vehicles such as health exchanges, as well as registries. Although registries are primarily a clinical tool to facilitate ongoing care management, they can also serve

as a data repository related to outcomes of care. Many states use data sources such as registries to productively link Medicaid data to population health data using birth and death records.

Innovation

The success of the Medicaid program depends on the ability to innovate at the state level. Task Force members noted that innovation can be as minor as repurposing current patient experience surveys as mobile applications or as major as improving data infrastructure and interoperability of information technology. However, it will always be difficult to assess the impact of innovation in the short term. The Task Force members, as well as the state panelists, agreed that innovation is happening in measurement; however, the information regarding innovation is not readily available beyond those achieving the innovation. This may create inefficiencies through duplication of efforts at various levels and across states.

The meeting discussions highlighted that the voluntary nature of the Medicaid core sets allows for innovation, especially when measures need to be adapted for local considerations or used in novel ways for understanding variation or for improvement. To maximize the value of this voluntary effort, resources are needed to ensure effective communication, shared learning, and collaboration among states for improving technology, data systems, and measure applications. As the core sets evolve along with the Medicaid program, opportunities for learning and innovation are central to fostering state participation in data collection and submission.

State Participation

The ultimate goal of addressing data issues as well as innovation is to increase voluntary state participation in core set reporting. To this point, both Task Forces as well as the state panelists noted that reporting is affected by other factors such as measure alignment, cost of data abstraction, and infrastructure, along

with the intent of reporting. Task Force members acknowledged that the CHIPRA and Adult Medicaid Quality grants have helped states build infrastructure; however, the grants are finite, the need for infrastructure development and maintenance is ongoing. This issue of infrastructure for reporting can also be addressed through alignment of initiatives. The Task Force noted that aligning various quality improvement initiatives and measurement requirements across public and private sectors as well as core sets allows for economies of scale at the state level, where the same infrastructure and data can be used to fulfill multiple reporting requirements. Currently, states are circumspect in choosing measures to report based on the relative burden required to do so. Therefore, alignment of initiatives and measurement will alleviate the need to choose among competing initiatives and thereby increase overall reporting rates across states and providers.

Alignment in itself does not alleviate the need for building infrastructure and capacity. However, it does allow for focused improvements, where the cost of capacity-building can be dispersed through many different funding streams. Task Force members noted that data collection and reporting

at the state level currently vary between fee-for-service (FFS) and managed care in Medicaid. The type of delivery system affects measurement as much as the goals of measurement. For example, managed care is less likely to report on measures with high provider performance, since their focus is to manage cost and improve performance; whereas, states have more control in collecting data from FFS plans. Plans are also more likely to report on HEDIS measures compared to others in the core set. The Task Force noted that higher levels of measure reporting by all states will require reporting mandates. Additionally, states will need to innovate in measurement based on state-specific needs and resources so as to maximize the use of the core sets.²⁷

Task Force members as well as state panelists encouraged CMS to engage and support states in efforts to adopt and report on measures. This recommendation included consideration for innovation happening at the state level as well as allowing for a degree of flexibility at the point of implementation. Ultimately, any core set adoption and reporting activities need to balance the cost of implementation versus benefits gained at the local health system, state, and federal levels.

OVERARCHING POLICY THEMES

Background

The rapid growth and adoption of quality measurement has created a proliferation of measures. This proliferation has increased the burden on providers and hindered benchmarking efforts due to a lack of alignment and harmonization within areas of measure focus. Given the expansion of the number of measures as well as increased requirements for reporting, measure developers, policymakers, and quality improvement organizations are slowly changing their focus to create parsimony, alignment, and harmonization among the existing measures.²⁸

As part of this effort, the Task Force discussed the **Vital Signs Core Metrics for Health and Health Care Progress report** from the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine). The report describes the Vital Signs core metrics as a parsimonious set of measures for health and healthcare that can contribute to reducing the burden of measurement and improving health outcomes nationwide.²⁹ The report advocates for measuring “what matters most” and aims at addressing some of the performance measurement gap areas addressed by both the Medicaid Adult and Child Task Forces, such as chronic condition measures in the ambulatory setting for prevalent conditions such as diabetes. MAP considered the overall intent of the report and discussed issues around alignment, care coordination, and community linkage.

Public comments amplified MAP’s discussions in these areas by highlighting the importance of alignment across core sets and reporting requirements while balancing the need for parsimony and measure set stability with the need to evolve and stay current through the addition of new measures.

Alignment

Previous iterations of the core set reports have looked at macro-level alignment of measures between the Adult and Child Core Sets. The intent of measure alignment is to decrease burden and stretch available resources to the maximum and use the same data collection and reporting infrastructure for multiple measures. The focus of alignment across measures has mostly been in the area of perinatal and maternity care, as this is a frequently measured topic across the core sets.

Task Force members acknowledged that alignment is a broader concept and expanded their focus from a concentration on specific measures to a fuller discussion encompassing the types of alignment as well as conceptualizing alignment at the point of implementation. The group discussed how alignment can be defined as the same measure, the same measure concept, or the same measure across multiple different programs, populations, or ages.

The MAP Coordinating Committee’s 2015/2016 definition of alignment as the use of the same or a related measure unless there is a compelling reason for multiple similar or narrowly focused measures was revisited as a starting point for discussion.³⁰ The Task Forces and state panelists expanded MAP’s definition with the understanding that alignment can be viewed as mandated alignment of measures (of specific measures or of measure concepts) or alignment of measurement methodology. Alignment of measure concepts allows for flexibility and variation as long as the conceptual basis for measurement is held constant. In contrast, alignment of specific measures is more restrictive and requires the same measure to be implemented across the board. The value of the conceptual alignment is in the flexibility it allows for balancing the goal

of measurement with the effort required for implementation.³¹

The Task Force noted that alignment should also consider data implications such as time intervals and alignment across different age groups, (i.e., infancy, childhood, adolescence, adulthood). Another data issue to consider in alignment is the level of comparability. If the extent of variation between measures is not known, then two measures addressing the same concept can be capturing disparate data. For example, measuring assessed versus actual measured ranges of HbA1c provides different information, and these are two different measures capturing different but related data. The appearance of comparability does not always equate to actual comparability.

Ideally, alignment would address all levels and components of the Medicaid system within a state as well as across states, including health plans and managed care organizations. However, this system level alignment requires resources for which states need to make a political as well as policy case. Task Force members noted that performance measures and performance measurement are complex, and explaining this complexity to policy makers requires a clear clinical and policy rationale. The eventual success of the core sets will depend on building political will and financial sustainability by focusing on clearly demonstrable results of measurement that affect health, healthcare, and value.

Care Coordination

Given the importance of integrating behavioral health and primary care as well as coordinating care for Medicaid beneficiaries more generally, Task Force members and state presenters noted that no formal or standard definition of care coordination currently exists at the federal level. The absence of a clear definition along with a lack of financial and structural integration for most healthcare environments creates ongoing challenges in the development of viable care coordination measures.

Given the potential benefits of care coordination, Task Force members recommended that one way to promote successful care coordination across all states is to allow physicians and other appropriately trained professionals to code for it and bill for care coordination as a separate service. The Task Force recognized that this would require the development of new codes as well as allocation of resources to compensate for care coordination services. The Task Force noted that complex care management codes are currently being reimbursed by the Medicare program, and suggested that CMS should clarify if state Medicaid programs can get a federal match for those codes.

The Task Force members also noted that care coordination is a concept that may look different based on patient needs and the lens of analysis. For example, a chronically ill adult may need care coordination in the form of support with coordinating clinical care; whereas, a child with disabilities may need a lot more coordination including management of connection to supports and services for clinical and behavioral health, including rehabilitation and social services.³² Accordingly, Task Force members suggested that future discussions regarding care coordination should evolve to address available models and frameworks,³³ and acknowledged that successful adoption of care coordination at the state level will require resource allocation and availability of services.

