NATIONAL QUALITY FORUM

Web Meeting Agenda

Measure Applications Partnership (MAP)

Joint Meeting of the Medicaid Adult and Child Task Forces

Monday, April 27, 2015

12:00-2:00 pm ET

Participant Instructions:

- Please log in 10 minutes prior to the scheduled start to allow time for troubleshooting
- Direct your browser to: http://nqf.commpartners.com for slides and streaming audio
- Under "Enter a Meeting," type in the meeting number **599356** and click "Enter"
- In the "Display Name" field, type in your first and last name and click "Enter Meeting"
- Task force members dial **(877) 331-3815** to access the audio platform.
- Public participants dial **(855) 500-8563** to access the audio platform.

Meeting Objectives:

- Orient both Task Forces to MAP's charge in providing input to CMS on the Medicaid Adult Core Set and Child Core Set of measures
- Review MAP's prior input and the measures currently planned for use in both measure sets
- Identify information needs to support Medicaid Task Forces decisionmaking at the in-person meeting

12:00 pm **Welcome and Review of Meeting Objectives**

Foster Gesten, Medicaid Child Task Force Chair
Harold Pincus, Medicaid Adult Task Force Chair

12:10 pm **Introductions of Task Force Members and Disclosures of Interest**

Ann Hammersmith, General Counsel, NQF

12:25 pm **CMS Goals for Adult and Child Quality Measurement Programs**

Marsha Lillie-Blanton, Chief Quality Officer, CMCS & Director, Division of Quality, Evaluation & Health Outcomes
Karen LLanos, Director, Medicaid Innovation Accelerator Program, Center for Medicaid and CHIP Services, CMS
Foster Gesten

- Program structure and CMS goals for the Adult Core Set and Child Core Set
- Input requested from MAP in 2015
- Questions from task force members

12:45 pm **Child Core Set: Recent Changes and Properties of the Measures**
Shaconna Gorham, Senior Project Manager, NQF
Foster Gesten

- MAP's 2014 measure and gap recommendations for the Child Core Set
- Review current measures in the Core Set and note recent changes based on CMS updates for FFY 2015
- Questions and comments from task force members related to opportunities to further strengthen the Child Core Set

1:15 pm **Adult Core Set: Recent Changes and Properties of the Measures**

Sarah Lash, Senior Director, NQF
Harold Pincus

- MAP's 2014 measure and gap recommendations for the Adult Core Set
- Review current measures in the Core Set and note recent changes based on CMS updates for FFY 2015
- Questions and comments from task force members related to opportunities to further strengthen the Adult Core Set

1:45 pm **Looking Ahead to the In-Person Meeting: Opportunities for Further Strengthening the Measure Sets**

Sarah Lash
Harold Pincus

- Planned agenda and resources for in-person meeting
- What information is needed about the implementation experience from participating and/or non-participating states?
- What additional information do the task forces need to support their deliberations?

1:55 pm **Opportunity for Public Comment**

2:00 pm **Next Steps and Adjourn**
Shaconna Gorham

NATIONAL QUALITY FORUM

Roster

Measure Applications Partnership
Medicaid Adult Task Force

COMMITTEE CHAIRS (VOTING)

Harold Pincus, MD (Chair)

ORGANIZATIONAL MEMBERS (VOTING)

Academy of Managed Care Pharmacy
Marissa Schlaifer

American Academy of Family Physicians
Alvia Siddiqi, MD, FAAFP

American Academy of Nurse Practitioners
Sue Kendig

America's Health Insurance Plans
Kirstin Dawson

Humana, Inc.
George Andrews, MD, MBA, CPE, FACP

March of Dimes
Cynthia Pellegrini

National Association of Medicaid Directors
Daniel Lessler, MD, MHA, FACP

National Rural Health Association
Brock Slabach, MPH, FACHE

SUBJECT MATTER EXPERTS (VOTING)

Nancy Hanrahan, PhD, RN, FAAN

Ann Marie Sullivan, MD

Anne Cohen, MPH

Marc Leib, MD, JD

Measure Applications Partnership

Joint Web Meeting of the Medicaid Adult and Child Task Forces

April 27, 2015

NATIONAL QUALITY FORUM

Welcome and Review of Meeting Objectives

Meeting Objectives

- Orient both Task Forces to MAP's charge in providing input to CMS on the Medicaid Child Core Set and Adult Core Set of measures
- Review MAP's prior input and the measures currently planned for use in both measure sets
- Identify information needs to support Medicaid Task Force decisionmaking at the in-person meeting

Introductions of Task Force Members and Disclosures of Interest

Medicaid Child Task Force Membership

Task Force Chair: Foster Gesten, MD, FACP

Organizational Members

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 Hospitals	Denise Cunill, MD, FAAP
Blue Cross and Blue Shield Association	Carole Flamm, MD, MPH
Children's Hospital Association	Andrea Benin, MD
Kaiser Permanente	Jeff Convissar, MD
March of Dimes	Cynthia Pellegrini
National Partnership for Women and Families	Carol Sakala, PhD, MSPH
Patient-Centered Primary Care Collaborative	Amy Gibson

Medicaid Child Task Force Membership

Subject Matter Experts

Luther Clark, MD
Anne Cohen
Marc Leib, MD, JD

Federal Government Members

Health Resources and Services Administration (HRSA)	Ashley Hirai
Office of the National Coordinator for Health IT (ONC)	Kevin Larsen

Medicaid Adult Task Force Membership

Taskforce Chair: Harold Pincus, MD

Organizational Members

Academy of Managed Care Pharmacy	Marissa Schlaifer
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
American Academy of Nurse Practitioners	Sue Kendig
America's Health Insurance Plans	Kirstin Dawson
Humana, Inc.	George Andrews, MD, MBA, CPE, FACP
March of Dimes	Cynthia Pellegrini
National Association of Medicaid Directors	Daniel Lessler, MD, MHA, FACP
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Medicaid Adult Task Force Membership

Subject Matter Experts

Nancy Hanrahan, PhD, RN, FAAN
Ann Marie Sullivan, MD
Marc Leib, MD, JD
Anne Cohen

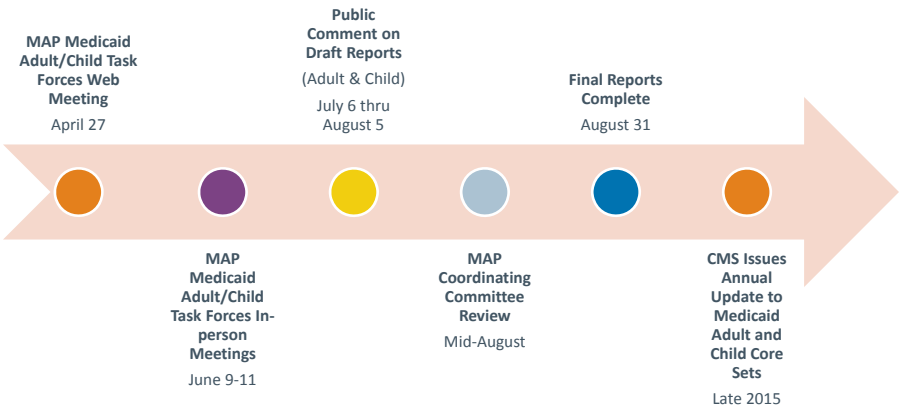
Federal Government Members

Substance Abuse and Mental Health Services Administration (SAMHSA)	Lisa Patton
Centers for Medicare & Medicaid Services (CMS)	Marsha Smith, MD, PhD, FAAP

MAP Medicaid Child and Adult Task Forces Charge

- For this review, the charge of the MAP Medicaid Child and Adult Task Forces is to:
  - Review states' experiences reporting measures to date
  - Refine previously identified measure gap areas and recommend potential measures for addition to the set
  - Recommend measures for removal from the set that are found to be ineffective
- The task force consists of current MAP members from the MAP Coordinating Committee and MAP workgroups with relevant interests and expertise.
- MAP will convene the task force beginning April 2015, with a report due to CMS by August 2015.

2015 Timeline



Overview of the Child and Adult Core Sets

MAP Web Meeting April 2015

Marsha Lillie-Blanton & Karen LLanos
Center for Medicaid and CHIP Services
Centers for Medicare &Medicaid Services

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CMS Goals
Child and Adult Core Sets

- Three-part goal for Child and Adult Core Sets:
  1. Increase number of states reporting Core Set measures
  2. Increase number of measures reported by each state
  3. Increase number of states using Core Set measures to drive quality improvement

Child and Adult Core Set: In Different Stages of Development

- Child Core Set: CMS has spent the past five years working with states to understand the Child Core Set measures and to refine the reporting guidance provided.
- Adult Core Set: New program. As with any new reporting program, the early years focus on working with states to understand the Core Set measures and to refine the reporting guidance provided.

Children's Core Set Measures

- Initial Core Set released in Feb 2011
  - 24 measures, had to be "in use"
- Voluntary reporting of measures occurs at state-level
  - Closed 5th year of reporting
  - CMS updates technical specifications manual annually
  - States submit data to CMCS
  - Technical Assistance and Analytic Support Program for States
- Most recent Child Core Set released in January 2015

Improving the Child Core Set

- CHIPRA requires the initial core set of measures to be "improved" annually beginning in January 1, 2013
- In the past, CMCS partnered with AHRQ's Subcommittee to the National Advisory Committee to provide multi-stakeholder feedback
- Previous updates to the Child Core Set
  - 2012: Retired 1, added 3
  - 2013: Retired 3
  - 2014: Retired 1 measure , added 2 new measures

Medicaid Adult Core Set Measures

- Core Set required by the Affordable Care Act section 2701
  - Identification of parsimonious core set of measures that is reflective of the diverse health care quality needs of adults in Medicaid
  - Initial core set of 26 measures released 2012
- Voluntary reporting to CMS occurs at state-level
  - Closed second year of reporting
  - CMS updates technical specifications manual annually
  - States submit data to CMCS
  - Technical Assistance and Analytic Support Program for States
  - CMS updates technical specifications manual annually

Medicaid Adult Core Set Measures

- CMS launched two-year grant program December 2012 to support Medicaid agencies in testing the collection and reporting of the Core Set
  - 26 grantees were required to report at least 15 measures in the first year. All grantees reported at least 10 measures the second year
  - Commonalities of the measures grantees selected for reporting (and those not selected) provide insight on why some measures are more challenging than others to report

Improving the Adult Core Set

- Annual improvements (defined as “strengthening”) to Core Set are required
- Previous updates to the Adult Core Set
  - 2013 changes
    - Replaced one measure
  - 2014 changes
    - Retire 1 measure, added 1 measure

Input Requested From Child & Adult MAPs in 2015

- Focus on incremental changes
  - CMS and states continue to learning about current Child & Adult Core Set measures
  - Take into account the state staff time and resources it takes to learn/incorporate a new measure
- MAP can assist CMS identify ways to strengthen the Child & Adult Core Set:
  - Which measures can be added to fill key gap areas
  - Which measures to retire
  - Ways to better align with other CMS/HHS programs

Next Steps (after MAP feedback process)

- CMS reviews MAP feedback with various internal/external stakeholders:
  - Internal discussions at the Center for Medicaid and CHIP Services
  - Broader discussions with CMS's agency-level Quality Measures Task Force
- Annual updates to both Core Sets to be released by January 2016

Next Steps
(after MAP feedback process)

- CMS to issue public reports (separate for Child and Adult)
  - Annual Secretary's Report (September 30th annually)
  - Report to Congress every three years
- Measure development and refinement
  - Child measures:
    - Past 4 years focused on measurement development in collaboration with through seven centers of excellence
  - Adult measures:
    - Development activities planned

Questions?

