NATIONAL QUALITY FORUM

Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2014

EXPEDITED REVIEW, DRAFT REPORT FOR PUBLIC COMMENT

October 27, 2014

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Contents

Introduction and Purpose

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

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

MAP's input on the Medicaid Child Core Set begins with an expedited review, described in this report, scheduled to be completed by November 14, 2014. MAP will also conduct a second, more in-depth review scheduled to be completed in August 2015. Because a comprehensive retirement review was recently completed by the Agency for Healthcare Research and Quality (AHRQ), the focus for MAP's expedited review was to recommend measures to fill critical gap areas. In tandem with the MAP Measure Selection Criteria (MSC) (Appendix C), MAP considered states' experiences implementing the Child Core Set in making its recommendations. HHS will use MAP's findings to inform an update of the Medicaid Child Core Set required by statute to occur by January 2015. NQF will continue to convene the Medicaid Child Task Force and MAP Coordinating Committee to provide additional review and recommendations in 2015 for the January 2016 update.

Background on Medicaid and the Child Core Set

Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals. CHIP provides coverage to children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. Both Medicaid and CHIP are financed through federal-state partnerships; each state designs and operates its own programs within federal guidelines.[1]

Medicaid and CHIP Benefits for Children

Together, Medicaid and CHIP cover more than 43 million children, which is more than 1 in every 3,[2] and about 40 percent of all births.[3] The federal government sets minimum guidelines for Medicaid eligibility, but states can choose to expand coverage beyond the minimum threshold. Most states have elected to provide Medicaid to children with family incomes above the minimum of 100 percent of the Federal Poverty Level (FPL);[4] the FPL is determined by family size, and is $19,790 for a family of three in 2014.[5] As of April 2014, 29 states (including DC) covered children in families with income up to at least 250 percent FPL under Medicaid or CHIP. 19 of these states covered children with income up to at least 300 percent FPL.[6]

States establish and administer their own Medicaid programs but are required to cover certain mandatory benefits, and can choose to provide other optional benefits. All children enrolled in Medicaid are entitled to the comprehensive set of health care services known as Early, Periodic Screening, Diagnosis and Treatment (EPSDT). This benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The preventive focus of EPSDT helps to ensure that health problems, including behavioral health issues, are identified and treated early, before problems become more complex and their treatment more costly.[7] Although pharmacy coverage is an optional benefit under federal Medicaid law, all States currently provide coverage for outpatient prescription drugs to all categorically eligible individuals and most other enrollees within their Medicaid programs.[8]

CHIP also ensures a comprehensive set of benefits for children, but states have flexibility to design the benefit package depending on how the CHIP program is set up. States can design their CHIP program in one of three ways: as an expansion of the Medicaid program, as a separate Child Health Insurance Program, or as a combination of the two approaches. If it is a Medicaid Expansion CHIP program, it will provide the standard Medicaid benefit package, including EPSDT. Separate CHIP programs can provide either Benchmark coverage or Benchmark-equivalent coverage.[9]

Health Issues for Children in Medicaid and CHIP

Understanding the health-related needs of children in Medicaid and CHIP contributes to the selection of appropriate measures across the continuum of child health. Data from the National Health Interview Survey (NHIS) in 2012 found that 83 percent of U.S. children under age 18 had excellent or very good health.[10] While most children are healthy, an important sub-group to consider is children with complex health needs. Approximately two-thirds of all children with complex health needs are covered by Medicaid, accounting for about about 6 percent of the total number of children on Medicaid. However, this 6 percent of enrollees incur nearly 40 percent of costs.[11]

In 2010, children constituted one-fifth of the approximately 130 million visits to hospital-affiliated emergency departments (EDs) in the United States. The vast majority—96 percent—of ED visits resulted in the child being treated and released from the ED rather than being admitted to a hospital for further care. An analysis of Healthcare Cost and Utilization Project (HCUP) data found that two-thirds of ED visits for infants younger than one year were billed to Medicaid. Medicaid was also the largest primary expected payer for ED visits among children aged 1-4 and 5-9 years. Injuries and poisoning and respiratory disorders were the most common reasons for all ED visits, followed by nervous system disorders and infectious and parasitic diseases. When the data are broken out by age, injuries and poisoning were the most common reasons for ED visits for older children, while respiratory disorders were the most common reasons for ED visits for younger children. Among ED visits that result in the child being admitted to a hospital for further, dehydration and respiratory conditions, especially asthma, were common reasons. Additionally, mood disorders and conduct or disruptive behavioral disorders were frequent reasons for ED visits resulting in admission among older children.[12]

Health expenditures provide another lens on children's health issues. According to MEPS data, $117.6 billion was spent for the medical care and treatment of children in 2011. The five most costly medical

conditions in terms of total direct medical spending were mental disorders, asthma, trauma-related disorders, acute bronchitis and upper respiratory infections, and otitis media, as defined by the Clinical Classification System (CCS). Of the five most costly conditions for children, mental disorders affected the fewest children but had the highest average expense per child; nearly half of the $13.8 billion spent on mental disorders in 2011 was covered by Medicaid. About 41.5 percent of mental health expenditures on children were for prescription medications.[13]

While poor birth outcomes lead to high average expenditures per infant, they do not occur as frequently as other high-impact conditions, and so do not appear in the list of top five most costly medical conditions. If examining average expenditures per case, the three most costly conditions are infant respiratory distress syndrome, premature birth/low birth weight, and cardiac and circulatory birth defects, all of which are regarded as poor birth outcomes. Moreover, more than half of hospital stays related to short gestation, low birth weight, or inadequate fetal growth were covered by Medicaid.[14]

Dental caries are the most common chronic disease in children in United States,[15] and, if left untreated, can lead to problems in eating, speaking, learning, and lower quality of life.[16] Six percent of children had an unmet dental need because their families could not afford dental care.[17] The percentage of children ages 2 to 18 who receive dental benefits from Medicaid increased from 20.5 percent in 2000, to 36.8 percent in 2011.[18]

Medicaid Child Core Set

With such a large share of children relying on Medicaid and CHIP for comprehensive health services, the quality of these services is paramount. Performance measurement provides the health system with information it needs to monitor quality and undertake improvement activities when deficits are identified.