Community Linkage

In discussing care coordination and the Vital Signs report, the Task Force members also addressed the importance of coordination across medical, behavioral, and community supports and services through integration and community linkages. Task Force members noted that homelessness is a major issue for many Medicaid recipients, especially for those seeking care in the behavioral health setting. Ideally, providers should conduct an assessment of housing stability and link enrollees

with appropriate community services. However, Task Force members acknowledged that most community supports and services organizations are financially challenged nonprofit organizations and may not have adequate resources to provide support for large populations in need. This issue is magnified when considering the increase in the number of Medicaid enrollees. The Task Force

members expressed concern that these individuals may present with needs for care coordination and linkage with community supports and services that far exceed the capacity of the social service and support system. Moreover, even if these organizations are providing services, capturing the long-term outcomes of these services is difficult.

CONCLUSION

With the expansion of the Medicaid adult population, the need for measures in the Medicaid Adult Core Set has become critical not only to assess the appropriateness of care, but also to capture population-level improvements in health. MAP's recommendations to HHS are intended to strengthen the program measure set to increase state participation in reporting and inform quality initiatives. MAP supported all current measures in the Adult Core Set for continued use in the program. This year's recommendations for new measures focus on the high-impact areas of behavioral health, medication adherence, asthma, and reproductive health. MAP recommended a total of six measures for addition to the Adult Core Set over time.

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

MAP also emphasized the importance of considering the overlap and alignment of the measures across the Child and Adult Core Sets, especially for high-impact conditions like reproductive and behavioral health. Alignment of asthma measures was promoted in the current cycle of review with the addition of an asthma measure that, if added to the Adult Core Set, would span both core sets. Aligned measures are expected to result in less burdensome data collection, and ultimately, better rates of state reporting. MAP will continue to collaborate with CMS as infrastructure is enhanced to support states' efforts to gather, report, and analyze data that inform quality improvement initiatives.

The discussion of alignment was extended this year to include policy aspects and implications of alignment, care coordination, and linking with community supports and services. The goal is to address both Adult and Child Core Set evolution within the changing policy structure of the Medicaid program and the evolution of thinking regarding "measures that matter."

ENDNOTES

- 1 HHS. *2014 CMS Statistics*. Baltimore, MD: Centers for Medicare & Medicaid Services (CMS); 2013. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf. Last accessed June 2016.
- 2 HHS. *2014 CMS Statistics*. Baltimore, MD: Centers for Medicare & Medicaid Services (CMS); 2013. Table I.16. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf. The blind/disabled total includes some children.
- 3 Kaiser Family Foundation (KFF). *Low-Income Adults Under Age 65-Many are Poor, Sick, and Uninsured* [policy brief]. Washington, DC: KFF; 2009.
- 4 Government Accountability Office (GAO). *Medicaid Preventive Services: Concerted Efforts Needed to Ensure Beneficiaries Receive Services*. Washington, DC: GAO; 2009.
- 5 Damler R. Medicaid expansion under the Affordable Care Act. *Health Watch*. 2013;73(October):31-34.
- 6 HHS. *2015 Annual Report on the Quality of Care for Adults in Medicaid*. Washington, DC: HHS; 2015.
- 7 Blumenthal D, Malphrus E, McGinnish JM, eds. *Vital Signs Core Metrics for Health and Health Care Progress*. Washington, DC: National Academies Press; 2015. Available at <http://iom.nationalacademies.org/Reports/2015/Vital-Signs-Core-Metrics.aspx>. Last accessed June 2016.
- 8 HHS. *2014 CMS Statistics*. Baltimore, MD: Centers for Medicare and Medicaid Services (CMS); 2013. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf. Last accessed June 2016.
- 9 HHS. *Medicaid & CHIP: February 2015 Monthly Applications, Eligibility Determinations and Enrollment Report*. Baltimore, MD: CMS; 2015. Available at <http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-february-2015-application-eligibility-and-enrollment-data.pdf>. Last accessed June 2015.
- 10 Garfield, R. Licata R, Young K. *The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA*. Washington, DC: KFF; 2014. Available at <http://kff.org/uninsured/report/the-uninsured-at-the-starting-line-findings-from-the-2013-kaiser-survey-of-low-income-americans-and-the-aca/>. Last accessed June 2016.
- 11 HHS. *2013 Annual Report on the Quality of Care for Children in Medicaid and CHIP*. Washington, DC: HHS; 2013. Available at <http://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-adult-sec-rept.pdf>. Last accessed June 2015.
- 12 CMS. Medicaid benefits website. Available at <http://www.medicare.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html>. Last accessed August 2015.
- 13 Brooks T, Miskell S, Artiga S, et al. *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey*. Washington, DC: KFF; 2016. Available at <http://kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey/>. Last accessed March 2016.
- 14 Kaiser Commission on Medicaid and the Uninsured. *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence*. Washington, DC: KFF; 2013.
- 15 Mendes E. *Preventable Chronic Conditions Plague Medicaid Population*. Washington, DC: Gallup Inc; 2014. Available at <http://www.gallup.com/poll/161615/preventable-chronic-conditions-plague-medicare-population.aspx>. Last accessed May 2016.
- 16 Goldman ML, Spaeth-Rublee B, Pincus HA. Quality indicators for physical and behavioral health care integration. *JAMA*. 2015;314(8):769-770.
- 17 CMS. Adult health care quality measures website. Available at <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html>. Last accessed May 2016.
- 18 The first update was issued via a CMCS Informational Bulletin "2014 Updates to the Child and Adult Core Health Care Quality Measurement Sets." Available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf>. Last accessed July 2016
- 19 Medicaid.gov website. <https://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-medicare-quality-grants.html>. Last accessed June 2016.
- 20 Agency for Healthcare Research and Quality (AHRQ). National evaluation of the CHIPRA quality demonstration grant program website. <http://www.ahrq.gov/policymakers/chipra/demoeval/index.html>. Last accessed June 2016.

- 21** NQF. Slide presented at Measure Applications Partnership Medicaid Adult & Child In-person Meeting. May 24-26, 2016. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=82541>. Last accessed June 2016.
- 22** NQF. Slide presented at Measure Applications Partnership Medicaid Adult & Child In-person Meeting. May 24-26, 2016. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=82541>. Last accessed June 2016.
- 23** AHRQ. National evaluation of the CHIPRA quality demonstration grant program website. <http://www.ahrq.gov/policymakers/chipra/demoeval/index.html>. Last accessed June 2016.
- 24** NQF. Slide presented at Measure Applications Partnership MAP Medicaid Adult Core Set Workgroup In-person Meeting. May 24-25, 2016. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=82541>. Last accessed June 2016.
- 25** NQF. Slide presented at Measure Applications Partnership MAP Medicaid Adult Core Set Workgroup In-person Meeting. May 24-25, 2016. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=82541>. Last accessed June 2016.
- 26** NQF. Slide presented at Measure Applications Partnership MAP Medicaid Adult Core Set Workgroup In-person Meeting. May 24-25, 2016. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=82541>. Last accessed June 2016.
- 27** NQF. Slide presented at Measure Applications Partnership MAP Medicaid Adult Core Set Workgroup In-person Meeting. May 24-25, 2016. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=82541>. Last accessed June 2016.
- 28** Schiff J, Lloyd R. *Too Many & Not Enough: "DHS - What Matters Most" Care Quality Measures Implementing the IOM Vital Signs Core Metrics*. Minneapolis, MN: Minnesota Department of Human Services; 2015.
- 29** Blumenthal D, Malphrus E, McGinnish JM, eds. *Vital Signs Core Metrics for Health and Health Care Progress*. Washington, DC: National Academies Press; 2015. Available at <http://iom.nationalacademies.org/Reports/2015/Vital-Signs-Core-Metrics.aspx>. Last accessed February 2015.
- 30** NQF. *Cross-Cutting Challenges Facing Measurement: MAP 2016 Guidance*. Washington, DC: NQF; 2016. Available at http://www.qualityforum.org/Publications/2016/03/Cross-Cutting_Challenges_Facing_Measurement__MAP_2016_Guidance.aspx. Last accessed June 2016.
- 31** NQF. Slide presented at Measure Applications Partnership MAP Medicaid Adult Core Set Workgroup In-person Meeting. May 24-25, 2016. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=82541>. Last accessed June 2016.
- 32** NQF. Slide presented at Measure Applications Partnership MAP Medicaid Adult Core Set Workgroup In-person Meeting. May 24-25, 2016. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=82541>. Last accessed June 2016.
- 33** NQF. Slide presented at Measure Applications Partnership MAP Medicaid Adult Core Set Workgroup In-person Meeting. May 24-25, 2016. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=82541>. Last accessed June 2016.