Child Core Set: Recent Changes and Properties of the Measures

MAP's Initial Assessment of the Core Set – Fall 2014

- MAP's input on the Child Core Set began with an expedited review, over the course of ten weeks, in the fall of 2014 .
- The expedited review focused on recommending measures to fill critical gap areas.
- MAP's review informed the annual update of the measure set released by CMS on December 30, 2014.
- Strategic issues and newly endorsed measures in critical gap areas will be reviewed during the June 2015 meeting.

Medicaid Child Core Set Measures for FFY 2015 Use

NQF #	Measure Name	Measure Steward
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/Adolescents	NCQA
0033	Chlamydia Screening in Women	NCQA
0038	Childhood Immunization Status	NCQA
0108	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA
0139	Pediatric Central-line Associated Bloodstream Infections–Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CDC
0471	Cesarean Rate for Nulliparous Singleton Vertex (PC-02)	Joint Commission
0576	Follow-up After Hospitalization for Mental Illness	NCQA
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)*	AMA-PCPI
1382	Live Births Weighing Less than 2,500 Grams	CDC
1391	Frequency of Ongoing Prenatal Care	NCQA
1392	Well-Child Visits in the First 15 Months of Life	NCQA

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* This measure was added to the 2015 Child Core Set.
AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CDC = Centers for Disease Control and Prevention; NCQA = National Committee for Quality Assurance

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Medicaid Child Core Set Measures for FFY 2015 Use - Continued

NQF #	Measure Name	Measure Steward
1407	Immunization Status for Adolescents	NCQA
1448	Developmental Screening in the First Three Years of Life	OHSU
1516	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA
1517	Timeliness of Prenatal Care	NCQA
1799	Medication Management for People with Asthma	NCQA
1959	Human Papillomavirus (HPV) Vaccine for Female Adolescents	NCQA
2508	Prevention: Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL)*	DQA (ADA)
n/a	Ambulatory Care - Emergency Department (ED) Visits	NCQA
n/a	Adolescent Well-Care Visit	NCQA
n/a	Behavioral Health Risk Assessment (for Pregnant Women)	AMA-PCPI
n/a	Child and Adolescents' Access to Primary Care Practitioners	NCQA
n/a	Consumer Assessment of Healthcare Providers and Systems® CAHPS 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)	NCQA
n/a	Percentage of Eligibles That Received Preventive Dental Services	CMS

Measure Applications Partnership
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*This measure was added to the 2015 Child Core Set.
n/a denotes measure is not NQF endorsed
DQA (ADA) = Dental Quality Alliance (American Dental Association); OHSU = Oregon Health and Science University.

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Medicaid Child Core Set Properties: Conditions

Clinical Conditions in Current Medicaid Child Core Set	Number of Measures (n = 24)
Access to Care	1
Behavioral Health	3
Care of Acute and Chronic Conditions (e.g., Asthma, Overweight/Obesity)	3
Experience of Care*	1
Maternal and Perinatal Care	6
Oral Health	2
Preventive Care	8

*CMS will also pilot a reporting process for the Child HCAHPS survey (NQF #2548)

Medicaid Child Core Set Properties: NQS

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

Medicaid Child Core Set Properties: Measure Characteristics

Medicaid Child Core Set Characteristics		Number of Measures (n = 24)
NQF Endorsement Status	Endorsed	18
	Not Endorsed	6
Measure Type	Structure	0
	Process	21
	Outcome	3
Data Collection Method	Administrative Claims	19
	Electronic Clinical Data	15
	eMeasure Available	6
	Survey Data	2
Alignment	In use in one or more other federal programs	9
	In the Medicaid Adult Core Set	3*

*Frequency of Ongoing Prenatal Care has one rate in the child set and one rate in the adult set

MAP's Recommendations to Fill Critical Gap Areas – Fall 2014

- MAP identified numerous gaps in measures in the 2014 Child Core Set, including:
  - Care coordination
  - Screening for abuse and neglect
  - Injuries and trauma
  - Mental health
  - Overuse/medically unnecessary care
  - Inpatient measures
  - Durable medical equipment (DME)
  - Cost measures

MAP's Recommendations to Fill Critical Gap Areas – Fall 2014, Continued

- MAP noted measures in various stages of development under the auspices of the AHRQ-CMS Pediatric Quality Measures Program (PQMP)
  - Measures will help address relative lack of measures designed for use with the pediatric population
  - Care coordination, behavioral health and inpatient care measures were scheduled to be completed by February 2015

MAP Measure Specific Recommendations – Fall 2014

- **MAP supported all but one measure in the Child Core Set for continued use in the program.**
- Removal: Percentage of Eligibles That Received Dental Treatment Services
  - MAP recommended that the measure be removed because it is not an effective tool for quality improvement. It is unclear if an increase or decrease in the rate is desirable.

MAP Measure-Specific Recommendations – Fall 2014, Continued

MAP recommended six measures for phased addition:

1. NQF #2508 Prevention: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk

2. #2548 Child HCAHPS

3. #2509 Prevention: Dental Sealants for 10-14 Year Old Children at Elevated Cares Risk

4/5 (tie). #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

4/5 (tie). #0477 Under 1500g Infant Not Delivered at Appropriate Level of Care

6. #0480 PC-05 Exclusive Breast Milk Feeding

CMS - Child Core Set Update for 2015 Reporting

Issued December 30, 2014

- Informed by MAP's recommendations, CMS updated the Child Core Set:
  - Retired one measure:
    - Percentage of Eligibles that Received Dental Treatment Services
  - Added two measures:
    - Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk;
    - Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
  - In addition, CMS will pilot a reporting process for the child version of the Hospital Consumer Assessment of Healthcare Providers and Systems survey (Child HCAHPS)
- These updates correspond well to MAP's suggested course of action.

Source: CMCS Informational Bulletin "2015 Updates to the Child and Adult Core Health Care Quality Measure Sets."

Overview of Medicaid Child Core Set FFY 2013 Reporting (most recent data available)

All states voluntarily reported two or more of the Child Core Set measures

- The term "states" includes the 50 states and the District of Columbia
- Median number of measures reported was 16
- 33 states reported at least 13 of the 25 core measures
- Data completeness improved; 41 states now include both Medicaid and CHIP populations in one or more measures
- Most frequently reported measures include assess to primary care, well-child visits, and use of dental services

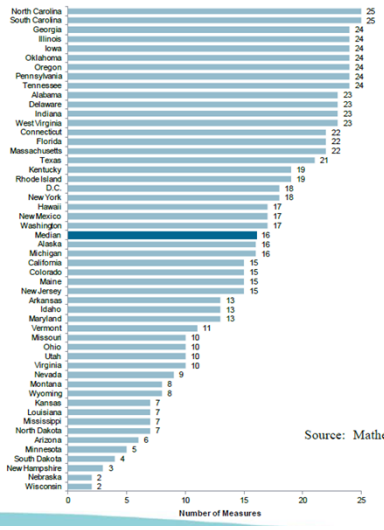
Source for slides 28-31: The Department of Health and Human Services 2014 Annual report on the Quality of Health Care for Children in Medicaid and CHIP

Overview of Medicaid Child Core Set FFY 2013 Reporting

- First year reporting of three newest measures was encouraging
  - 23 states reported the HPV Vaccine for Female Adolescents and Medication Management for People with Asthma measures
  - Two states reported the Behavioral Health Risk Assessment (for Pregnant Women) measure
    - » requirement for EHRs to calculate measure was a barrier

Source: Based on Mathematica analysis of FFY 2012 CARTS reports.
Notes: Analysis was conducted on 16 Child Core Set measures reported by 25 states or more. Ambulatory Care ED visits and CLABSI were excluded from this analysis. Also, Appropriate Testing for Pharyngitis was retired from the core set.

Number of Medicaid/CHIP Children's Health Care Quality Measures Reported by States, FFY 2013



Source: Mathematica analysis of FFY 2013 Child CARTS reports.

Centers for Medicare & Medicaid Services
Medicaid/CHIP
Health Care Quality Measures

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Notes: This figure is based on state reporting of 25 core set measures for FFY 2013. This figure excludes the Central Line-Associated Bloodstream Infection (CLABSI) measure. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC National Healthcare Safety Network. The term "states" includes the 50 states and the District of Columbia.

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Number of States Reporting the Core Set of Medicaid/CHIP Children's Health Care Quality Measures, FFY 2013

Source: Mathematica analysis of FFY 2013 Child CARTS reports and Form CMS-416 reports.

Centers for Medicare & Medicaid Services
Medicaid/CHIP
Health Care Quality Measures

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Notes: Beginning in FFY 2013, to minimize state burden, CMS began calculating the two dental measures on behalf of states using data reported on Form CMS-416. The term "states" includes the 50 states and DC.