The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) provided for the development of a core set of healthcare quality measures for children enrolled in Medicaid and CHIP. The Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) jointly charged a group of experts with creating this core set of measures in 2009.[19] The initial core set of 24 measures contained within the set are relevant to children ages 0-18 as well as pregnant women in order to encompass both pre-natal and post-partum quality of care issues.

CMS' three-part goal for the Child Core Set is to increase the number of states reporting Core Set measures, increase the number of measures reported by each state, and increase the number of states using Core Set measures to drive quality improvement. CHIPRA also required CMS to update the initial core set annually. The 2013 Child Core Set revision added three measures and retired one measure, for a total of 26 measures.[20] For the 2014 update, CMS focused only on measures for retirement. In December 2013, CMS released the 2014 Child Core Set, which retired three measures and brought the total to 23 measures.[21]

Characteristics of the Medicaid Child Core Set

The 2014 Child Core Set contains 23 measures (Appendix D) that are concentrated in the National Quality Strategy priority area of Healthy Living and Well-Being (Exhibit 1).

Exhibit 1. National Quality Strategy

National Quality Strategy Priority	Number of Measures in the Child Core Set (n = 23)
Patient Safety	1
Person- and Family-Centered Experience of Care	1
Effective Communication and Care Coordination	3
Prevention and Treatment of Chronic Disease	0
Healthy Living and Well-Being	16
Affordability	2

Viewed as an array of measure types, the set contains no structural measures, 19 process measures, 4 outcome measures, and 1 experience of care measure. Additionally, the Child Core Set is well-aligned with other quality and reporting initiatives: seven of the measures are used in one or more federal programs, including the Medicaid Adult Core Set and the Health Insurance Marketplace Quality Rating System Measure Set.[22,23] Representing the diverse health needs of the child Medicaid and CHIP population, the Child Core Set measures span many clinical topic areas (Exhibit 2).

Exhibit 2. Clinical Areas Covered by Measures in the Medicaid Child Core Set

Clinical Topics	Number of Measures in the Child Core Set (n = 23)
Access to Care	1
Acute Care and Chronic Conditions (e.g., Asthma, Overweight/Obesity)	3
Behavioral Health	3
Consumer Experience	1
Oral Health	2
Perinatal Care	6
Preventive Care and Screening	7

State Experience Collecting and Reporting the Core Set

MAP values implementation and impact information about measures and uses this feedback to inform its decisionmaking. MAP received feedback on the implementation of the Child Core Set from presentations from states that participated in reporting and from the 2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP. This report states that in 2012, all states reported on at least two measures, with a median of 14 measures per state. Appendix E provides more details. CMS now has four years of experience with this voluntary reporting program and providing technical assistance and analytic support for states. These valuable inputs informed MAP's measure-specific and strategic recommendations for the Medicaid Child Core Set to achieve CMS' three-part goal.

Presentations from two states highlighted that the Child Core Set measures are being used as an important tool to drive improvements on priority issues. The panelists identified implementation and measure-specific challenges to reporting the Medicaid Child Core set, including:

- Greater clarity is needed in the technical specifications, especially around definitions.
- Measures that require chart review pose significant data collection burdens. Not only can they be resource-intensive, but also there may be legal and or technical barriers for the state to review medical records from hospitals and health systems.
- The differences in reporting mechanisms across care settings and benefit structures also pose challenges. States that have "carve-outs" for mental health services experience challenges in gathering data on follow-up care and other details.
- States and their contracted health plans and providers are involved in multiple quality reporting initiatives, such as the Meaningful Use incentives and accreditation for managed care organizations. Greater alignment of measures among these programs would improve the efficiency of participation.

The presenters also provided feedback on strategic issues and measure gap areas:

- Greater capacity for electronic data abstraction and measurement would reduce some of the effort associated with data collection and quality reporting for multiple programs. It would also allow for quality improvement activities that are incorporated into the EHR clinical workflow.
- More measures are needed on mental health topics, such the complex care issues of children in the foster care system, medication use and overuse, and adolescent suicide.

There are various potential reasons states have for reporting relatively few of the Child Core Set measures, including data access and technical capacity. Additionally, states may be using other measures to address local needs and not sharing those results with CMS.

MAP Review of the Medicaid Child Core Set

The focus for MAP's expedited review was to identify opportunities to strengthen the Child Core Set by recommending measures to fill critical gap areas. Prior to MAP's opportunity to provide input on the Child Core Set, the Subcommittee of the National Advisory Council on Healthcare Research and Quality (SNAC) convened by the Agency for Healthcare Research and Quality (AHRQ) reviewed the measures to determine which should be retired from the set.[24] CMS acted on the SNAC's 2013 recommendations and removed three measures from the set in its January 2014 update: pharyngitis testing, annual HbA1c testing, and the asthma ED measure. The removal of these measures created capacity for a small number of new measures to be added in the next annual update, scheduled to occur by January 2015.