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, affordable care, and healthy people/healthy communities. 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 the 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

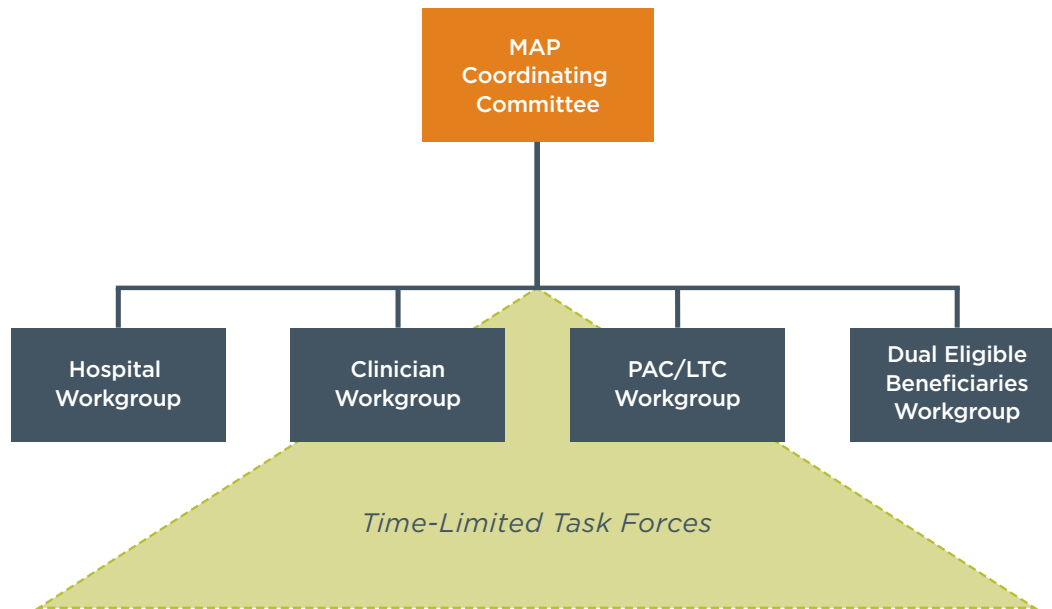
measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.

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 Figure 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 specific topics provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

FIGURE A1. MAP STRUCTURE



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

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see [MAP 2015 Pre-Rulemaking Deliberations](#)). Additionally, MAP engages in strategic activities throughout the year to inform MAP's pre-rulemaking input. To date MAP has issued a [series of reports](#) that:

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

ENDNOTE

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

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

MAP Medicaid Adult Task Force

CHAIR (VOTING)

Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)

Academy of Managed Care Pharmacy

Marissa Schlaifer, RPh

American Association of Nurse Practitioners

Sue Kendig, JD, WHNP-BC, FAANP

American College of Physicians

Michael Sha, MD, FACP

America's Health Insurance Plans

Grant Picarillo

Association for Community Affiliated Health Plans

Jenny Babcock

Humana, Inc.

George Andrews, MD, MBA, CPE, FACP

March of Dimes

Cynthia Pellegrini

National Association of Medicaid Directors

Kathleen Dunn, RN, MPH

National Rural Health Association

Brock Slabach, MPH, FACHE

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)

Ann Marie Sullivan, MD

Kim Elliott, PhD, CPHQ

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)

**Substance Abuse and Mental Health Services
Administration (SAMHSA)**

Lisa Patton, PhD

MAP Coordinating Committee

CO-CHAIRS (VOTING)

Elizabeth McGlynn, PhD, MPP

Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)

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

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)

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

Debjani Mukherjee

Senior Director

Shaonna Gorham

Senior Project Manager

Severa Chavez

Project Analyst

APPENDIX C: MAP Measure Selection Criteria

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

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

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

- Subcriterion 1.1** Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need
- Subcriterion 1.2** Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs
- Subcriterion 1.3** Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

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

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

- Subcriterion 2.1** Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment
- Subcriterion 2.2** Healthy people/healthy communities, demonstrated by prevention and well-being
- Subcriterion 2.3** Affordable care

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

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

- Subcriterion 3.1** Program measure set includes measures that are applicable to and appropriately tested for the program’s intended care setting(s), level(s) of analysis, and population(s)
- Subcriterion 3.2** Measure sets for public reporting programs should be meaningful for consumers and purchasers
- Subcriterion 3.3** Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)
- Subcriterion 3.4** Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program
- Subcriterion 3.5** Emphasize inclusion of endorsed measures that have eMeasure specifications available

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

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

- Subcriterion 4.1** In general, preference should be given to measure types that address specific program needs
- Subcriterion 4.2** Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes
- Subcriterion 4.3** Payment program measure sets should include outcome measures linked to cost measures to capture value

5. Program measure set enables measurement of person- and family-centered care and services

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration

- Subcriterion 5.1** Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination
- Subcriterion 5.2** Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives
- Subcriterion 5.3** Measure set enables assessment of the person’s care and services across providers, settings, and time

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

APPENDIX D: Adult Core Set and MAP Recommendations

In January 2012, HHS published a final notice in the *Federal Register* to announce the initial core set of healthcare quality measures for Medicaid-eligible adults; annual updates including a **2016 version** followed. Exhibit D1 below lists the measures included in the 2016 Adult Core Set along with their current NQF endorsement number and status, including rates of state participation in **2014 reporting**. Reporting data for 2015 were

unavailable during the 2016 review. In FFY 2016, states are voluntarily collecting the Medicaid Adult Core Set measures using the **2016 Technical Specifications and Resource Manual**. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's **Quality Positioning System**. Exhibit D2 lists the measures supported by MAP for potential addition to the Adult Core Set.