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Child Task Force Discussion and Questions

- Questions or comments about the data presented?
- Observations about the updates that CMS made based on MAP's 2014 review?
- Have any measure gap areas been satisfied or emerged as a result of the most recent update?
  - Measures suggested by MAP for addition but not yet added by CMS may need to be re-evaluated in 2015 along with other priorities for updates.

Adult Core Set: Recent Changes and Properties of the Measures

MAP 2014 Assessment of the Adult Core Set

- The composition of the Medicaid Adult Core Set is well-matched with CMS' stated goals for the program
- The Core Set's strong alignment with other program sets and parsimonious number of measures should continue
- MAP encourages the inclusion of relevant outcome measures in future iterations of the set
- MAP strongly prefers that the set contain the most current NQF-endorsed® measures to ensure validity and reliability
- MAP observed changes had been made to several measures to enable state-level reporting

Medicaid Adult Core Set Measures for FFY 2015 Use

NQF #	Measure Name	Measure Steward
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA
0006	CAHPS Health Plan Survey v 4.0—Adult Questionnaire with CAHPS Health Plan Survey v 5.0 (Medicaid)	AHRQ
0018	Controlling High Blood Pressure	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA
0032	Cervical Cancer Screening	NCQA
0033	Chlamydia Screening in Women Ages 21-24	NCQA
0039	Flu Vaccinations for Adults Age 18 and Older	NCQA
0057	Comprehensive Diabetes Care: Hemoglobin A1c Testing	NCQA
0059	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)	NCQA
0105	Antidepressant Medication Management	NCQA
0272	PQI 01: Diabetes, Short-Term Complications Admission Rate	AHRQ
0275	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	AHRQ

Medicaid Adult Core Set Measures for FFY 2015 Use - Continued

NQF #	Measure Name	Measure Steward
0277	PQI 08: Congestive Heart Failure (CHF) Admission Rate	AHRQ
0283	PQI 15: Adult Asthma Admission Rate	AHRQ
0418	Screening for Clinical Depression and Follow-Up Plan	CMS
0469	PC–01: Elective Delivery	Joint Commission
0476	PC–03 Antenatal Steroids	Joint Commission
0576	Follow-Up After Hospitalization for Mental Illness	NCQA
0648	Care Transition—Transition Record Transmitted to Health Care Professional	AMA-PCPI
1517	Prenatal and Postpartum Care: Postpartum Care Rate	NCQA
1768	Plan All-Cause Readmission Rate	NCQA
2082	HIV Viral Load Suppression	HRSA
2371	Annual Monitoring for Patients on Persistent Medications	NCQA
2372	Breast Cancer Screening	NCQA
n/a	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA
n/a	Adult Body Mass Index (BMI) Assessment	NCQA

Medicaid Adult Core Set Properties: Conditions

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

Medicaid Adult Core Set Properties: NQS

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

Medicaid Adult Core Set Properties: Measure Characteristics

Medicaid Adult Core Set Characteristics		# of Measures
NQF Endorsement Status	Endorsed	24
	Not Endorsed	2
Measure Type	Structure	0
	Process	19
	Outcome	6
	Patient 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*

*Frequency of Ongoing Prenatal Care has one rate in the child set and one rate in the adult set

MAP's 2014 Recommendations to Address High Priority Gaps

- MAP identified gaps in measures in the Adult Core Set, including:
  - Access to primary and specialty care
  - Beneficiary-reported outcomes
  - Care coordination
  - Cultural competency of providers
  - Efficiency
  - Long-term supports and services
  - Maternal health
  - Promotion of wellness
  - Treatment outcomes for behavioral health conditions and substance use disorders
  - Workforce

MAP's 2014 Recommendations to Address High Priority Gaps

- MAP particularly emphasized three gap areas for future action:
  - Maternal health relating to risk for poor birth outcomes
  - Behavioral health and substance abuse treatment to prevent readmission
  - Access to primary care

MAP Measure Specific Recommendations – Fall 2014

- MAP recommended that 25 of 26 measures continue to be used (three with conditional support)
- MAP suggested the removal of:
  - NQF #0063 - Comprehensive Diabetes Care: LDL-C Screening
- **MAP recommended the phased addition of:**
  - NQF #0059 – Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
  - NQF #1799 – Medication Management for People with Asthma as a complement to #0283 Asthma in Younger Adults Admission Rate (PQI 15).
  - NQF #0647 – Transition Record with Specified Elements Received by Discharged Patients

CMS– Adult Core Set Update for 2015 Reporting

Issued December 30, 2014

- Based on MAP's recommendations, CMS updated the 2015 Adult Core Set:
  - Retired one measure:
    - » Comprehensive Diabetes Care: LDL-C Screening measure
  - Added one measure:
    - » Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) measure
- These updates correspond well to MAP's suggested course of action.

Source: CMCS Informational Bulletin "2015 Updates to the Child and Adult Core Health Care Quality Measure Sets."

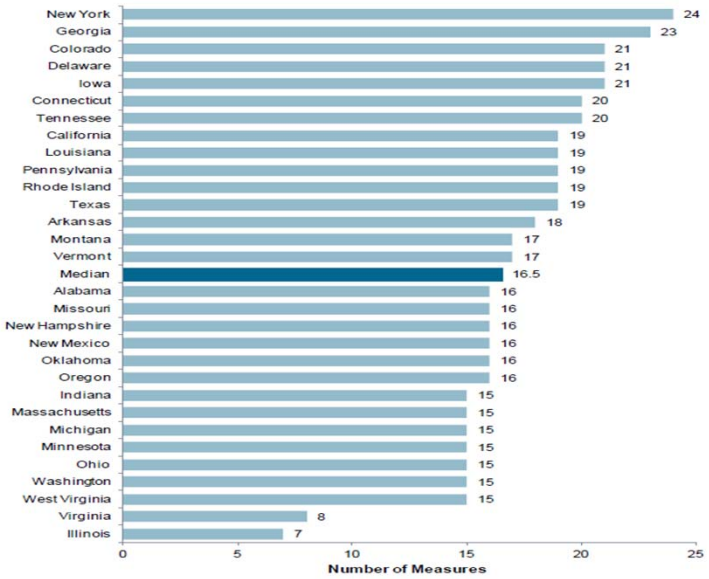
Overview of Medicaid Adult Core Set FFY 2013 Reporting

Adult Core Set participation is strong, with room for improvement

- 30 states reported a median of 16.5 measures
- The term "states" includes the 50 states and the District of Columbia
- Eight measures were reported by at least 25 states
- Most frequently reported measures focused on:
  - Diabetes care management
  - Postpartum care visits
  - Mental health treatment
  - Women's preventive health care

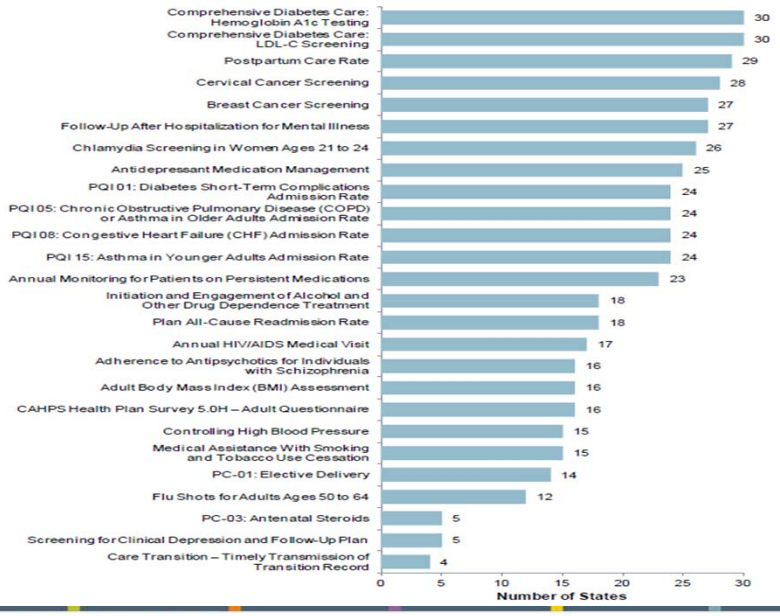
Source for slides 44-46: The Department of Health and Human Services 2014 Annual report on the Quality of Health Care for Adults Enrolled in Medicaid

Number of Medicaid Adult Core Set Measures Reported, by State, FFY 2013



Source: Based on Mathematica analysis of FFY 2013 Adult CARTS reports.
Notes: This figure is based on state reporting of 26 Core Set measures for FFY 2013. The term "states" includes the 50 states and the District of Columbia.

Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2013



Source: Based on Mathematica analysis of FFY 2013 Adult CARTS reports.
Notes: The term "states" includes the 50 states and the District of Columbia.

Adult Task Force Discussion and Questions

- Questions or comments about the data presented?
- Observations about the updates that CMS made based on MAP's 2014 review?
- Have any measure gap areas been satisfied or emerged as a result of the most recent update?
  - Measures suggested by MAP for addition but not yet added by CMS may need to be re-evaluated in 2015 along with other priorities for updates.

Looking Ahead to the In-person Meeting: Opportunities for Further Strengthening the Measure Sets

June In-Person Meeting Objectives

- Consider states' experiences implementing the Medicaid Adult and Child Core Sets
  - Like last year, panelists from states will join MAP's meetings
- Develop concrete recommendations for strengthening the Medicaid Adult and Child Core Sets through identification of:
  - Most important measure gaps and potential measures to address them
  - Measures found to be ineffective, for potential removal
  - Other strategic or implementation issues

Planned Sources of Information

- Evaluation of the current Medicaid Adult and Child Core Sets of measures against the MAP Measure Selection Criteria and the NQS
- Feedback from participating States to include:
  - Measures selected for reporting *and why they were selected*
  - Most common types of technical assistance requests
  - Data collection challenges and solutions
  - How states are using the measure results
- Measure-specific information collected through CMS' CARTS system
- Aggregated quality results for select measures with a minimum threshold of reporting

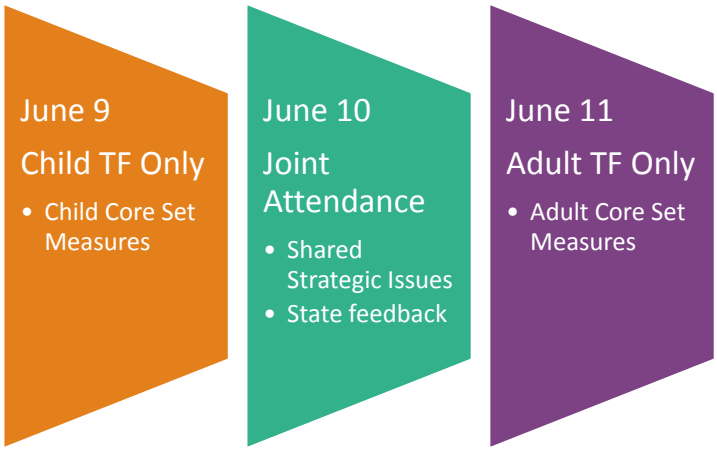
Task Force Discussion

- What additional information do the task forces need to support their deliberations?
- What other information is needed about the implementation experience from participating and/or non-participating states?