High Priority Gaps

During a September 2014 web meeting, MAP identified numerous gaps in measures in the current Child Core Set. These were reviewed and refined at the October in-person meeting and include:

- Care coordination
    - Home- and community-based care

    - Social services coordination
- Screening for abuse and neglect
- Injuries and trauma
- Mental health
    - Access to outpatient and ambulatory mental health services
    - ED use for behavioral health
- Overuse/medically unnecessary care
    - Appropriate use of CT scans
- Inpatient measures
- Durable medical equipment
- Cost measures
    - Targeting people with chronic needs
    - Enrollees' out-of-pocket spending

Although the current version of the Medicaid Child Core Set includes measures pertaining to some of these topics, MAP did not perceive them as comprehensive. For example, two measures in the Child Core Set relate to mental health, but others are available and in development that could be considered for future addition to the set.

Based on the prioritization of gap areas, MAP reviewed available NQF-endorsed measures for potential addition to the measure set. MAP's Measure Selection Criteria (Appendix C) dictate that NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective. NQF-endorsed® measures have undergone a rigorous multi-stakeholder evaluation to ensure they address aspects of care that are important and feasible to measure, provide consistent and credible information, and can be used for quality improvement and decision-making.

MAP also took note of a large number of measures in various stages of development under the auspices of the AHRQ-CMS Pediatric Quality Measures Program (PQMP).[25] Seven CHIPRA Pediatric Healthcare Quality Measures Program Centers of Excellence (COEs) have received cooperative agreement grants to support measure development activities. When complete, these measures will be publicly available for use and will help address the relative lack of measures designed for use with the pediatric population. A large volume of measures on care coordination, behavioral health, and inpatient care are scheduled to be completed by February 2015 and NQF anticipates receiving many of them for endorsement review. MAP will review these new measures in more detail as part of the 2015 process.

Measure-Specific Recommendations

MAP supported all but one of the measures in the current Child Core Set for continued use in the program. Maintaining stability in the measure set will allow states to continue to gain experience reporting the measures, potentially increasing the number of individual measures they are able to submit to CMS on an annual basis. State participants identified some feasibility concerns related to the current measures, but detailed exploration of those challenges will be better addressed during MAP's planned 2015 review. MAP's measure-specific recommendations are described below, with details on the individual measures provided in Appendix D.

Measures for Removal from the Child Core Set

MAP recommends removal of the measure Percentage of Eligibles That Received Dental Treatment Services. CMS and other stakeholders described that the measure is not an effective tool for quality improvement because it is unclear if an increase or decrease in the rate is desirable. For example, a higher number of Medicaid enrollees receiving dental treatment could indicate the positive outcome of improved access to care or the negative outcome of more individuals needing treatment for caries or other poor oral health outcomes. The information collected is not actionable by states or CMS. The measure is not NQF-endorsed.

Measures for Phased Addition to the Child Core Set

MAP recommends that CMS consider up to six measures for phased addition to the Child Core Set. These measures received the approval of 60 percent or more of voting MAP Task Force members. Their use would strengthen the measure set by promoting the measurement of a variety of high-priority quality issues, including oral health, beneficiary experience, and maternity care. However, MAP is aware that additional federal and state resources are required for each new measure. Past revisions to the measure set have not altered more than three measures at a time, indicating that the immediate addition of all measures supported by MAP is highly unlikely. MAP rank-ordered the measures it supports for inclusion in the Child Core Set to provide CMS with a clear sense of priority among the potential measures. CMS may need flexibility to add the measures gradually and only if they are found to be feasible to implement at the state level.

Exhibit 5: Ranking of Measures Supported for Addition to the Child Core Set

Ranking	Measure Number and Title	Votes for Prioritization
1	NQF #2508 Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk	10
2	NQF #2548 Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS)	7
3	NQF #2509 Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk	5
4 (tie)	NQF #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment NQF #0477 Under 1500g infant Not Delivered at Appropriate Level of Care	4
6	NQF #0480 PC-05 Exclusive Breast Milk Feeding	3

MAP awards particular emphasis to the first three measures. NQF #2508 Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk is intended as a replacement for the dental treatment measure recommended for removal. It is clearly linked to improved outcomes and will more accurately capture the quality of care delivered than the original utilization-oriented measure. The use of this measure will also allow CMS to respond to a legislative mandate to measure the use of dental sealants in this age group. Measure #2509 is similar but evaluates the application of sealants to the second set of

molars, which develop at a later age. MAP members discussed whether the use of both measures is necessary, noting that children of all ages need to benefit from these services but also that use of one measure is likely to drive broader changes in practice.

MAP also prioritized the new CAHPS® tool focused on evaluating the family's experience of care when a child is hospitalized. The use of this measure would help to address two gaps that were noted in the measure set; specifically, inpatient measures and patient experience. Hospitals may be using a variety of local, proprietary tools to gauge pediatric patient/family experience at the present time. Broad adoption of a survey that is in the CAHPS family will enhance comparability across sites and across populations. The survey contains a field to capture the payer of care, so MAP concluded that it would be feasible for survey administrators to subset those that apply to Medicaid for the purposes of reporting.

MAP also supported the remaining measures because they addressed important gaps in the current measure set. Specifically, MAP determined that suicide risk screening among children and adolescents with depression was an important intervention for one of the most common behavioral health diagnoses in this population. Participants also flagged the issue of rising rates of antipsychotic use as a prime opportunity for quality improvement, especially among children in the foster care system insured by Medicaid. One measure of antipsychotic use in young children was considered by the group but did not reach the consensus threshold necessary to gain MAP's support. Because several measures are nearly complete but have not yet been reviewed by NQF for endorsement, MAP plans to re-evaluate the measures on this topic during its next review.