EXHIBIT D1. CURRENT ADULT CORE SET FOR FFY 2016

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment
<p>0004 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment <i>Measure Steward: National Committee for Quality Assurance (NCQA)</i></p>	<p>The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.</p> <p>a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.</p> <p>b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.</p>	<p>24 states reported FFY 2014 Alignment: Meaningful Use Stage 2 - Eligible Professionals (MU-EP), PQRS, HEDIS, Health Insurance Marketplace Quality Rating System (HIX-QRS), Physician Value-Based Payment Modifier</p>
<p>0006 Endorsed CAHPS Health Plan Survey - Adult Questionnaire <i>Measure Steward: NCQA</i></p>	<p>30-question core survey of adult health plan members that assesses the quality of care and services they receive.</p>	<p>18 states reported FFY 2014 Alignment: Medicare Shared Savings Program (MSSP), HEDIS, HIX-QRS</p>
<p>0018 Endorsed Controlling High Blood Pressure Measure Steward: NCQA</p>	<p>The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.</p>	<p>19 states reported FFY 2014 Alignment: MU-EP, MSSP, PQRS, HEDIS, HIX-QRS, Physician Compare, Physician Value-Based Payment Modifier</p>

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment
<p>0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation <i>Measure Steward: NCQA</i></p>	<p>Assesses different facets of providing medical assistance with smoking and tobacco use cessation:</p> <p>Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.</p> <p>Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.</p> <p>Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.</p>	<p>16 states reported FFY 2014 Alignment: HEDIS, HIX-QRS</p>
<p>0032 Endorsed Cervical Cancer Screening <i>Measure Steward: NCQA</i></p>	<p>Percentage of women 21-64 years of age received one or more Pap tests to screen for cervical cancer.</p>	<p>33 states reported FFY 2014 Alignment: MU-EP, PQRS, HEDIS, HIX-QRS, Physician Value-Based Payment Modifier</p>
<p>0033 Endorsed Chlamydia Screening in Women [ages 21-24 only] <i>Measure Steward: NCQA</i></p>	<p>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.</p>	<p>32 states reported FFY 2014 Alignment: MU-EP, PQRS, HEDIS, HIX-QRS, Physician Value-Based Payment Modifier, Medicaid Child Core Set (ages 16-20)</p>
<p>0039 Endorsed Flu Vaccinations for Adults Ages 18 and Over <i>Measure Steward: NCQA</i></p>	<p>The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.</p>	<p>15 states reported FFY 2014 Alignment: HEDIS, HIX-QRS</p>
<p>0057 Endorsed Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing <i>Measure Steward: NCQA</i></p>	<p>The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.</p>	<p>34 states reported FFY 2014 Alignment: HEDIS, HIX-QRS</p>

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment
<p>0059 Endorsed Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) <i>Measure Steward: NCQA</i></p>	<p>The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.</p>	<p>New measure added to 2015 Adult Core Set Alignment: MU-EP, PQRS, MSSP, Physician Compare, Physician Value-Based Payment Modifier</p>
<p>0105 Endorsed Antidepressant Medication Management (AMM) <i>Measure Steward: NCQA</i></p>	<p>The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.</p> <p>a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).</p> <p>b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).</p>	<p>31 states reported FFY 2014 Alignment: MU-EP, PQRS, HEDIS, Physician Value-Based Payment Modifier, HIX-QRS</p>
<p>0272 Endorsed Diabetes Short-Term Complications Admissions Rate (PQI 1) <i>Measure Steward: Agency for Healthcare Research and Quality (AHRQ)</i></p>	<p>The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.</p>	<p>25 states reported FFY 2014 Alignment: N/A</p>
<p>0275 Endorsed Chronic obstructive pulmonary disease (PQI 5) <i>Measure Steward: AHRQ</i></p>	<p>This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.</p>	<p>24 states reported FFY 2014 Alignment: MSSP</p>
<p>0277 Endorsed Heart Failure Admission Rate (PQI 8) <i>Measure Steward: AHRQ</i></p>	<p>This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.</p>	<p>25 states reported FFY 2014 Alignment: MSSP</p>
<p>0283 Endorsed Asthma in Younger Adults Admission Rate (PQI 15) <i>Measure Steward: AHRQ</i></p>	<p>Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.</p>	<p>25 states reported FFY 2014 Alignment: N/A</p>

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment
<p>0418 Endorsed Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan <i>Measure Steward: Centers for Medicare and Medicaid Services (CMS)</i></p>	<p>Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.</p>	<p>5 states reported FFY 2014 Alignment: MU-EP, MSSP, PQRS, Physician Compare, Physician Value-Based Payment Modifier</p>
<p>0469 Endorsed PC-01 Elective Delivery <i>Measure Steward: The Joint Commission</i></p>	<p>This measure assesses patients with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)</p>	<p>12 states reported FFY 2014 Alignment: Meaningful Use Stage 2 -Hospitals and CAHs</p>
<p>0476 Endorsed PC-03 Antenatal Steroids <i>Measure Steward: The Joint Commission</i></p>	<p>This measure assesses patients at risk of preterm delivery at ≥ 24 and < 32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).</p>	<p>3 states reported FFY 2014 Alignment: N/A</p>
<p>0576 Endorsed Follow-Up After Hospitalization for Mental Illness <i>Measure Steward: NCQA</i></p>	<p>This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.</p> <p>Rate 1. The percentage of members who received follow-up within 30 days of discharge</p> <p>Rate 2. The percentage of members who received follow-up within 7 days of discharge.</p>	<p>30 states reported FFY 2014 Alignment: Medicaid Child Core Set, HEDIS, HIX-QRS</p>

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment
<p>0648 Endorsed Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) <i>Measure Steward: AMA-convened Physician Consortium for Performance Improvement (AMA-PCPI)</i></p>	<p>Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge</p>	<p>4 states reported FFY 2014 Alignment: N/A</p>
<p>1517 Endorsed Prenatal & Postpartum Care [postpartum care rate only] <i>Measure Steward: NCQA</i></p>	<p>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.</p> <p>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.</p> <p>Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</p>	<p>34 states reported FFY 2014 Alignment: Medicaid Child Core Set, HEDIS, HIX-QRS</p>
<p>1768 Endorsed Plan All-Cause Readmissions <i>Measure Steward: NCQA</i></p>	<p>For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:</p> <ol style="list-style-type: none"> 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/ Denominator) 5. Total Variance <p>Note: For commercial, only members 18-64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.</p>	<p>21 states reported FFY 2014 Alignment: HEDIS, HIX-QRS</p>

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment
<p>1932 Endorsed Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) <i>Measure Steward: NCQA</i></p>	<p>The percentage of patients 18 - 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.</p>	<p>New measure added to 2016 Adult Core Set Alignment: N/A</p>
<p>2082 Endorsed HIV Viral Load Suppression <i>Measure Steward: HRSA</i></p>	<p>Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.</p> <p>A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.</p>	<p>3 states reported FFY 2014 Alignment: PQRS, Physician Value-Based Payment Modifier</p>
<p>2371 Endorsed Annual Monitoring for Patients on Persistent Medications <i>Measure Steward: NCQA</i></p>	<p>The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.</p> <p>Report each of the four rates separately and as a total rate :</p> <p>Rates for each: Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), Digoxin, diuretics, or anticonvulsants</p> <p>Total rate (the sum of the four numerators divided by the sum of the four denominators)</p>	<p>27 states reported FFY 2014 Alignment: HEDIS, HIX-QRS</p>
<p>2372 Endorsed Breast Cancer Screening <i>Measure Steward: NCQA</i></p>	<p>Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.</p>	<p>31 states reported FFY 2014 Alignment: HEDIS, HIX-QRS</p>
<p>Not NQF-endorsed Adult Body Mass Index Assessment <i>Measure Steward: NCQA</i></p>	<p>The percentage of Medicaid Enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.</p>	<p>26 states reported FFY 2014 Alignment: HEDIS</p>

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment
<p>Not NQF-endorsed Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) <i>Measure Steward: NCQA</i></p>	<p>The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).</p>	<p>21 states reported FFY 2014 Alignment: HEDIS</p>
<p>Not NQF-endorsed Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer: Opioid High Dosage <i>Measure Steward: PQA</i></p>	<p>The proportion (XX out of 1,000) of individuals without cancer receiving a daily dosage of opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.</p>	<p>New measure added to 2016 Adult Core Set Alignment: N/A</p>