Opportunity for Public Comment

Next Steps

Structure of June Task Force Deliberations



Important Dates

- June 9 - 10: In-person meeting of Medicaid Child Task Force
- June 10 – 11: In-person meeting of Medicaid Adult Task Force
- July 6 – August 5: 30-day public comment period on draft reports
- August, Date TBD: MAP Coordinating Committee review of draft reports
- August 31: Final reports due to HHS and made available to the public

Thank You for Participating!

MEASURE APPLICATIONS PARTNERSHIP

Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2014

FINAL REPORT

AUGUST 29, 2014

NATIONAL QUALITY FORUM

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CONTENTS

EXECUTIVE SUMMARY

Medicaid is the single largest source of health insurance in the United States and a vital support for low-income Americans. States' Medicaid programs enroll a large—and increasing—share of the country's population, from 15 percent in 2010 to a projected 25 percent in 2020.[1] About half of the people covered by Medicaid are adults, many of whom have significant healthcare needs associated with pregnancy, chronic conditions, behavioral health, disability, and other factors. Medicaid is a major payer, financing about 16% of total personal health spending in the U.S. and a core source of financing for providers that serve low-income communities.[2] When measuring the quality of healthcare provided to adults with Medicaid, it is essential to focus on their unique needs and the context in which they receive care.

The Measure Applications Partnership (MAP) has been charged with providing input on the use of performance measures to assess and improve the quality of care delivered to adults who are enrolled in Medicaid. The National Quality Forum convenes MAP to provide input to the Department of Health and Human Services (HHS) on the selection of performance measures for more than 20 public reporting and performance-based payment programs. This report contains MAP's 2014 recommendations to HHS for strengthening the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) as well as the identification of high-priority measure gaps.

Following the enactment of the Affordable Care Act (ACA), HHS established the Adult Medicaid Quality Measurement Program to standardize the measurement of healthcare quality across state Medicaid programs, assist states who elect to collect and report on the measures, and facilitate the use of the measures for quality improvement. The 26 measures in the 2013 version of the Adult Core Set were compiled to broadly address quality and relate to issues of general adult health, maternal/reproductive health, complex healthcare needs, and mental health and substance use.

MAP's 2014 Recommendations on Strengthening the Medicaid Adult Core Set

To conduct this review, MAP applied its standard measure selection criteria (MSC) and considered states' feedback from the first year of implementation to carefully evaluate and identify opportunities to improve the Medicaid Adult Core Set. MAP recognized the investment made in the initial version of the measure set as well as the need for states and CMS to gain experience with its use. As such, making drastic changes to the measures in the early years of program implementation would be premature and might discourage states' participation in quality measurement and improvement. Therefore, MAP recommends CMS focus in the short term on addressing known challenges in data collection and reporting, monitoring the program's continuing development, and considering MAP's measure-specific recommendations:

- **MAP supports the continued use of most measures in the Medicaid Adult Core Set**. MAP recommends that 22 of 26 measures continue to be used to provide stability and the opportunity to gain additional experience and data. No serious feasibility challenges were identified among these measures.
- **MAP conditionally supports the continued use of three measures**.
  - NQF #2371 Annual Monitoring for Patients on Persistent Medications: Pending the renewed NQF endorsement of this measure, MAP conditionally supports the continued use of this measure as an important indicator of safety. It is currently undergoing review and is expected to pass. MAP also recommended the addition of NQF# 0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category because of its focus on medication adherence.
  - NQF #1768 Plan All Cause Readmission: MAP conditionally supported the continued use of this measure or an alternative measure of all-cause readmission. HHS should determine which measure is the best fit for the specific goals of this program.
  - NQF #2372 Breast Cancer Screening: MAP's support is conditional upon this measure regaining NQF endorsement. It is currently undergoing review and is expected to pass.
- **MAP suggests the removal of one measure**. The measure NQF #0063 Comprehensive Diabetes Care: LDL-C Screening should be retired because clinical guidelines underpinning this measure are currently in flux. In addition, NCQA has removed it from HEDIS 2015.
- **MAP recommends three measures for phased addition to the Medicaid Adult Core Set.** Because of the high prevalence of diabetes in the adult Medicaid population, MAP prioritized NQF #0059 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) as the most urgent addition to the measure set. In future iterations, HHS should consider the addition of measures NQF #1799 Medication Management for People with Asthma and NQF #0647 Transition Record with Specified Elements Received by Discharged Patients to fill other gaps in the measure set.

MAP identified several priority measure gap areas within the Adult Core Set. The field lacks strong measures to address several complex quality issues that are particularly relevant to the adult Medicaid population. These include: maternal health relating to risks for poor birth outcomes, behavioral health and substance abuse care to prevent hospital readmission, and the relationship between social factors and access to primary care. Later updates to the Adult Core Set should prioritize these topic areas.

In the long term, MAP recommends that CMS continue to support states' efforts to gather, report, and analyze data that informs quality improvement activities. Uses of quality data are expected to gradually mature from an internal focus on accuracy and year-over-year improvement to a more sophisticated approach involving benchmarking and public reporting. At the same time, CMS and MAP remain conscious of the voluntary nature of participation in submitting data on the Medicaid Adult Core Set; rigor must be tempered with a realistic understanding of abilities and potential trade-offs. The program measure set will continue to evolve in response to changing federal, state, and stakeholder needs and its maintenance should be considered a long-term strategic process.

INTRODUCTION AND PURPOSE

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

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

Guided by the MAP Measure Selection Criteria (MSC) (Appendix C), MAP considered states' experiences implementing the Adult Core Set in making its recommendations. To inform MAP's review, CMS provided detailed summaries of the number of states reporting each measure, deviations from the published measure specifications, technical assistance requests, and actions taken in response to questions and challenges. This report summarizes select states' feedback on collecting and reporting measures. It also includes measure-specific recommendations, high-priority gaps, and potential gap-filling measures (Appendix D). In addition, MAP identified several strategic issues related to the programmatic context for the Adult Core Set. This report follows an expedited review MAP performed in 2013 and contains more detailed information.

BACKGROUND ON MEDICAID AND THE ADULT CORE SET

Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals. Medicaid is financed through a federal-state partnership; each state designs and operates its own program within federal guidelines.

Medicaid Adult Population

In 2013, 72.8 million individuals were enrolled in Medicaid at some point in time, of which about half were adults.[3] Before the enactment of the Affordable Care Act of 2010 (ACA), federal funding for Medicaid could only be used for specific categories of low-income individuals: children, pregnant women, parents of dependent children, individuals with disabilities, and people age 65 and older. In other words, most low-income, nonelderly adults without dependent children were excluded from Medicaid. States now have the option to expand Medicaid eligibility to nearly all nonelderly adults with incomes at or below 138 percent of the federal poverty level (FPL). [4] In 2014, 138 percent of FPL is $16,105 for an individual and $32,913 for a family of four.[5]

Each state will decide whether to expand its Medicaid eligibility.[6] To date, 27 states including the District of Columbia are implementing expansion in 2014, 3 states are still debating expansion, and 21 states are not moving forward with expansion at this time.[7] Enrollment data for April 2014 indicate that enrollment growth in states that have expanded Medicaid to low-income adults has outpaced the national average and is significantly higher than growth in nonexpansion states (15.3 percent vs. 3.3 percent).[8] Because nonelderly adults covered by Medicaid are more likely than uninsured adults to report receiving timely healthcare visits, the expansion offers an important opportunity to improve access and health outcomes.[9]

Because Medicaid expansion is a state decision, an eligibility "coverage gap" is created for adults who live in states that opt not to expand who would otherwise be eligible for the Medicaid expansion. Nearly 80 percent of the 4.8 million uninsured adults who fall into the coverage gap live in southern states, and the coverage gap in that region disproportionately affects people of color.[10]

Medicaid covers many of the highest-need populations in the nation. When combined with the fact that there is a strong correlation between poverty and poor health, one observes a poorer health profile among Medicaid beneficiaries than in privately insured and uninsured populations.[11] Adults with Medicaid report both worse overall health and worse mental health than their peers with similar income. Medicaid beneficiaries also experience multiple chronic conditions and activity limitations at higher rates than other populations.[12] A recent analysis by the Healthcare Cost and Utilization Project (HCUP) found that nonelderly adult Medicaid beneficiaries experienced a total all-cause, 30 day hospital readmission rate of 14.6 per 100 admissions, in contrast to 8.7 per 100 admissions among privately insured adults 18 to 64. The cost of these 700,000 readmissions of adult Medicaid enrollees totaled approximately $7.6 billion in 2011.[13] MAP's understanding of the healthcare needs of the adult Medicaid population influenced its recommendations on the most important measures of quality.

Role of Medicaid in Covering Services for Low-Income Adults

Medicaid covers a broad range of services to meet the diverse needs of its enrollees. Federal law requires many medically necessary services to be covered by Medicaid (e.g., hospital care,

laboratory services, and physician/midwife/nurse practitioner visits). Many states also cover services that federal law designates as optional for adults, including prescription drugs, dental care, and durable medical equipment. Notably, Medicaid also covers a broad spectrum of long-term services and supports (LTSS) not provided by Medicare or private payers. Because of this, Medicaid is the most significant source of financing for nursing home and community-based long-term care.

The ACA established an array of new authorities and funding opportunities to promote high-quality, cost-effective care for Medicaid enrollees. These new opportunities have accelerated opportunities for innovation within Medicaid. Because Medicaid covers many of the highest-need, highest-cost adults in the country, the urgency of delivery system reform is particularly intense.