Use of measures #0477 and #0480 would strengthen the presence of perinatal care issues in the Child Core Set. While delivery of a low birthweight infant at a facility not well-equipped to handle complex cases is not always avoidable, MAP members agreed that there is much room for improvement on this indicator. It represents an opportunity for women experiencing high-risk pregnancy to receive counseling about the appropriate site of delivery and for regional medical systems to coordinate and communicate about their NICU capabilities. Similarly, breast milk feeding is associated with a variety of positive downstream health outcomes for both mothers and babies, including lowering risk of asthma, allergies, obesity, and certain infections.[26]

Two of the above measures received MAP's conditional support for inclusion because they are currently undergoing review for NQF endorsement. NQF #2548 Child HCAHPS and NQF #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment have both been recommended for endorsement by standing committees.

Strategic Issues

During MAP's review of measures in the Child Core Set, members discussed numerous cross-cutting and strategic issues. While not specific to the use of particular measures, these observations can guide ongoing implementation of the measurement program and inform future iterations of the set.

Feasibility of Reporting and Electronic Data Infrastructure

Several important factors underpin the feasibility of reporting state-level data on quality measures. MAP discussed the impact of the lack of Medicaid data infrastructure and limited resources available to invest in analytics. States have varied, but generally limited, capacity to collect clinical quality information

electronically as eMeasures at this time. Although MAP discussed the possibility of adding more eMeasures to the Child Core Set, most participants felt that uptake of those measures would be quite low in the near term. However, the group called for continued development of eMeasures that are appropriate for use in the Medicaid population, understanding that is the future direction of the quality measurement enterprise. Finally, feasibility of measure implementation can be diminished when measures designed to be used in facilities and/or health plans are retrofitted for state-level reporting. CMS needs to provide clear technical guidance for states to ensure uniformity in data collection and reporting.

Pipeline of Measures in Development

A major strategic consideration for the future direction of the Child Core Set is the large volume of measures undergoing developing and testing in Pediatric Centers of Excellence under the PQMP. As previously described, dozens of measures pertaining to important issue areas will become available for MAP's consideration over the course of the next year. Knowing that other measures were on the horizon influenced MAP's decision-making related to behavioral health and care coordination measures, in particular. The majority of participants wanted to defer action on supporting measures in these topic areas until more information on the new measures could be made available for MAP's review. Some, but not all, of the new measures are expected to be submitted to NQF for endorsement review. Submission to NQF was encouraged but not a grant requirement.

Some measures created by the PQMP grantees are already included in the Child Core Set. For example, the measure of behavioral health risk screening for pregnant women was developed as part of the PQMP. Conscious that the current grant support is scheduled to end in 2015, MAP recognized the need for additional long-term planning for measure development to ensure that work on high-priority pediatric care measures continues to be pursued.

Alignment of Measures

When making recommendations about measures for the Child Core Set, MAP considered the relationship between the selected measures and those contained in the Adult Core Set. Though the two measurement programs are separate, both CMS and States regard them as working together to provide an overall picture of quality within Medicaid and CHIP. Additionally, MAP's 2014 review of the Adult Core Set noted this inter-relationship. Alignment of measures across the programs is especially apparent when considering the quality of the continuum of the prenatal, maternity, and postnatal care of mothers and infants. There is a large presence of perinatal measures in the Child Core Set and three others are contained in the Adult Core Set (i.e., elective delivery, antenatal steroids, and postpartum care rate). This accurately reflects the longstanding importance of Medicaid in providing health coverage to low-income women and babies. MAP discussed the need to further explore health outcomes of the mother/child dyad, specifically how a mother's health and healthcare affects that of her child or children.

Alignment is important on other planes as well. MAP discussed the synergies that arise when measures are shared across the physician-level EHR Incentive Program, better known as Meaningful Use, and the National Committee for Quality Assurance's (NCQA) HEDIS® measure set for health plans. Overlap with HEDIS is especially helpful for states with a significant presence of managed care in their Medicaid

delivery systems because the collection of common measures can satisfy multiple program reporting requirements.

Conclusion

Medicaid is the largest health insurance program in the United States and, together with CHIP, provides for coverage for more than a third of the nation's children. [27] States' participation in reporting measures in the Medicaid Child Core Set greatly contributes to understanding how successful Medicaid programs are in delivering high-quality care to their enrollees. MAP's recommendations are intended to strengthen the measure set and support the three-part goal of CMS for increasing the scope of participation in the program.

MAP requests that CMS remove a measure of the utilization of dental treatment services because it is not actionable for quality improvement purposes. MAP supports the addition of up to six measures to the measure set, including two measures that better address oral health care. In general, the measures recommended for addition address healthcare services and clinical conditions that have significant impact on low-income families and long-term health outcomes.

This expedited review was completed over a period of ten weeks to assist CMS in meeting a statutory deadline, limiting its scope and ability to thoroughly explore states' experiences reporting the current measures and the status of numerous measures still undergoing development and testing. MAP will conduct a more in-depth review of the Medicaid Child Core Set in 2015 to inform the next annual update of the measure set.