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

Measure & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
<p>2152 Endorsed Preventive Care and Screening: Unhealthy Alcohol <i>Measure Steward: AMA</i></p>	<p>This measure assesses the percentage of patients aged 18 years and older who were screened at least once within the last 24 months of the measurement year for unhealthy alcohol use using a systematic screening method and who received brief counseling if identified as an unhealthy alcohol user.</p>	N/A	<p>The measure addresses the behavioral health and substance use gap area. MAP recommended the inclusion of this measure as a way to capture access to behavioral health related services as well data on those who receive treatment following screening for behavioral health issues.</p>
<p>0541 Endorsed Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category <i>Measure Steward: PQA</i></p>	<p>This measure assesses the percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% or greater during the measurement year. As part of this measure, a performance rate is calculated separately for the following medication categories: Renin Angiotensin System (RAS) Antagonists, Diabetes Medications, and Statins.</p>	N/A	<p>This measure addresses patient adherence by evaluating the supply of chronic medication available to the patient over time. This is important because successful treatment of chronic conditions require medication management and patient adherence with regards to prescription medications.</p>
<p>2607 Endorsed Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) <i>Measure Steward: NCQA</i></p>	<p>This measure assesses the percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%.</p>	N/A	<p>This measure is complementary to NQF #0059 measure already in the Adult Core Set. This measure addresses integration by reinforcing shared accountability and linkage of medical and behavioral health care; as well as, chronic disease management for people with serious mental illness.</p>

Measure & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
<p>2605 Endorsed Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence <i>Measure Steward: NCQA</i></p>	<p>This measure assesses the percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year and who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.</p>	<p>N/A</p>	<p>This measure addresses the issue of access and follow-up of care.</p>
<p>2829 Not NQF Endorsed Elective Delivery (Conditionally Support) <i>Measure Steward: The Joint Commission</i></p>	<p>This measure is an electronic version of measure #0469 which assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is conditionally supported pending NQF endorsement and is being considered by the 2015-2016 Perinatal and Reproductive Health Standing Committee.</p>	<p>N/A</p>	<p>Addition of this measure would provide greater choice with regards to measure formats.</p>
<p>1799 Endorsed Medication Management for People with Asthma <i>Measure Steward: NCQA</i></p>	<p>This measure assesses 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.</p>	<p>Alignment: HEDIS, Medicaid Child Core Set, HIX-QRS</p>	<p>MAP noted that this measure is already part of the Child Core Set and recommended the measure in an effort to address asthma in the adult Medicaid population as well as align the core sets.</p>

*MAP has conditionally supported measures that are pending endorsement by NQF, a change by the measure steward, CMS confirmation of feasibility, etc.

APPENDIX E: Additional Measures Considered

MAP considered several measures that did not pass the consensus threshold (>60 percent of voting members) to gain MAP's support or conditional support for use in the Adult Core Set. MAP needed to limit the number of measures it supported for the sake of parsimony and

practicality; lack of support for one of these measures does not indicate that the measures are flawed or unimportant. These and other measures could be reconsidered during a future review of the Adult Core Set.

Measure Number and NQF Endorsement Status	Measure Title	Measure Steward
0055 Endorsed	Comprehensive Diabetes Care: Eye Exam (performed)	National Committee for Quality Assurance
2111 Endorsed	Antipsychotic Use in Persons with Dementia	Pharmacy Quality Alliance
1933 Endorsed	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	National Committee for Quality Assurance
2903 Not NQF-endorsed	Contraceptive Care – Most & Moderately Effective Methods	U.S. Office of Population Affairs
2902 Not NQF-endorsed	Contraceptive Care – Postpartum	U.S. Office of Population Affairs
1800 Endorsed	Asthma Medication Ratio	National Committee for Quality Assurance
0275 Endorsed	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05)	Agency for Healthcare Research and Quality
Not Endorsed	Cesarean Delivery for Nulliparous (NTSV) Women (Appropriate Use)	PQPM (PMCOE)

APPENDIX F: Public Comments

General Comments

American Academy of Family Physicians

Sandy Pogones

The AAFP supports endorsement of the Core Measure Set for ACO/PCMH/Primary Care that was established by the multi-payer Core Quality Measures Collaborative in February 2016 and encourages the MAP Medicaid initiative to adopt the same measure set for adults. The Centers for Medicare and Medicaid Services (CMS), health plans, the National Quality Forum, primary care and other physician specialty organizations, the National Committee for Quality Assurance consumers and employers worked together through the Collaborative to identify core sets of quality measures that payers have committed to using for reporting as soon as feasible to create consistency and alignment across measures being used by both public and private payers. The Collaborative promotes measures that are evidence-based for use in quality improvement, decision-making, and value-based payment and purchasing. The core measure sets are designed to be meaningful to patients and consumers and to physicians, while maintaining parsimony and reducing the collection burden and cost.

The AAFP opposes endorsement of measure sets that are not part of the Core Measures as established by the Collaborative. The simple fact that a measure has been collected in the past is not sufficient reason to continue collecting it in the future, and we must actively pursue a reduction in reporting burden particularly for physicians, especially those in primary care.

American Psychiatric Foundation

Samantha Shugarman

The APA identifies that there is likely to be intermediate to long-term Impact to our patients if implementation of these measures lead to policy decisions to address inadequate screening and treatment for alcohol use disorders; screening and

treatment for diabetes in patients with serious mental illness; and policy decisions that lead to increased care planning and access to care for individuals with mental illness.

Negative impact to psychiatrists and then indirectly to patients, may occur if there is increased burden for psychiatrists to provide data to state departments that collect these data and report them to HHS. This burden will exist independently of the proposed new standards in this report, as there already are other existing standards relevant to psychiatrists and individuals with mental illness.

America's Health Insurance Plans

Carmella Bocchino

AHIP supports efforts by the MAP to drive quality improvement among Medicaid Providers and improved health outcomes for Medicaid beneficiaries through the Adult Medicaid Core Set. Additionally, we are encouraged by the alignment between many measures included in the Adult Set and measures included in the various core sets developed by the Core Quality Measures Collaborative; for example, controlling high blood pressure, tobacco use cessation, cancer screenings, and management of chronic disease such as diabetes and asthma. However, we believe additional alignment between these two efforts would further help reduce burden among providers and have a greater impact on quality improvement. We applaud MAP's effort to identify gap areas and suggest future alignment with the Core Quality Measures Collaborative when addressing those gap areas in future years.

Additionally, it would be helpful for CMS or the respective measure developers to share the challenges and results implementing these measures from all states that have reported, since the states highlighted in NQF's report seemed to have limited exposure to all measures. It would be valuable to reporting entities to learn what measures among the

measure sets have valid and consistent data year to year. This information could help with establishing reliable national benchmarks for non-HEDIS measures.

Anthem, Inc.

Amy Ingham

Anthem appreciates the work that MAP has undertaken to produce its 2016 report. However, we are generally concerned with the number of measures that MAP has recommended be added and removed over the years to the Adult core measure set. We believe that the success of quality measurement and improvement is best achieved through ensuring a stable, concise set of targeted and meaningful measures from which states may choose. Data set stability is important to states and Medicaid managed care organizations (MCOs) in the design of data collection and implementation approaches as well as helps ensure meaningful analysis of quality improvement projects.

Furthermore, we believe that a parsimonious approach to the addition of new measures assists in increasing collections of those measures already included in the set.

It would be helpful for CMS to share the challenges and results of these measures from all states that have reported, since the states highlighted in NQF's report seemed to have limited exposure to all measures. It is valuable to reporting entities to learn what measures among the measure sets have valid and consistent data year to year. This information could help with establishing reliable national benchmarks for non-HEDIS measures.

Anthem supports MAP's focus on parsimony and alignment of measures and would also emphasize that alignment of measures for ease in collection by providers including hospitals, practitioners and health plans would result in improvements in the overall delivery of healthcare.

Connecticut Pharmacists Association

Margherita Giuliano

The mission of the Connecticut Pharmacists Association is to advance the practice of pharmacy in our state and engage in positive patient care. To that end, we would like to state our support for the recommendation for addition of medication adherence measures (NQF 0541) for treatment and prevention in patients with diabetes, high cholesterol and high blood pressure.