Medicaid Adult Core Set

In addition to the expansion of Medicaid coverage to adults, ACA called for the creation of a core set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid. Although many states were already monitoring and seeking to improve quality in Medicaid, the core set of measures will standardize and align measurement efforts. HHS identified the initial core set of healthcare quality measures to standardize the measurement of healthcare quality across state Medicaid programs, assist states who elect to collect and report on the measures, and facilitate the use of the measures for quality improvement.[14] HHS published the initial Adult Core Set of measures in 2012 and also released a two-year competitive grant funding opportunity to assist states in building capacity to participate in reporting. CMS' three-part goal for the Adult Core Set is:

1. Increase number of states reporting Adult Core Set measures
2. Increase number of measures reported by each state
3. Increase number of states using Core Set measures to drive quality improvement

The measures in the Adult Core Set were compiled to address quality issues related to general adult health, maternal/reproductive health, complex healthcare needs, and mental health and substance use. Statute also requires HHS to make annual updates to the Adult Core Set, starting in January 2014. CMS uses MAP's input to identify potential updates.[15]

ACA requires CMS to release annual reports on behalf of the Secretary on the reporting of state-specific adult Medicaid quality information. CMS is also required to issue reports to Congress every three years. The 2014 Report to Congress: HHS Secretary's Efforts to Improve the Quality of Health Care for Adults Enrolled in Medicaid highlights CMS's use of the National Quality Strategy (NQS) to guide healthcare improvement efforts and to measure progress toward achieving the goals of better care, healthy people/healthy communities, and affordable care.[16] This report also includes a summary of technical assistance and analytic support provided to states in the first year of reporting Adult Core Set measures.

Characteristics of the Medicaid Adult Core Set

The 2013 Adult Core Set contains 26 measures (Appendix D) that cover all 6 areas of the NQS and CMS Quality Strategy priorities (Exhibit 1).

EXHIBIT 1. NQS AND CMS QUALITY STRATEGY PRIORITIES

NQS and CMS Quality Strategy Priorities	Number of Measures in the Adult Core Set (n = 26)
Patient Safety	7
Person- and Family-Centered Experience of Care	1
Effective Communication and Care Coordination	7
Prevention and Treatment of Chronic Disease	2
Healthy Living and Well-Being	8
Affordability	1

It also contains a mix of structure, process, outcome, and patient experience of care measures. Six of the measures are sensitive to known healthcare disparities. Additionally, the Adult Core Set is well-aligned with other quality and reporting initiatives: 15 of the measures are used in one or more federal programs, 3 in the Medicaid Children's Core Set, and 12 are included in the Health Insurance Marketplace Quality Rating System Beta Test Measure Set.[17,18] Representing the diverse health needs of the adult Medicaid population, the Adult Core Set measures span many clinical conditions (Exhibit 2).

EXHIBIT 2. CLINICAL CONDITIONS COVERED BY MEASURES IN THE MEDICAID ADULT CORE SET

Clinical Conditions	Number of Measures in the Adult Core Set (n = 26)
Preventive Screening and Care	6
Behavioral Health and Substance Use	5
Cardiovascular Disease and Diabetes	5
Care Coordination and Experience of Care	4
Maternal and Prenatal Health	3
Respiratory Care, COPD, and Asthma	2
HIV/AIDS	1

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 Adult Core Set from CMS and states in three formats: 2013 Medicaid Adult Core Set implementation information, presentations from states that participated in reporting, and communication of barriers from nonreporting states. These valuable inputs informed the measure-specific and strategic recommendations for the Medicaid Adult Core Set to achieve CMS' three-part goal.

Participation in Reporting Measures

During the first year of data collection and reporting, CMS recorded feedback from states on the implementation experience of each Medicaid Adult Core Set measure. The number of states that reported each measure ranged from a low of 4 to a high of 29 states (Exhibit 3). The most common reason given for not reporting a measure was that the information was not collected because the measure was not identified as a key priority this year. MAP considered the number of states that were able to report each measure and sought to understand states' priorities to inform its recommendations.

CMS replaced the measure Annual HIV/AIDS Medicaid Visit with NQF #2082 HIV Viral Load Suppression in the 2014 Adult Core Set update.[19] MAP recommended this substitution because the original measure had NQF endorsement removed and it had too much of a process focus rather than the intermediate outcome focus of viral load suppression. As a result, FFY 2014 is the first year in which the measure of viral load suppression will be reported. No other additions, deletions, or substitutions were made in this first update.[20,21]

Implementation Feedback from Reporting States

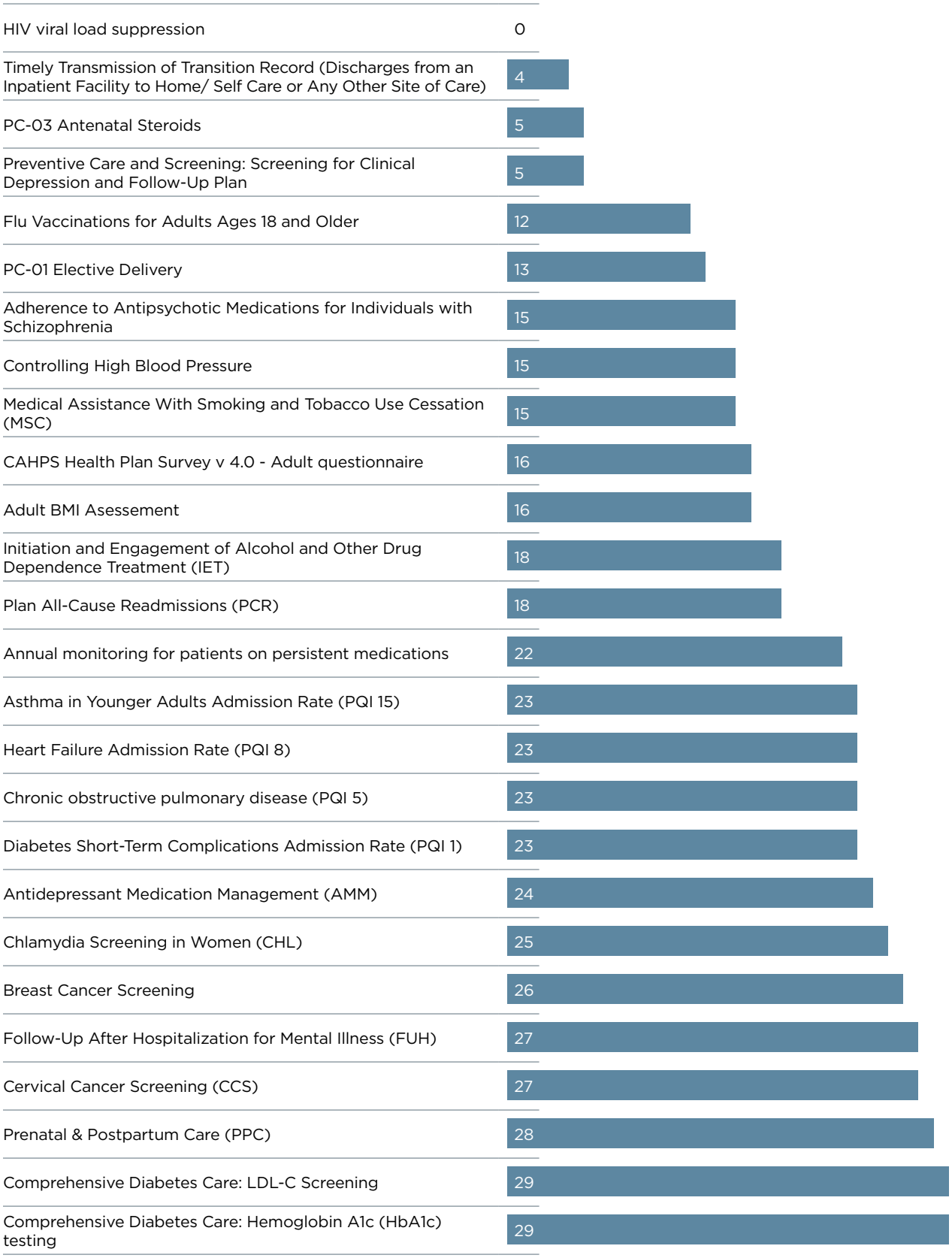
Three states—Louisiana, New Hampshire, and Virginia—shared their implementation experiences collecting and reporting measures to CMS to inform the MAP review of the Adult Core Set. These perspectives are a sample and not representative of all state Medicaid programs. This dialogue was highly informative, and MAP will continue to pursue opportunities to receive direct feedback from users of measures to guide decisionmaking.

Louisiana

In the state of Louisiana, nearly 500,000 adults received Medicaid services in 2010.[22] Until 2011, Louisiana Medicaid operated in a fee-for-service model; since 2012 almost all beneficiaries have been enrolled in a managed care benefit with one of the five participating health plans across the state. Louisiana is a recipient of an Adult Medicaid Quality Grant and reported 19 of the 26 measures in the core set. Prior to the grant program, Louisiana Medicaid collected 18 HEDIS measures and 10 Children's Core Set measures.

Facilitated by the grant, the State is collecting nine additional measures. When selecting measures, Louisiana chose those that matched their interests and purposefully avoided those requiring medical record review. From the state perspective, medical record review is thought to be labor intensive, relatively costly, and to require a specific skill set. To collect and report additional measures from the Medicaid Adult Core Set, Louisiana built new internal capacity, partnered with others in the

EXHIBIT 3. NUMBER OF STATES REPORTING MEASURES IN MEDICAID ADULT CORE SET IN FFY 2013[23]



state, and demonstrated successful innovations that will be useful across the state Medicaid programs.

Linking Claims Data and Vital Records: Louisiana celebrated the creation of a link between vital records and claims data for the collection and reporting of #0469 PC-01 Elective Delivery. This method has been validated by the National Perinatal Information Center/Quality Analytic Services (NPIC/QAS) and has the potential to eliminate the need to review medical records for this measure.

Medical Record Review: Though challenging from the outset, Louisiana selected and successfully reported #1517 Prenatal and Postpartum Care (Postpartum care rate only). This measure was collected through hybrid data collection. The state selected this measure because administrative claims data was already available, but later observed it produced inaccurate results due to the clinical importance of timing of care for this measure and missing data due to bundled payments including postpartum care. In response, Louisiana Medicaid formed a new partnership with the Louisiana Office of Public Health Nursing Services to implement a new medical record review process.