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Appendix A: MAP Background

Purpose

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

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

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

MAP's objectives are to:

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

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology to improve patient care, and providing knowledge and tools to healthcare providers and professionals to

help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare. Foundational to the success of all of these efforts is a robust quality enterprise that includes:

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

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

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

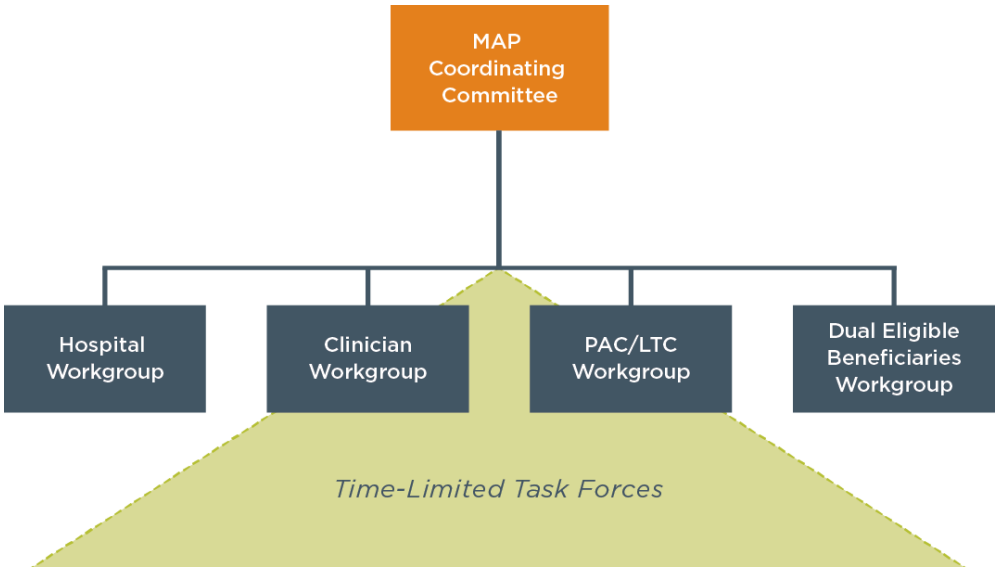
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for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

Impact and Evaluation. Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate if 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 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 initiatives 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 2014 Pre-Rulemaking Report).

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall 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 Core Set and the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces.
- Developed **coordination strategies** intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives.

[1] Patient Protection and Affordable Care Act (ACA), Pub L No. 111-148 Sec. 3014.2010: p.260. Available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Last accessed October 2014.

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

Roster for the MAP Medicaid Child Task Force

CHAIR (VOTING)
Foster Gesten, MD, FACP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
Aetna	Sandra White, MD, MBA
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
American Academy of Pediatrics	Terry Adirim, MD, MPH, FAAP
American Nurses Association	Susan Lacey, RN, PhD, FAAN
America's Essential Hospital's	Beth Feldpush, DrPH
Children's Hospital Association	Andrea Benin, MD
Kaiser Permanente	Susan Fleischman, MD
March of Dimes	Cynthia Pellegrini
National Partnership for Women and Families	Carol Sakala, PhD, MSPH

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Disability	Anne Cohen, MPH
State Medicaid	Marc Leib, MD, JD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Centers for Medicare & Medicaid Services (CMS)	Marsha Smith, MD, PhD, FAAP

MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

Roster for the MAP Coordinating Committee

CO-CHAIRS (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Shaun O'Brien
American Board of Medical Specialties	Lois Margaret Nora, MD, JD, MBA
American College of Physicians	Amir Qaseem, MD, PhD, MHA
American College of Surgeons	Frank Opelka, MD, FACS
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
America's Health Insurance Plans	Aparna Higgins, MA
Blue Cross and Blue Shield Association	Trent T. Haywood, MD, JD
Catalyst for Payment Reform	Shaudi Bazzaz, MPP, MPH
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip N. Kahn, III
Healthcare Financial Management Association	Richard Gundling, FHFMA, CMA
Healthcare Information and Management Systems Society	Representative TBD
The Joint Commission	Mark R. Chassin, MD, FACP, MPP, MPH
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
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	Margaret E. O'Kane, MHS
National Partnership for Women and Families	Alison Shippy
Pacific Business Group on Health	William Kramer, MBA
Pharmaceutical Researchers and Manufacturers of America (PhRMA)	Christopher Dezii, RN, MBA,CPHQ

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Marshall Chin, MD, MPH, FACP
Harold Pincus, MD
Carol Raphael, MPA

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

NQF Staff

Sarah Lash	Senior Director
Elizabeth Carey	Senior Project Manager
Nadine Allen	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 strengths and weaknesses of a program measure set, and how the addition of measures would contribute to the set.

Criteria

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 [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

Appendix D: Medicaid Child Core Set and MAP Recommendations

In February 2011, HHS published the initial core set of quality measures for children enrolled in Medicaid and CHIP. The authorizing legislation also requires HHS to publish annual changes to the Child Core Set beginning in January 2013. Table D1 below lists the measures included in the current version of the Child Core Set along with their current NQF endorsement number and status. States voluntarily collect the Medicaid Child Core Set measures using the 2014 Technical Specifications and Resource Manual. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's Quality Positioning System. Table D2 lists the measures supported by MAP for potential addition to the Child Core Set.