Medication adherence is extremely critical for improving patient outcomes, especially in patients being treated for chronic conditions. Including medication adherence measures in the Adult Core Measure Set will provide health plans and states with valuable information that can be used to improve the quality of patient care.

We believe this addition will strengthen the Adult Core Measure Set and that this recommendation should be accepted by CMS.

National Alliance of State Pharmacy Associations

Krystalyn Weaver

The National Alliance of State Pharmacy Associations (NASPA) would like to state our support for the recommendation for addition of medication adherence measures (NQF 0541) for treatment and prevention in patients with diabetes, high cholesterol and high blood pressure.

Medication adherence is extremely critical for improving patient outcomes, especially in patients being treated for chronic conditions. Including medication adherence measures in the Adult Core Measure Set will provide health plans and states with valuable information that can be used to improve the quality of patient care.

We believe this addition will strengthen the Adult Core Measure Set and that this recommendation should be accepted by CMS.

National Partnership for Women & Families**Debra Ness**

With Medicaid expansion, the work of the Adult and Child Task Forces contributes to the care of over 80 million beneficiaries. The National Partnership for Women & Families commends the exemplary MAP process of multi-stakeholder collaboration that brings together members of MAP Medicaid Adult Task Force, members of the MAP Medicaid Child Task Force (for areas of overlapping scope), state Medicaid program leaders, CMS staff, NQF staff and interested members of the public. This provides a strong basis for work to strengthen the core adult measure set program and improve the quality of care provided to adults covered by Medicaid, the nation's largest insurer. The Adult Task Force recommendations for new measures that fill important gaps will strengthen the core measure set and enhance the ongoing development of this important, maturing program.

TX HHSC**Denbigh Shelton**

Thank you for the opportunity to comment on the draft MAP report. Texas reports on the adult core set annually and values the ability to look our quality performance in the national context and in comparison to other states. At the same time, core set reporting requires time and resources and so we have a stake in ensuring that the measures

are as meaningful as possible and that reporting is practicable within our resource limitations.

Texas generally supports the measure selection criteria used by MAP and believes more emphasis could be placed on prevention. Texas would like to see consideration of measures that lead to value-based performance as well as measures that assess care coordination and look at social determinants of health. Other than the diabetes measures, the measure set is primarily process focused rather than outcome focused.

The community linkages, described as an outcome of the feedback from stakeholders, does not seem to have been incorporated in the measure set. Additionally, it is not clear if the recommendations made by the Oregon team have been implemented; they provide a rigorous framework for measure development.

University of Kentucky College of Pharmacy**Clark Kebodeaux**

Clark Kebodeaux, Pharm.D., BCACP is very pleased to see the recommendation for addition of medication adherence measures (NQF 0541) for treatment and prevention in patients with diabetes, high cholesterol and high blood pressure. I believe this addition will strengthen the Adult Core Measure Set and give health plans and states the tools they need to improve the quality of care.

Measure-Specific Recommendations

Academy of Managed Care Pharmacy**Susan Oh**

The Academy of Managed Care Pharmacy (AMCP) appreciates this opportunity to offer comments on the draft report "Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2016."

AMCP is a professional association of pharmacists and other practitioners who serve society by the application of sound medication management principles and strategies to improve health care for all. The Academy's 8,000 members develop and

provide a diversified range of clinical, educational, medication and business management services and strategies on behalf of more than 200 million Americans covered by a managed care pharmacy benefit.

AMCP provides the following comments on two identified measures recommended for addition to the Adult Core Set.

AMCP supports the inclusion of NQF measure #0541 Proportion of Days Covered (PDC) 3 Rates by Therapeutic Category (Renin Angiotensin System (RAS) Antagonists, Diabetes Medications,

and Statins). These currently align to the existing Medicare Stars and Quality Rating System measures for adherence to diabetes, cholesterol, and hypertension. These measures are a good starting point to ensure compliance with therapeutic regimens. However, adherence to medications is only one consideration in managing diabetes and does not necessarily ensure optimal outcomes. Therefore, AMCP supports work toward outcomes measures that do not just focus on adherence.

AMCP acknowledges the importance of alignment between the two Core Sets, but does not support the inclusion of NQF measure #1799 Medication Management for People with Asthma in the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid. This measure does not necessarily assess appropriateness of medications for asthma, but rather that the patient has some level of a controller medication during a certain length of time thus identifying false positives. Patients may use inhalers for reasons other than persistent asthma. In addition, evidence of cost-effectiveness of presently available agents is insufficient to support investing additional health care resources towards adherence to controller medication regimens. Until the cost of controller medications is reduced through generic or other competition, it is unlikely that these agents will be shown to be cost-effective.

American Academy of Family Physicians

Sandy Pogones

The AAFP supports the Core Measure set for ACO/PCMH/Primary Care as determined by the Core Measure Collaborative (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>).

America's Health Insurance Plans

Carmella Bocchino

We are generally supportive of the measure specific recommendations made by the MAP including for example #1799 Medication Management for People with Asthma which is included in the Core Quality Measures Collaborative ACO/PCMH and Primary Care Core Set. We would encourage MAP to consider other measures also included in the Core Quality Measure Collaborative ACO/PCMH and Primary Care

Core Set such as #0097 – Medication Reconciliation and #0421 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up for future inclusion into the Adult Medicaid Core Set.

However, we are concerned with the number of measures that MAP has recommended be added and removed over the years to the Adult core measure set. We believe that the success of quality measurement and improvement is best achieved through ensuring a stable, concise set of targeted and meaningful measures from which states may choose. Data set stability is important to states and Medicaid managed care organizations (MCOs) in the design of data collection and implementation approaches as well as helps ensure meaningful analysis of quality improvement projects. Furthermore, we believe that a parsimonious approach to the addition of new measures assists in increasing collections of those measures already included in the set.

Anthem, Inc.

Amy Ingham

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%): Anthem does not support the addition of this measure. We note that no states currently report on the Diabetes HbA1c (Poor Control) measure, so adding an additional similar measure at this time would be premature. Furthermore, we wish to note that for many plans, the denominator may be too small to contribute to meaningful reporting of this measure, leading to statistically invalid results.

Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence: Anthem finds this measure to be duplicative of the above measure regarding unhealthy alcohol usage. We suggest recommending addition of only one of these measures, instead of both.

California Pharmacists Association (CPhA)

Brian Warren

The California Pharmacists Association (CPhA) enthusiastically supports the recommendation for addition of medication adherence measures (NQF

0541) for treatment and prevention in patients with diabetes, high cholesterol and high blood pressure.

Medication adherence is extremely critical for improving patient outcomes, especially in patients being treated for chronic conditions. Including medication adherence measures in the Adult Core Measure Set will provide health plans and states with valuable information that can be used to improve the quality of patient care.

CPhA believes this addition will strengthen the Adult Core Measure Set and that this recommendation should be accepted by CMS.

CVS Health

Emily Kloeblen

CVS Health supports the NQF's task force recommendation for the addition of the medication adherence measure "Proportion of Days Covered (PDC) – three rates" (NQF 0541) for inclusion into the Medicaid Adult core set for treatment and prevention in patients with diabetes, high cholesterol and high blood pressure.

Proportion of Days Covered (PDC) is the PQA-recommended metric for estimation of medication adherence for patients using chronic medications. This metric is also endorsed by the National Quality Forum (NQF). The metric identifies the percentage of patients taking medications in a particular drug class that have high adherence (PDC > 80% for the individual). The measure tracks medication adherence for conditions that are highly prevalent in the Medicaid population and aligns with other quality programs (e.g., Medicare STARS, the Health Insurance Marketplace Quality Rating System, etc.) managed by CMS.

CVS Health is also very pleased to see the recommendation the measure 'Medication Management for People with Asthma' (#1799) to the Adult Core Set of measures.