This new process, developed over several months, uses administrative claims data that is highly familiar to the state for HEDIS reporting to streamline data collection and improve the efficiency of medical record review. The ultimate result was improved measurement accuracy. The state hopes to use this method for other measurement efforts and to share this best practice with other states. Despite successfully developing methods to address the complexity of medical record review, the state recommends that future updates to the set favor measures that use automated methods such as claims and eMeasures.

Measurement Driving Improvement: Representatives from Louisiana identified several avenues through which Medicaid Adult Core Set measures are helping drive improvement. As a result of the grant program, Louisiana has enhanced capacity for analyzing and reporting quality measures across all Medicaid programs. The results are used to steer state-level Medicaid policy and interventions to improve outcomes in the population.

Other recommendations from Louisiana's representatives to CMS and MAP for the core set focused on reducing reporting burden. CMS and MAP are encouraged to consider alignment of the measures in the Adult Core Set with other measurement programs. The use of the same measures across programs produces efficiencies. Representatives also suggested including additional measures that address needs of large segments of the population, such as asthma, appropriateness of care, access to preventive care and ambulatory care, and emergency department utilization.

New Hampshire

The State of New Hampshire provided Medicaid-funded healthcare services to approximately 68,000 adults in 2010.[24] In 2014, New Hampshire chose to expand Medicaid coverage through provisions in ACA.[25] As a result, 30 percent of the currently uninsured adult population is expected to gain Medicaid eligibility. During the first year of participation in the quality reporting program, New Hampshire submitted 16 measures in the Adult Core Set to CMS. To select and report these measures, state officials balanced political, logistical, and financial realities. Three key features influenced the selection of measures to report: feasibility, efficiency, and capacity building.

Feasibility: The state preferred measures that did not present significant challenges in collection or reporting of the data. The state sought measures that had clear specifications; unclear guidance increases the resources required to collect and report a measure. Representatives encouraged the continued availability of clear, thorough technical

manuals to improve the data collection process, accuracy, and ability to eventually compare results among states.

Efficiency: New Hampshire sought to limit the financial investment required to participate in reporting by avoiding measures that were most laborious to collect. Measures collected through administrative claims data were thought to be most efficient and therefore heavily favored over medical record review. In the future, understanding the potential return on investment of measurement in driving improvement would be highly valuable in measure selection.

Capacity Building: The state appreciated the flexibility to use grant funds to explore linking data sets to collect data for measures. Once established, this infrastructure and knowledge could improve the feasibility and efficiency of future collection. Linked data sets were pursued for measures #0576 Follow-up After Hospitalization for Mental Illness, and #0469 PC-01 Elective Delivery, and ultimately successful for the former. The state found linking data sets to be valuable because it yielded techniques that may contribute to other state-wide quality improvement efforts. Over time, the state plans to build additional capacity to report additional measures from the Medicaid Adult Core Set.

Overall, New Hampshire representatives communicated their appreciation for the new reporting program and the associated grant opportunity. They support the structure of the program and its voluntary nature, the common core set, and the ability for states to select measures to report. Over time, representatives encouraged CMS to make the results of the measures transparent to allow for comparisons between states that would drive improvement. New Hampshire identified gaps in measures of long-term supports and services, beneficiary and consumer experience, and quality of Medicaid administration and services.

Virginia

The Commonwealth of Virginia Department of Medical Assistance Services funds Medicaid services for more than 350,000 adults.[26] Enrollees receive services through managed care health plans, all of which are required to maintain National Committee for Quality Assurance (NCQA) accreditation. Virginia's full-risk model for health plans provides budgetary certainty for the state and opportunities for marketplace competition and innovation. Virginia was not a recipient of the Medicaid Adult Quality Grant, but voluntarily reported 8 measures in the Adult Core Set.

Quality Strategy: Virginia maintains a Medicaid Managed Care Quality Strategy with a population health focus. The Quality Strategy defines the quality measures required by all participating health plans and prioritizes HEDIS to align with NCQA accreditation requirements. The state currently requires health plans to report 18 HEDIS measures. The Quality Strategy will be updated over the next year to identify the priority quality measures for performance improvement and consider the demographics of Medicaid enrollees and medical trends.

Performance Measure Incentive Program: Virginia is implementing a financial incentive program for quality and cost containment outcomes. The program will reward health plan performance and phase in over three years. The state program focus is on quality through the assessment of three HEDIS measures and three health plan administration process metrics. Fiscal awards will be proportionate to the achievements of the health plan against the benchmark for each measure.[27]

In the first year of reporting, Virginia submitted 8 of the HEDIS measures from the Adult Core Set to CMS. State representatives identified participation in the Adult Core Set as a valuable opportunity because it is the first national core measure set for Medicaid programs for adults. The representatives recommend that the measures' results be

available for valid benchmarking and comparisons through consistent the collection across states. To enable this, they advocate that the measure specifications in the data entry system be clear and up to date with HEDIS, NQF endorsement, clinical practice guidelines, and other nationally recognized standards. They also recommend that the Adult Core Set continue to align across public and private measurement programs and focus on improving population health.

Nonreporting States

Roughly half of state Medicaid programs did not submit data on measures in the Adult Core Set to CMS for the first year of the voluntary reporting program. One of CMS' primary program goals is to increase the number of states participating in reporting measures in the Adult Core Set. To inform its recommendations, MAP sought feedback from nonreporting states to identify barriers to reporting and avenues to overcome them. Representatives from two states shared their reasoning with MAP. While not identified for purposes of confidentiality, their perspectives added helpful insights to inform measure-specific and general recommendations. MAP encouraged subsequent reviews of the Adult Core Set to be informed by additional discussions with nonreporting Medicaid programs. Several themes arose from their feedback, some of which are congruent with opinions of reporting states:

- Broad factors influence state decisions to report the measures, including political, feasibility, and financial concerns;
- Stakeholders were uncertain about the reporting requirements and use of data for comparisons or public reporting in the new program;
- Ability of the measures to compare states' performance may be compromised due to differences in benefit structures, payment models, diverse enrollee populations, or other factors;
- Some states have already invested in tailored quality measurement programs that have longitudinal results comparing providers within the state and externally to national benchmarks;
- Measurement priorities include access to care, primary care, and preventative care and should be aligned with other programs.

MAP REVIEW OF THE MEDICAID ADULT CORE SET

MAP reviewed the measures in the Adult Core Set and provides the following recommendations to strengthen the measure set and support CMS' stated goals for the program. To conduct this review, MAP applied the measure selection criteria (MSC) and feedback from the first year of state implementation to carefully evaluate and identify opportunities to improve the Adult Core Set. MAP also identified priority measure gap areas to address healthcare quality for the Adult Medicaid population.[28]

The 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. The criteria favor the selection of high-quality measures that optimally address the NQS, fill critical measurement gaps, and increase alignment across programs. In the application of the MSC to the Adult Core Set, MAP noted the following:

- The composition of the Medicaid Adult Core Set is well-matched with CMS' stated goals for the program;
- The Adult Core Set's strong alignment with other program sets and parsimonious number of measures should continue;
- While the mix of measure types is satisfactory, MAP encourages the inclusion of relevant outcome measures in future iterations of the set;
- MAP strongly prefers that the set contain the most current NQF-endorsed® measures to ensure validity and reliability.
  - MAP observed changes had been made to several measures to enable state-level reporting, including the use of a more restricted age range, setting a specific date for age calculation, and changing denominator populations from "enrollees" to "member-months." These minor edits are not expected to have a significant impact on the scientific properties of the measure. However, deviations from a measure's risk adjustment methodology would constitute a material change and warrant additional testing to ensure reliability and validity are not damaged.
  - For measures that have not been endorsed or have had endorsement removed, CMS should consider updates or substitutions.

MAP recognized the investment made in the initial version of the Adult Core Set measures as well as the need for states and CMS to gain experience with their use. As such, making drastic changes to the measures in the first two years of program implementation would be premature. Such changes could have the unintended consequence of discouraging states' participation in quality measurement and quality improvement. Therefore, the most important efforts for CMS to undertake now to achieve the program goals are to address known challenges in data collection and reporting, monitor the program's continuing development, and consider the measure-specific recommendations in this report.

Measure-Specific Recommendations

MAP supported the majority of the measures in the Adult Core Set for continued use in the program. **Appendix D** provides further details

on MAP's measure-specific recommendations and decision rationale. Although MAP discussed concerns about the feasibility of reporting complex measures that require hybrid specifications, medical record review, or data linkages, members were comfortable retaining them in the set to challenge states. As previously discussed, it is important that the measure set remain stable to enable states to gain experience and build capacity for reporting. A few commenters recommended MAP reevaluate the feasibility of some labor-intensive measures; MAP will continue to monitor the use of all measures in the Core Set to inform future recommendations. See Appendix F for commenters' full remarks on this subject.

Measures for Phased Addition to the Adult Core Set

MAP recommends that CMS consider three measures for phased addition to the Adult Core Set. Their use would strengthen the measure set, but MAP is aware that additional resources are required for each new measure and understands that CMS may need flexibility to add the measures gradually and only if they are found to be feasible to implement at the state level.

1. First, MAP prioritized the addition of #0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) to the Adult Core Set to address the highly prevalent condition of diabetes and facilitate state efforts to drive quality improvement on the risk factor of poor HbA1c control. A measure of HbA1c testing is currently a part of the measure set, but MAP is more interested in measuring the intermediate outcome than the process.
2. Second, MAP recommended the addition of #1799 Medication Management for People with Asthma as a complement to #0283 Asthma in Younger Adults Admission Rate (PQI 15) because it focuses on upstream activities to control asthma symptoms. The Centers for Disease Control and Prevention (CDC) estimates the national prevalence of asthma among adults to be 8.6 percent.[29] It is a common health condition, but not as widespread as diabetes.
3. Third, consistent with prior recommendations, #0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) was supported for addition to the Adult Core Set. This measure is paired and intended to be used with #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), which had relatively low levels of reporting by states because of data collection challenges. Care coordination is an important topic area, and using these paired measures together may improve the feasibility of the measures.