Table D1: Current Medicaid Child Core Set

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0024 Endorsed Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) Measure Steward: National Committee for Quality Assurance	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: • Body mass index (BMI) percentile documentation • Counseling for nutrition • Counseling for physical activity	27 states reported FY 2012 Alignment: Meaningful Use (EHR Incentive Program) - Eligible Professionals (MU-EP), Physician Feedback, Physician Quality Reporting System (PQRS), Health Insurance Exchange–Quality Rating System (HIX-QRS)	Support continued use of this measure in the program. No significant implementation issues identified at this time.
0033 Endorsed Chlamydia Screening in Women (CHL) Measure Steward: National Committee for Quality Assurance	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.	35 states reported FY 2012 Alignment: Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (Medicaid Adult Core Set), MU-EP, PQRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0038 Endorsed Childhood Immunization Status (CIS) Measure Steward: National Committee for Quality Assurance	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B(HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	34 states reported FY 2012 Alignment: MU-EP, PQRS, HRSA program(s), HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
0108 Endorsed Follow-Up Care for Children Prescribed ADHD Medication (ADD) Measure Steward: National Committee for Quality Assurance	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. • Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. • Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	29 states reported FY 2012 Alignment: MU-EP, PQRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0139 Endorsed National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure Measure Steward: Centers for Disease Control and Prevention	Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • other inpatient locations. (Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.	40 states reported FY 2012 Alignment: Hospital Acquired Condition Reduction Program, Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, Long-term Care Hospital Quality Reporting, PPS-Exempt Cancer Hospital Quality Reporting	Support continued use of this measure in the program. No significant implementation issues identified at this time.
0471 Endorsed PC-02 Cesarean Section Measure Steward: Joint Commission	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	12 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0576 Endorsed Follow-Up After Hospitalization for Mental Illness (FUH) Measure Steward: National Committee for Quality Assurance	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: - The percentage of discharges for which the patient received follow-up within 30 days of discharge - The percentage of discharges for which the patient received follow-up within 7 days of discharge.	27 states reported FY 2012 Alignment: Dual Eligibles Core Quality Measures - Capitated Demonstrations and Managed Fee For Service Demonstrations, Medicaid Adult Core Set, Inpatient Psychiatric Hospital Quality Reporting, Medicare Part C Plan Rating, HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1382 Endorsed Percentage of low birthweight births Measure Steward: Centers for Disease Control and Prevention	The percentage of births with birth weight <2,500 grams	15 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1391 Endorsed Frequency of Ongoing Prenatal Care (FPC) Measure Steward: National Committee for Quality Assurance	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: •<21 percent of expected visits •21 percent–40 percent of expected visits •41 percent–60 percent of expected visits •61 percent–80 percent of expected visits •> or =81 percent of expected visits	25 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
1392 Endorsed Well-Child Visits in the First 15 Months of Life (W15) Measure Steward: National Committee for Quality Assurance	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported: •No well-child visits •One well-child visit •Two well-child visits •Three well-child visits •Four well-child visits •Five well-child visits •Six or more well-child visits	43 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1407 Endorsed Immunizations for Adolescents (IMA) Measure Steward: National Committee for Quality Assurance	The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.	32 states reported FY 2012 Alignment: HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1448 Endorsed Developmental Screening in the First Three Years of Life Measure Steward: Oregon Health & Science University	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.	12 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1516 Endorsed Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) Measure Steward: National Committee for Quality Assurance	Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	46 states reported FY 2012 Alignment: HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
1517 Endorsed Prenatal & Postpartum Care (PPC)* Measure Steward: National Committee for Quality Assurance *Medicaid Child Core Set includes "Timeliness of Prenatal Care" rate only. "Postpartum Care" rate is evaluated in Medicaid Adult Core Set.	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	31 states reported FY 2012 Alignment: Medicaid Adult Core Set, HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1799 Endorsed Medication Management for People with Asthma (MMA) Measure Steward: National Committee for Quality Assurance	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.	0 states reported FY 2012 (New)	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1959 Endorsed Human Papillomavirus Vaccine for Female Adolescents (HPV) Measure Steward: National Committee for Quality Assurance	Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	0 states reported FY 2012 (New)	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
N/A Not Endorsed Maternity Care: Behavioral Health Risk Assessment Measure Steward: AMA-PCPI/NCQA/ACOG	Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: screening for depression, alcohol use, tobacco use, drug use, and intimate partner violence screening	0 states reported FY 2012 (New)	Support continued use of this measure in the program. No significant implementation issues identified at this time.
N/A Not Endorsed Percentage of Eligible Children Who Received Dental Treatment Services Measure Steward: CMS	The percentage of individuals ages one to twenty years old eligible for Medicaid or CHIP Medicaid Expansion programs (that is, individuals eligible to receive EPSDT services) who received dental treatment services.	51 states reported FY 2012	Recommend the removal of this measure from the program. Measure is not actionable for quality improvement because it is unclear whether an increase in the number of children receiving dental treatment is a positive outcome (e.g., access is improved) or a negative outcome (e.g., more children require treatment because of poor oral health).
N/A Not Endorsed Children and Adolescents' Access to Primary Care Practitioners Measure Steward: NCQA	The percentage of children 12 months –19 years of age who had a visit with a primary care practitioner. Four separate percentages are reported: Children 12 through 24 months and children 25 months through 6 years who had a visit with a primary care practitioner during the measurement year; Children 7 through 11 years and adolescents 12 through 19 years who had a visit with a primary care practitioner during the measurement year or the year prior to the measurement year.	43 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
N/A Not Endorsed Adolescent Well-Care Visits Measure Steward: NCQA	The percentage of enrolled adolescents 12–21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.	43 states reported FY 2012 Alignment: HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
N/A Not Endorsed Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0, Child Version Measure Steward: NCQA	This measure provides information on parents' experience with their child's health care for population of children with chronic conditions. Results include same ratings, composites, and individual question summary rates as reported for the CAHPS Health Plan Survey 4.0H, Child Version. Three CCC composites summarize satisfaction with basic components of care essential treatment, management and support of children with chronic conditions. 1. Access to Specialized Services; 2. Family Centered Care: Personal Doctor Who Knows Child; 3. Coordination of Care for CCC. Question summary rates also reported individually for summarizing the following two concepts: 1. Access to Prescription Medicines; 2. Family Centered Care: Getting Needed Information. Five composite scores summarize responses in key areas: 1. Customer Service; 2. Getting Care Quickly: 3. Getting Needed Care: 4. How Well Doctors Communicate; 5. Shared Decision Making.	27 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
N/A Not Endorsed Percentage of Eligible Children Who Received Preventive Dental Services Measure Steward: CMS	The percentage of individuals ages one to twenty years old eligible for Medicaid or CHIP Medicaid Expansion programs (that is, individuals eligible to receive EPSDT services) who received preventive dental services.	51 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
N/A Not Endorsed Ambulatory Care: Emergency Department Visits Measure Steward: NCQA	The rate of emergency department visits per 1,000 member months among children up to age 19.	28 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Table D2: Measures Supported by MAP for Addition to the Medicaid Child Core Set