According to the CDC:

- Asthma: affects 25.7 million people, including 7.0 million children under 18,
- Is a significant health and economic burden to patients, their families, and society
- In 2010, 1.8 million people visited an emergency

department for asthma-related care and 439,000 people were hospitalized because of asthma and

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

We believe these additions will strengthen the Adult Core Measure Set and give health plans and states the tools they need to improve the quality of care.

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

Genentech

Sarah Donelson

Genentech is pleased to see the recommendation for the addition of medication adherence measures (NQF 0541) for statins, diabetes drugs and ACE/ARBs in the Centers of Medicare and Medicaid (CMS) Medicaid Adult Core Set. Adherence to medication is critical to successfully treat and manage patients with diabetes, high cholesterol and high blood pressure. These three measures are currently NQF-endorsed and used by CMS in the Medicare Part C and D Star Ratings Program. Inclusion of these measures as part of the Medicaid Adult Core Set is an important step to ensure appropriate use of medications at the state level.

Furthermore, adherence to comorbid medications has been found to be predictive of Health Related Quality of Life (HRQoL). We recently investigated the association between healthy days (HDs), a measure of HRQoL, and comorbidity medication adherence (CMA) among cancer patients. After surveying oncology patients, we found that those with high comorbidity medication adherence reported fewer unhealthy days, in particular mentally unhealthy days, in the past 30 days. Research like this suggests that increasing comorbidity medication adherence, including medications for diseases such as diabetes, high cholesterol and high blood pressure, may be an avenue for improving the number of healthy days patients experience.

We support inclusion of the medication adherence measures (NQF 0541) to strengthen the Adult Core Measure Set and give health plans and states the tools they need to improve the quality of care for patients, thus enabling patients to experience more healthy days.

Humana

Laurin Dixon

Humana supports the recommendation for the addition of medication adherence measures (NQF 0541) for treatment and prevention in patients with diabetes, high cholesterol and high blood pressure. We believe these measures support improvement of disease control for three highly prevalent, chronic disease states. This addition will strengthen the Adult Core Measure Set and give health plans and states the tools they need to improve quality of care.

Johnson & Johnson Health Care Systems, Inc.

Ira Klein

Johnson & Johnson is very pleased to see the recommendation for addition of medication adherence measures (NQF 0541) for treatment and prevention in patients with diabetes, high cholesterol and high blood pressure. We believe this addition will strengthen the Adult Core Measure Set and give health plans and states the tools that they need to improve the quality of care.

March of Dimes

Edward McCabe

The March of Dimes, a unique collaboration of scientists, clinicians, parents, members of the business community, and other volunteers representing every state, the District of Columbia and Puerto Rico, appreciates this opportunity to offer comments on the draft report, “Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2016,” representing the recommendations of the National Quality Forum’s Measures Application Partnership.

The March of Dimes is deeply disappointed that two contraceptive measures, 2902: Contraceptive Care—Most and Moderately Effective Methods and 2903: Contraceptive Care—Postpartum, did not pass the consensus threshold needed for them to garner the MAP’s support for use in the Adult Core Set. The March of Dimes strongly supports both of these measures. Evidence shows that appropriate spacing between pregnancies improves a range of maternal and birth outcomes, including preterm birth and

low birthweight. All women of reproductive age and capability should have regular conversations with a health care provider to discuss reproductive life planning and, if pregnancy is not desired at that time, access to a most or moderately effective form of contraception that meets their particular needs. Each of these measures would be a critically important tool in measuring the health care system’s progress in working with women to improve birth outcomes.

The impact of appropriate birth spacing on birth outcomes, including the prevention of preterm birth, is so significant that the March of Dimes has incorporated it into our Prematurity Campaign as a key intervention to be promoted with the public, health care providers, and policymakers. In addition, the Center for Medicare and Medicaid Services’ Maternal and Infant Health Initiative recognizes the importance of contraceptive access and counseling in its efforts to promote birth spacing and improve health between pregnancies. The two contraceptive measures above, 2902 and 2903, are directly in line with the goals of the MIHI. The March of Dimes strongly supports their inclusion in the Adult Core Set in order to improve birth outcomes.

McKesson Corporation

Crystal Lennartz

Health Mart respectfully submits the following response to the July 6, 2016 draft report for public comment.

Health Mart is America’s largest independent pharmacy franchise with more than 4,700 locally owned community pharmacies across all 50 states. Health Mart pharmacists provide personalized care and take the time to help patients understand their prescription medications and coach them on the importance of adherence. As an important member of the healthcare team, Health Mart pharmacists possess strong clinical knowledge and partner with their patients, and their patients’ other healthcare providers to help them manage and improve patients’ health.

Health Mart is pleased to see the recommendation for addition of medication adherence measures (NQF 0541). We appreciate the Measure Application Partnership’s efforts to include measures to

help monitor and close gaps seen in medication adherence. We also see the pharmacist as a key provider whom secondary to multiple patient interactions can play a significant role in improving medication adherence. We believe this addition will strengthen the Adult Core Measure set and assist health plans and states in their efforts to improve the quality of care.

Minnesota Pharmacists Association

Marsha Millonig

MPhA would like to state our support for the recommendation for addition of medication adherence measures (NQF 0541) for treatment and prevention in patients with diabetes, high cholesterol and high blood pressure.

Medication adherence is extremely critical for improving patient outcomes, especially in patients being treated for chronic conditions. Including medication adherence measures in the Adult Core Measure Set will provide health plans and states with valuable information that can be used to improve the quality of patient care.

We believe this addition will strengthen the Adult Core Measure Set and that this recommendation should be accepted by CMS.

National Kidney Foundation

Roberta Reed

Comment on NQF #0541: Proportion of days covered (PDC) 3 Rates by Therapeutic Category, 3 medication categories.

I believe insertion of medications for CKD conditions- post transplant anti-rejection drugs should be incorporated into this measure. Without consistent use of these medications, transplanted organs will reject. In addition, cost considerations for such medications and guaranteed availability are needed to be written into this measure. Lifetime availability and affordability is essential. This does not exist today and thus places the individual at risk as well as the Medicaid system for future unnecessary expenses in caring for patients who will lose their viable transplanted organs.

National Partnership for Women & Families

Debra Ness

We welcome the availability of an emeasure for PC-01 Elective Delivery, which the Task Force is recommending for inclusion in the core set. Because this is identical to the paper measure (#0469), which is already included in the Adult Core Set, and offers a new way of collecting this measure, we encourage the report to frame this as the same measure with a new option for collection. This is relevant to considerations of burden on state Medicaid programs and decisions about uptake of additional measures for the set.

National Partnership for Women & Families

Debra Ness

The National Partnership for Women & Families notes that the draft MAP Medicaid Adult report identifies as current gap areas of the Adult Core Set promotion of wellness, interconception care and poor birth outcomes. In this context, we were disappointed that the Adult Task Force did not recommend for inclusion the two U.S. Office of Population Affairs measures that were considered: #2903 Contraceptive Care – Most & Moderately Effective Methods and #2902 Contraceptive Care – Postpartum. Of the over 300 measures currently endorsed by NQF, none pertain to family planning. These newly available measures address major gaps in measures for contraceptive access and counseling. Access to the full range of contraceptive methods and counseling is essential preventive health care for women, and has lifelong benefits for women’s well-being. Birth spacing contributes to healthy birth outcomes. Use of these measures is also crucial in the context of current concerns about the Zika virus and women’s decreasing access to many reproductive health services across the nation.

The Affordable Care Act has vastly increased women’s access to contraceptives, but gaps remain. Too often, a woman’s interaction with her provider is a missed opportunity for her to access this essential preventive health care. These measures would likely lead to more providers screening women for their pregnancy intentions, providing woman-centered

contraceptive counseling, and providing the full range of contraceptive methods so that women may choose the method that best suits their needs and goals during the many years when they could become pregnant.