Public comment indicated support for MAP's recommended additions to the measure set. One comment suggested #0055 Comprehensive Diabetes Care: Eye Exam could be added as a complement to other diabetes care measures in the set. Because of concerns about the size of the measure set, MAP is not recommending the addition of the eye exam measure at this time but may consider it in a future review.

Measures with Conditional Support for Continued Use in the Adult Core Set

MAP conditionally supported the continued use of three measures.

Medication Management and NQF #2371 Annual Monitoring for Patients on Persistent Medications

Medication management is critical to achieving high-quality care and positive health outcomes; measures related to this topic are very important quality indicators. The set contains #2371 Annual Monitoring for Patients on Persistent Medications (formerly NQF #0021).[30] This measure had NQF endorsement removed at one point in time but has now been updated and gained the approval of the Safety Standing Committee.

MAP conditionally supported the continued use of this measure, if its endorsement is renewed, as an important medication safety measure. However, its narrow focus on a single point in time, condition, or prescription does not reflect the overall quality of medication management. MAP would prefer the inclusion of a measure of medication adherence or shared decisionmaking about medication choices.

MAP undertook further review of issues related to medication management with the aim of identifying a more comprehensive measure for inclusion. After initially identifying three potential measures for addition, guidance from the MAP Coordinating Committee and a significant volume of public comment from stakeholders associated with the Pharmacy Quality Alliance (PQA) demonstrated consensus for supporting the use of #0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category. Medication adherence in the treatment of chronic conditions is closely tied to improved healthcare outcomes. This measure, as recently submitted to NQF measure maintenance process, is focused on renin-angiotensin antagonists, diabetes medications, and statins and calculated from prescription claims data. Further, this measure is also used within the Medicare Part D reporting program and other federal and industry quality programs.

MAP remains sensitive to the need to maintain a relatively stable measure set and the cost of adding new measures. Therefore, if it is possible for CMS to include only one of the medication measures, MAP expressed a slight preference for #0541 compared to #2371.

Hospital Readmission and NQF #1768 Plan All-Cause Readmissions (PCR)

NQF has endorsed two measures related to all-cause hospital readmissions. The two measures differ in their approach and underlying specifications due to the purposes for which they were designed. Measure #1768 Plan All-Cause Readmissions (PCR) is currently included in the Medicaid Adult Core Set. However, CMS is considering whether measure #1789 Hospital-Wide All-Cause Unplanned Readmission Measure would offer greater fit-for-purpose in the program. MAP urges CMS to consider the many potential uses of the measurement information and determine which one is primary because different "use cases" lead to different conclusions about which measure would be superior in this context. In particular, issues of alignment with other programs and the feasibility of data collection are critical factors to consider. The methodology for #1789 is aligned with CMS' other facility-level, condition-specific measures for readmission, while the methodology for #1768 is part of HEDIS and used for multiple types of health plans.

MAP supported the inclusion of both measures, if possible. Because they have different levels of analysis, they can provide two complementary pieces of information to support improvement of the critical quality issue of hospital readmission. However, MAP remains concerned about the lack of risk adjustment methodology available for the Medicaid adult population in #1768. Public comments shared this view. Without an appropriate risk-adjustment methodology, one cannot determine if differences in performance are due to overall quality, the characteristics of the denominator population, or randomness due to availability of data and collection methods and extrapolation for analysis. The health of the adult Medicaid population has been shown to differ significantly from the general population, and this difference justifies use of an appropriate risk adjustment methodology. Similarly, #1789 would need to be tested to ensure it would perform as expected in a state-level reporting program. MAP supports CMS' planned effort to work with the measures' stewards to address the known challenges in implementation. MAP recommends that the readmission measure (or measures) that is most actionable and best supports national standardization, stratification, and the ability to make valid comparisons be selected by CMS for use in the Adult Core Set.

NQF #2372 Breast Cancer Screening

Measure #2372 Breast Cancer Screening had NQF endorsement removed at one point in time but has been resubmitted, approved by the standing committee, and is currently in the late stages of the Consensus Development Process. The measure is expected to regain endorsement. MAP supports its continued use contingent upon endorsement.

Measures for Removal from the Adult Core Set

NQF #0063 Comprehensive Diabetes Care: LDL-C Screening

MAP noted that clinical guidelines for lipid management have recently changed; as such, the continued use of #0063 Comprehensive Diabetes Care: LDL-C Screening may no longer be appropriate. NCQA is the steward of this measure and decided to retire the measure from the 2015 version of HEDIS. MAP recommends that CMS remove the measure from the Adult Core Set. One commenter urged CMS and MAP to consider a replacement measure to evaluate the appropriate management of lipids. MAP has recommended the addition of a different measure for diabetes care, as discussed above.

Recommendations to Address High Priority Gaps

MAP identified numerous gaps in the Adult Core Set from state feedback, the review of current measures, and data on conditions associated with hospital readmissions. Future iterations of MAP's input on the Medicaid Adult Core Set will use the list of measure gaps a starting point for their discussion and identification of other measures available for addition. Given MAP's position that the measure set needs to be kept to a manageable size, the gaps will require prioritization. They include:

- Access to primary and specialty care
- Beneficiary-reported outcomes
- 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
- Maternal health
  - Inter-conception care to address risk factors
  - Poor birth outcomes (e.g., premature birth)
  - Postpartum complications
- Promotion of wellness
- Treatment outcomes for behavioral health conditions and substance use disorders
- Workforce

Although the Adult Core Set includes measures pertaining to some of these topics, they were not perceived as sufficient. For example, several measures in the Adult Core Set relate to the conditions causing hospital readmissions, but others are available and could be considered for future addition to the set (Appendix E). MAP particularly emphasized three gap areas for future action: maternal health relating to risks for poor birth outcomes, behavioral health and substance abuse treatment to prevent readmission, and access to primary care.

Maternal Health

Nearly three-quarters of women enrolled in Medicaid are in their reproductive years (18-44).[31] Medicaid covers nearly half of births in the U.S., with maternity procedures accounting for many of the top hospital procedures billed to Medicaid.[32] MAP identified reproductive, maternal, and prenatal care as an essential area for measurement to drive positive population health outcomes. MAP specifically suggested measures related to

progesterone use to prevent premature birth, inter-conception health to manage risk factors between pregnancies, contraception (e.g., LARC insertions), and maternal mortality. Detailed comments from one stakeholder discussed specific measures on maternal health that MAP may want to recommend in the future, including #0471 PC-02 Cesarean Section; #0480 PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice; #0716 Healthy Term Newborn; and IQI #22 Vaginal Birth After Cesarean Delivery Rate, Uncomplicated. See Appendix F for the commenter's full remarks on this subject.

Behavioral Health

In addition to the Medicaid adult population reporting high rates of poor mental health, 4 of the 10 most common conditions for readmission are behavioral health and/or substance use disorder (SUD) diagnoses. These conditions are often under-diagnosed and/or under-treated. One member suggested routinely integrating mental health screening in primary care visits and routine follow-up as a prime measurement opportunity.

MAP learned of joint efforts of the National Committee for Quality Assurance (NCQA) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to address measure gaps related to comorbid conditions among the behavioral health population. Currently in its third year, the project is developing measures that assess screening and follow-up care for adults with serious mental illnesses such as schizophrenia, bipolar disorder, major depression, alcohol and other drug dependence. MAP members discussed the lack of ambulatory services available to the behavioral health population and will continue to monitor these measure development efforts for their potential to address measure gaps.

Though not a priority for immediate use, MAP recommends that future reviews of the Adult Core Set consider potential complements to the current measure on antipsychotic adherence:#1927 Cardiovascular Screening for People with Schizophrenia or Bipolar Disorders Who Are Prescribed Antipsychotic Medications and #1932 Diabetes Screening for People with Schizophrenia or Mood Disorders Who Are Using Antipsychotic Medications.

Access to Primary Care

Finally, MAP emphasized the importance of measure development in access to preventive health services and wellness. Poor access and lack of care coordination contribute to overuse of emergency department and hospital services. In general, the Adult Core Set lacks measures of social determinants of health that contribute strongly to individual health outcomes (e.g., employment, social and community context, neighborhood). MAP specifically recommends measure development in the areas of person-centered care that would enable the tracking of longitudinal progress toward a health or quality of life goal.

STRATEGIC ISSUES

During MAP's review of measures in the Adult 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.

Building State Capacity

Since the start of the program just two years ago, many of the states participating in reporting the Adult Core Set have greatly increased their capacity and ability to use measures to advance quality improvement. State representatives enthusiastically discussed the vital importance of Medicaid in supporting low-income Americans in accessing basic health services, at the same time acknowledging that all Medicaid programs are under-resourced.

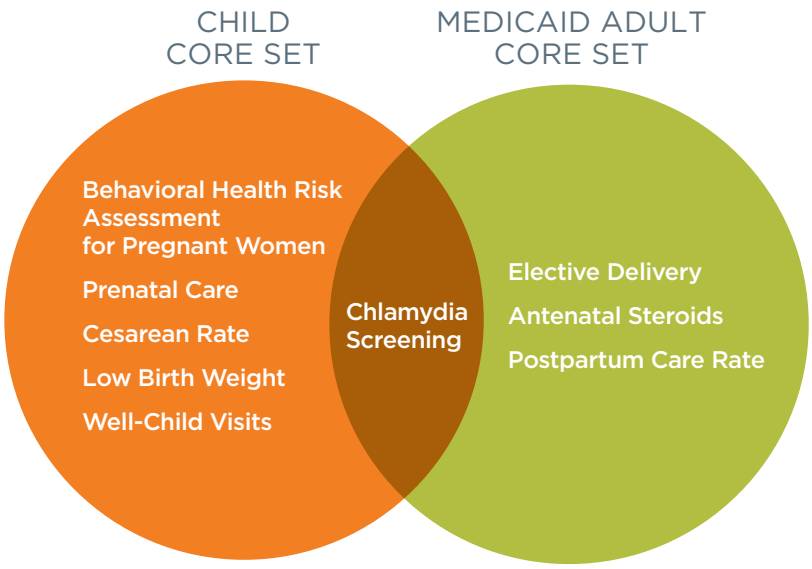
State representatives described the benefit of CMS' grant program in providing funding that allowed the Medicaid agencies to form data-sharing partnerships with the public health system and other key stakeholders. Developing linkages to vital records systems, for example, assisted with the calculation of some measures and will benefit other population health monitoring efforts. One commenter noted that health plans are currently exploring the use of data from state health information networks to improve reporting capabilities and reduce burden associated with data collection. In addition, state staff members are growing more practiced in the use of analytics to understand the health of their enrolled populations. MAP shared the view that while investment in measurement requires sustained funding, a lack of action in addressing quality is costly and detrimental to population health in the long term.