Measure Number & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
2508 Endorsed Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk Measure Steward: American Dental Association on behalf of the Dental Quality Alliance	Percentage of enrolled children in the age category of 6-9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year.		Support addition of this measure to the program. Potential replacement for measure of dental treatment services recommended for removal.
2548 Undergoing Endorsement Review Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS) Measure Steward: Center for Quality Improvement and Patient Safety -Agency for Healthcare Research and Quality	The Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS) is a standardized survey instrument that asks parents and guardians (henceforth referred to as parents) of children under 18 years old to report on their and their child's experiences with inpatient hospital care.		Support addition of this measure to the program. Addresses gaps in inpatient measures and beneficiary experience of care.
2509 Endorsed Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk Measure Steward: American Dental Association on behalf of the Dental Quality Alliance	Percentage of enrolled children in the age category of 10-14 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent second molar tooth within the reporting year.		Support addition of this measure to the program. Potential replacement for measure of dental treatment services recommended for removal.
1365 Endorsed Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	Meaningful Use (EHR Incentive Program) - Eligible Professionals; Physician Quality Reporting System (PQRS)	Support addition of this measure to the program. Addresses gap in behavioral health.

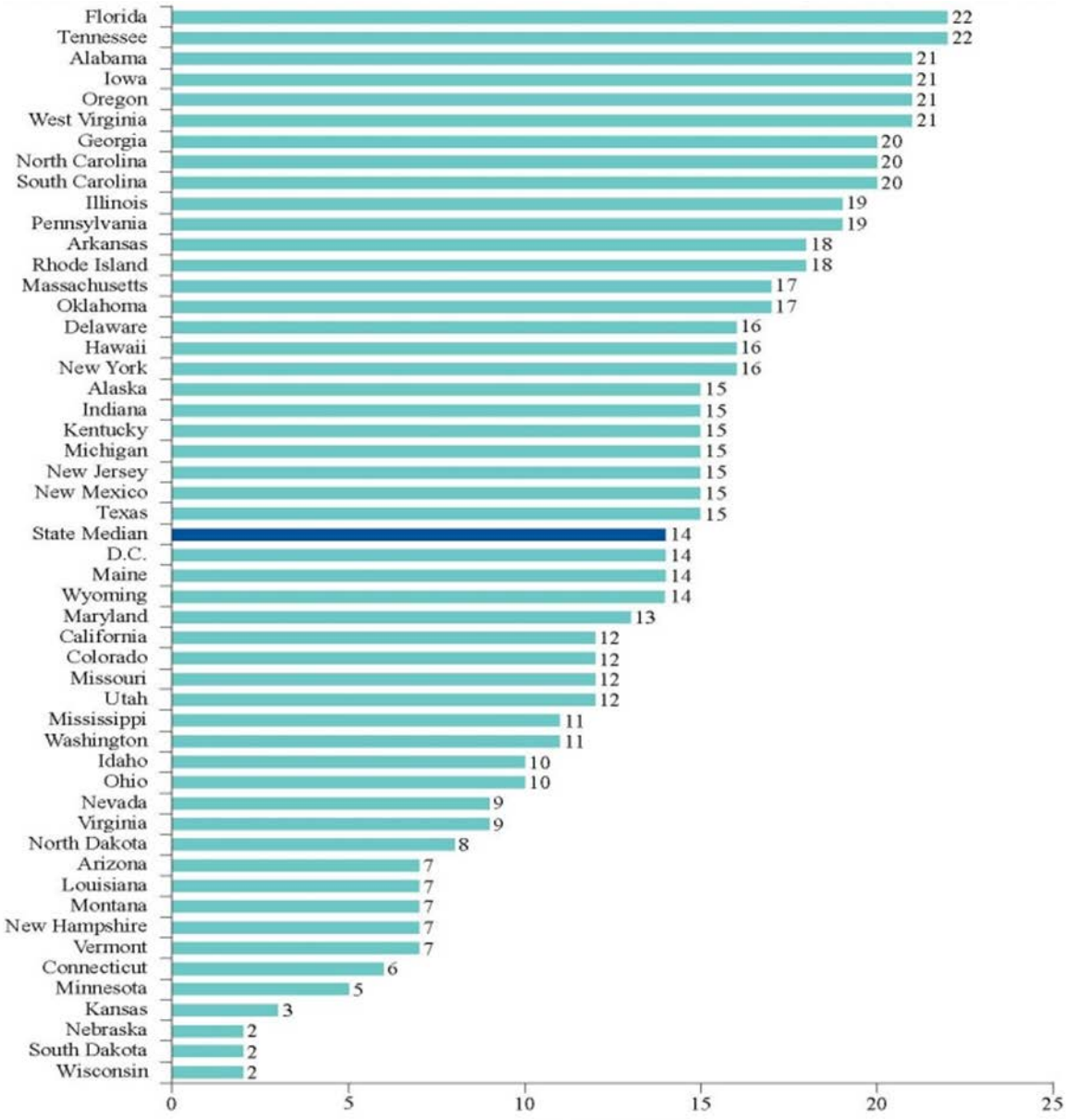
0477 Endorsed Under 1500g infant Not Delivered at Appropriate Level of Care Measure Steward: California Maternal Quality Care Collaborative	The number per 1,000 livebirths of <1500g infants delivered at hospitals not appropriate for that size infant.		Support addition of this measure to the program. Enhances perinatal measures and would improve regional care coordination for high-risk pregnancies.
0480 Endorsed PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice Measure Steward: The Joint Commission	PC-05 assesses the number of newborns exclusively fed breast milk during the newborn´s entire hospitalization and a second rate, PC-05a which is a subset of the first, which includes only those newborns whose mothers chose to exclusively feed breast milk. 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-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns).	Meaningful Use (EHR Incentive Program) - Hospitals, CAHs	Support addition of this measure to the program. Enhances perinatal measures and is associated with positive health outcomes for mother and child.