We commend the Child Task force for recommending inclusion of #2902 Contraceptive Care – Postpartum in the Child Core Set, which would apply to childbearing minors and women. We encourage the Adult Task Force to revisit and strongly consider recommendation of #2903 Contraceptive Care – Most and Moderately Effective Methods during the next MAP Medicaid cycle.

Pennsylvania Department of Human Services

Office of Medical Assistance Programs Clinical Quality Improvement

Pennsylvania’s Department of Human Services’ (DHS) Office of Medical Assistance Programs (OMAP) would like to comment on MAP: Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2016 report that endorsed the addition of six measures to the Adult Core Set to cover quality measurement gaps. MAP’s purpose is to deliver annual ideas and feedback on performance measure selections that evaluate and advance the quality of care provided to adults enrolled in Medicaid and we believe you perform an essential function in the continuous improvement of the Medicaid program. Please see DHS’ response to the six selections below.

1. Preventative Care and Screening: Unhealthy Alcohol Use: DHS cannot capture this measure in claims data and more specifications would need to be revealed in order for DHS to support this measure. We are also concerned that it is a potentially redundant measure to several others already included in the Adult Core Set.
2. Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category: DHS cannot support the inclusion of this measure at the present time as more details are needed for further review.
3. Diabetes Care for People with Serious Mental Issues: Hemoglobin A1c (HbA1c) Poor Control (>9.0%): DHS supports this measure and believes that it is an important addition to the Adult Core Set.

4. Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence: This is a measure that DHS addresses as per its Integrated Care Plan (ICP) and could potentially support once the full specifications are released.
5. Elective Delivery: DHS cannot support the inclusion of this measure at the present time as more details and specifications are needed for further review.
6. Medication Management for People with Asthma: This measure would help contribute to the alignment of both Adult and Child core sets and is a measure that DHS can support as it is a measure that we are currently working on.

In conclusion, DHS needs to see more specifications for a large majority of the suggested performance measure selections in order to make a concrete determination.

Pharmacy Quality Alliance

Woody Eisenberg

PQA is very pleased to see the recommendation for addition of its medication adherence measures for treatment and prevention in patients with diabetes, high cholesterol and high blood pressure. We believe this addition will strengthen the Adult Core Measure Set and give health plans and states the tools they need to improve the quality of care.

PhRMA

Kelsey Lang

PhRMA appreciates MAP’s effort to maintain and improve the Medicaid Adult Core Set. In particular, we support MAP’s recommendation to add NQF #0541 – Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category to the measure set. As MAP indicates, successful treatment of chronic conditions requires consistent medication management and patient adherence with regards to prescription medications. This measure addresses a high-leverage area for quality measurement and performance improvement and would be a valuable addition to the Adult Core Set.

Planned Parenthood Federation of America

Emily Stewart

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

We applaud MAP’s recommendation to add post-partum contraceptive care to the 2017 Core Set for children, recognizing the importance of family planning and birth spacing to birth outcomes. We agree the measure considered is an important quality measure for child health, and support MAP’s recommendation, conditional on endorsement.

However, it is disappointing that MAP is not supporting, as it has in the past, other contraceptive care measures, especially provision of a most or moderately effective method to women at risk of unintended pregnancy. This measure is highly appropriate for inclusion. There are compelling reasons to add it to both Core Sets, and to add the similar post-partum measure to the Adult Set.

In promulgating the Adult Core Set in 2012, the Centers for Medicare and Medicaid Services (CMS) gave particular emphasis to measures currently in use in federal programs, and continues to prioritize alignment with federal partners. The contraceptive care measure is currently in developmental use by CMS in the Medicaid Maternal and Infant Health Initiative, including 13 state grantees reporting on the measure. The federal Title X family planning program has also piloted the measure and initiated programs to assist grantees with contraceptive care quality measurement and improvement. The measure is now pending NQF endorsement, but it is important to note that CMS does not require it for inclusion in the Core Sets.

Reducing unintended pregnancy is an objective of national initiatives such as Health People 2020, and the Institute of Medicine has identified a need to measure contraception as a core health indicator. Adding this contraceptive measure to the Core Sets will fill a critical gap in Medicaid quality measurement,

ensure future Medicaid payment reforms reflect the majority of the Medicaid population, and improve women’s access to care. Across all ages, the majority of Medicaid enrollees are female. The vast majority of women enrolled in Medicaid are of reproductive age (18-44), and Medicaid funds nearly one half of U.S. births. It is critical that the Core Sets adequately reflect the people the Medicaid program serves and their basic health care needs, which absolutely include access to contraceptives. We thank MAP for its dedication to improving access to quality care, and we look forward to working with MAP and NQF in this important work.

TX HHSC

Denbigh Shelton

With regard to the measures supported by MAP for addition to the core set, most of the measures are ones that Texas can provide data on fairly easily. However, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) is something we will likely not be able to report because it is a hybrid measure. Texas contracts with 20 different MCOs each of which runs their own hybrids. Anytime we add a hybrid measure to the MCOs’ required reporting it involves additional resources from them and so we try to limit the number of hybrid measures we require.

Generally, when a NCQA measure is used but the core set specifications differ from the HEDIS specifications this creates additional work and causes some confusion when we are tracking and reporting the measure for other purposes using the HEDIS specifications (for example controlling high blood pressure).

Additional information is needed on the specifics of the Cesarean Delivery for Nulliparous (NTSV) Women (Appropriate Use) measure in order to evaluate the feasibility of reporting.

With regard to Antipsychotic Use in Persons with Dementia, obtaining Medicare data is an ongoing challenge that limits our ability to utilize quality measures for our dual eligible population. Additionally, this may be a very small population size which could have implications for usefulness of the data.

Again, thank you for the opportunity to comment.

WellCare Health Plans, Inc

Howard Shaps

In the report, the MAP lists out a series of factors that are considered before removing a measure. WellCare suggests that the Task Force consider examining a State's ability to obtain accurate measurement as an additional factor for consideration. For example, the California example notes that hybrid measures can be difficult to report on due to the blend of the data sources.

WellCare agrees with the remaining high priority gaps identified by the Task Force and supports

additional measures to strengthen the current measure set. We encourage the Task Force to examine measures currently utilized by HEDIS to try and fill in these gaps. Health plans and providers already submit HEDIS data to the Centers for Medicare and Medicaid Services (CMS), and aligning the additional core measures with HEDIS will ease the burden of data collection and may lead to greater participation. Additionally, WellCare suggests the Task Force consider measures using administrative data. Administrative data is readily available and easier to extract for data collection purposes.

Strategic Recommendations

Anthem, Inc.

Amy Ingham

Anthem agrees that reporting should be voluntary and not mandatory. While health plans have experience to report internally and externally (when states require it). The burden of collecting data is very high, especially for non-HEDIS measures where either medical record review or eRecord are expected. In several measures, such as elective deliveries, health plans may need to use much higher sample sizes than with HEDIS measures in order to simply achieve the right denominator (members in the right gestational age to fit the denominator definition). Now that more measures of this kind have been added, we support phasing in adoption to alleviate operational burdens.

We thank the MAP workgroups for seeking to ensure alignment with NQQA HEDIS measures.

We also recommend that measures track quality improvement and quality of care in the most efficient and accurate manners. Medical record review is unduly burdensome and vital statistics data is often not available or not timely. These barriers result in a lack of timely and complete data, which is necessary for effective interventions. Specific measure examples include elective deliveries.

Additionally, these measures also tend to have extra medical record burden just to find the right denominator. When looking at the Adult Core Set - elective delivery measure - we need to include many more individuals than necessary in the sample. This measure looks at members who delivered at 37 - 39 gestational weeks. However, this information is not provided by claims. To ensure our sample is appropriate, we need to oversample by 60% to ensure we have enough individuals included in the measure denominator.

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