Appendix E: State Implementation and Participation in Reporting Measures

CMS now has four years of experience with this voluntary reporting program and providing technical assistance and analytic support for states. In 2012, CMS began calculating the two dental measures, Percentage of Eligible Children Who Received Dental Treatment Services and Percentage of Eligible Children Who Received Preventive Dental Services, using data reported by states on Form CMS-416. Thus, all states report on at least two measures (Exhibit E1). Thirty-five states reported at least 11 of the 22 core measures to CMS, with a median of 14. Notably, Florida and Tennessee reported 22 of the core measures while Nebraska, South Dakota, and Wisconsin reported 2 measures. [1]

Exhibit E1. Number of Medicaid/CHIP Child Core Set Measures Reported by States in FY 2012

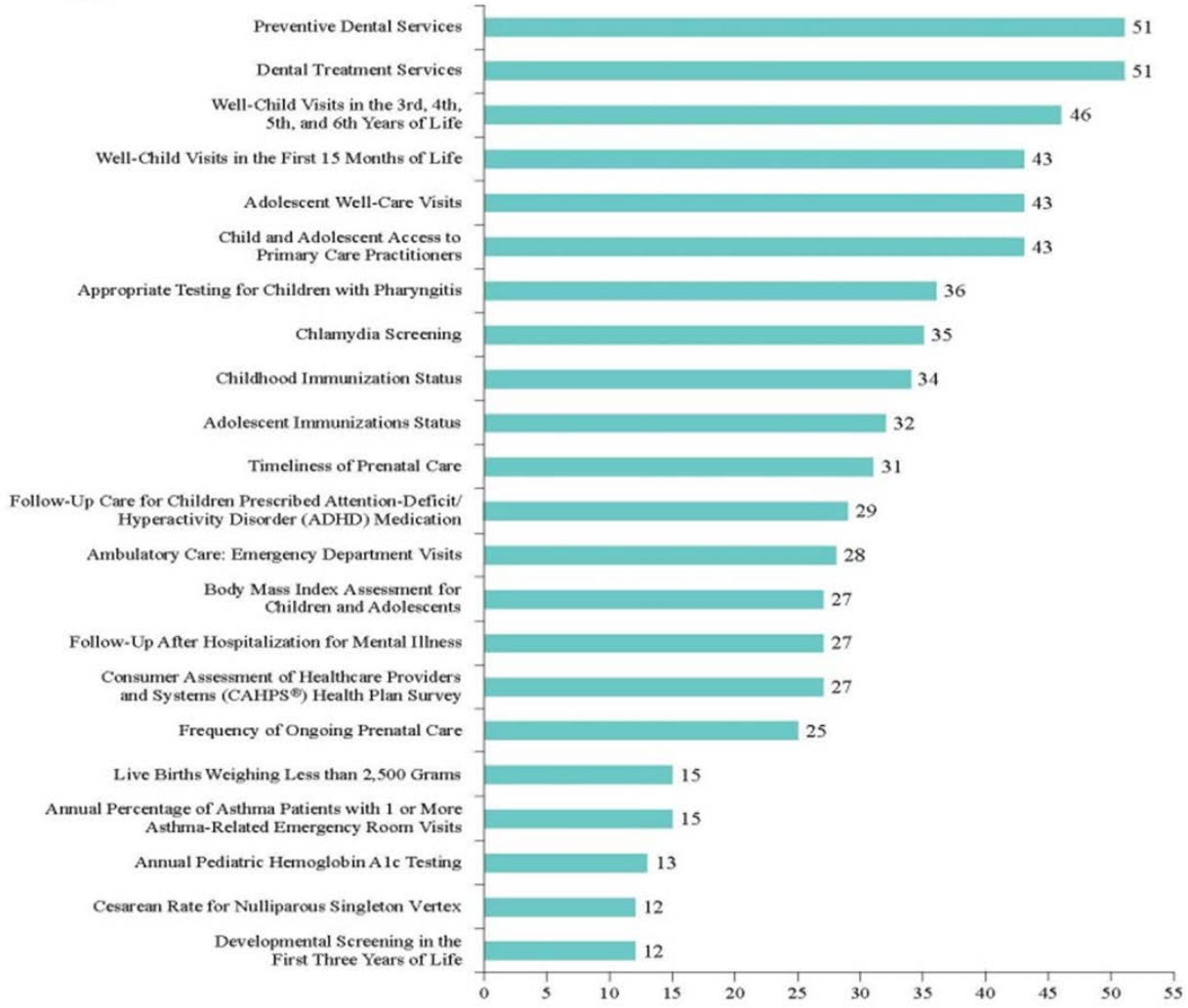
(Source: *2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP*)



As shown in Exhibit E2, The most frequently reported measures in FY2012 assess dental services, well-child visits, and access to care.[2]

Exhibit E2. Number of States Reporting Measures in Medicaid/CHIP Child Core Set in FY 2012

(Source: *2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP*)



[1] HHS. 2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf. Last accessed September 2014.

[2] HHS. 2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf. Last accessed September 2014.