Alignment of Measures Across Adult and Child Core Sets

When making recommendations about measures for the Adult Core Set, MAP recognized the importance of coordinating the selected measures with those contained in the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child 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. This is especially apparent when considering the quality of the continuum of the prenatal, maternity, and postnatal care of mothers and infants. As shown in Exhibit 5, several measures are in the Child Core Set because they are more closely tied with the health outcomes of the infant, while one is common to both sets and three others are unique to the Adult Core Set. It is necessary to view the two programs together to see the full spectrum of measures that promote better birth outcomes.

Other quality issues are important to all age groups and are also common to both measure sets. A measure of follow-up after hospitalization for mental illness is currently included in the Child and Adult Core Sets. MAP has also recommended that a measure of medication management for people with asthma be added to the Adult Core Set. This measure is currently in the Child Core Set. The alignment achieved by including the same chlamydia, asthma, and follow-up after hospitalization measures in both programs, rather than similar but different measures, is vitally important in controlling reporting burden on states and directing quality improvement efforts efficiently.

EXHIBIT 5. OVERLAPPING MATERNAL AND CHILD HEALTH MEASURES IN THE MEDICAID QUALITY PROGRAMS



Impact of Payment Models

Input from states brought to light two issues related to potential impact of payment models on measurement. First, bundled payment, the reimbursement of healthcare providers on the basis of expected costs for clinically defined episodes of care rather than fee-for-service (FFS), can limit the availability of data. Specifically, bundled payments for maternity care can include postpartum visits, and states expressed concern that results on the Postpartum Care Rate Measure would be underreported if based solely on claims. While a hybrid measure specification is available to address this issue, chart review is resource-intensive and not preferred by states that reported in year 1. Second, it is standard practice to audit measures derived from managed care data, but this is not routinely performed in FFS systems. This inconsistency might lead to poorer accuracy of measures based on FFS claims unless they are reviewed by an organization external to the state Medicaid agency. Although no immediate solutions were found, these factors directly relate to the feasibility of implementing measures and merit continued consideration. The variation in state payment models and implications for data collection could affect the future comparability of measure results across states.

Incorporating Beneficiaries' Perspectives on Quality

MAP found the Adult Core Set to be strong on many fronts, including its parsimonious size, its alignment with other programs, and its responsiveness to chronic conditions that are common in the Medicaid population. However, members were not confident that the measures would reflect the issues that matter most to Medicaid enrollees. A first step to ensuring that the measure set is responsive would be to gather evidence on the quality measures that most resonate with adults enrolled in Medicaid and let that evidence guide future decisionmaking. Specifically, MAP would benefit from more detailed information on the services that are most important to Medicaid enrollees to help prioritize improvement efforts.

The measure set currently gauges beneficiary experience of care through a CAHPS survey, but the scope of CAHPS items was felt to be limited. Implementation of CAHPS is uneven across states, with 16 states reporting to CMS in FFY 2013 that they collected this survey. While CMS plans to perform a nationwide CAHPS survey of adult Medicaid enrollees that will mitigate data collection burden on states in 2014, the Adult Core Set could be further strengthened to address the services most important to beneficiaries.[33] For example, MAP urges the future inclusion of performance measures based on patient-reported outcomes (PROs), to the extent that those measures are available for state-level programs. This resonated with stakeholders who commented on the importance of measures that include beneficiary perspectives. One noted support for CAHPS and PROs, and another commented that outcome measures are often more relevant for consumers and purchasers than other types of measures.

Balancing Rigor and Voluntary Participation

States vary in their infrastructure, political climates, and other factors that influence their participation in quality reporting. With the voluntary nature of the reporting program in mind, state representatives expressed different opinions on how challenging the measures within the Adult Core Set should be. At one end of the spectrum, some stakeholders believe that the role of a core measure set is to provide a modest baseline set of measures that are highly feasible for all to report. At the opposite end, others believe that the measure set should demand more significant and sophisticated analysis to understand and change health outcomes. States are not required to submit all of the measures in the Adult Core Set to CMS; they can select those that most closely meet their needs and capabilities. Although MAP felt the current set to be balanced in its level of rigor, it is not well understood if the complexity of the measures or the way in which they were presented discouraged any states from participating in reporting. Further outreach to representatives of nonparticipating states could be conducted to inform subsequent reviews.

Ultimate Uses of Measurement Information

The intention of measuring quality and performance in the health system is to provide data that informs and motivates improvement. One of the most straightforward uses of a quality measure is for a single entity to track its own data over time, monitor the trend, and initiate actions that would improve the results. This type of internally focused quality improvement effort is usually an appropriate starting place. Quality measures can also be used to compare an entity's performance to a benchmark level or to its peers to illuminate differences. Understanding one's own performance relative to others can be critical for understanding success. However, making comparisons across states must be done carefully to avoid reaching inaccurate conclusions. Populations of Medicaid enrollees vary tremendously by state, and it would not be fair to expect measured performance to be the same across the country. Causes of variation include, but are not limited to, urban/rural mix, financial and categorical eligibility policy, distribution of chronic diseases, age, gender, and other factors. The stakes would be further raised if the comparative performance information was made public or tied to a financial incentive.

Although CMS is required to issue annual reports to the HHS Secretary about state-specific information that includes the Adult Core Set, CMS does not plan to publish state-identifiable information in the first annual report. Given that this was the first year of reporting and some technical specifications were refined mid-year, CMS decided to use this year to assess the quality of the data, understand the challenges states faced in reporting, and refine the guidance

provided to states on the Core Set reporting. Measure results will be publicly reported in 2015. Some states have already expressed a strong desire to rate their own performance against others. CMS should consider the analytic supports necessary to enable valid cross-state comparisons or national benchmarking, such as risk adjustment to account for differences in states' enrolled populations.

CONCLUSION

MAP's recommendations to HHS on the Medicaid Adult Core Set are intended to strengthen the program measure set and assist in meeting the three-part goal to increase state participation in reporting and quality improvement. In summary, MAP suggests the continued use of most measures in the set to provide stability and the opportunity to gain additional experience and data. In the case of three measures, continued use is conditional upon further exploration or NQF endorsement of the measures. MAP also recommends that one measure be removed from the set because it no longer conforms to current clinical guidelines. Finally, MAP noted three measures for phased addition to the program measure set over time, beginning with a measure of poor hemoglobin A1c control among people with diabetes.

States' perspectives on the use of measures during their first year of implementation contributed greatly to MAP's discussion and decisionmaking process. State representatives enthusiastically described the value of participating in the Medicaid Adult Quality grant program and how they have used information to inform direct quality improvement efforts. MAP encourages further state efforts to report additional measures and capitalize upon the infrastructure and partnerships being developed. MAP endeavored to maintain a measure set that is feasible for states' continued engagement and reflective of the diversity found in state Medicaid programs, including variability in enrolled populations, capacity for data analysis, and quality issues of interest.

In the long term, MAP recommends that CMS continue to support states' efforts to gather, report, and analyze data that informs quality improvement activities. Uses of quality data are expected to gradually mature from an internal focus on accuracy and year-over-year improvement to a more sophisticated approach involving benchmarking and public reporting. At the same time, CMS and MAP remain conscious of the voluntary nature of participation in submitting data on the Adult Core Set; rigor must be tempered with a realistic understanding of abilities and potential trade-offs. The program measure set will continue to evolve in response to changing federal, state, and stakeholder needs and should be considered a long-term strategic process.

ENDNOTES

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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.

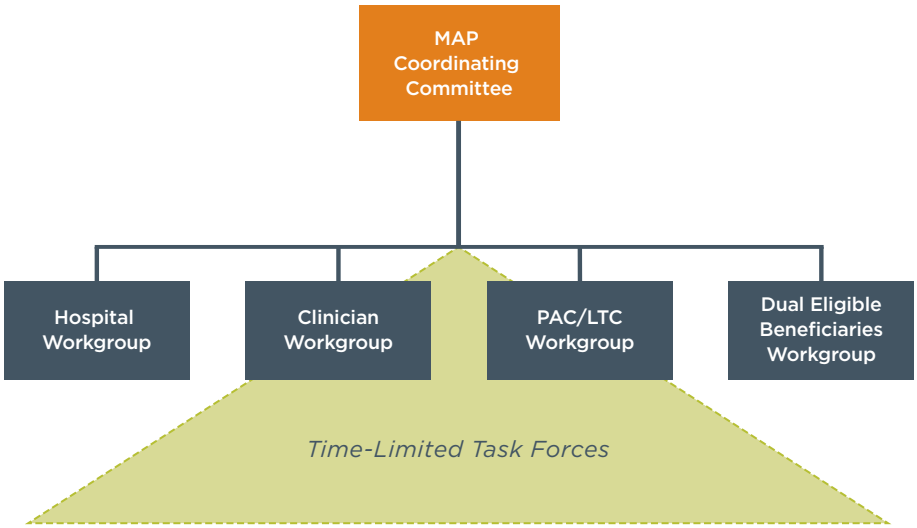
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for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

FIGURE A1. MAP STRUCTURE



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 developing "families of measures"—related measures that cross settings and populations—and a multiyear strategic plan provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

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 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.

ENDNOTE

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

Roster for the MAP Medicaid Task Force

CHAIR (VOTING)
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
Humana, Inc.	George Andrews, MD, MBA, CPE, FACP
L.A. Care Health Plan	Jennifer Sayles, MD, MPH
March of Dimes	Cynthia Pellegrini
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Consumer Voice for Quality Long-Term Care	Lisa Tripp, JD
National Rural Health Association	Brock Slabach, MPH, FACHE

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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.

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.

Sub-criterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need

Sub-criterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs

Sub-criterion 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:

Sub-criterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

Sub-criterion 2.2 Healthy people/healthy communities, demonstrated by prevention and well-being

Sub-criterion 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.

Sub-criterion 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)

Sub-criterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

Sub-criterion 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)

Sub-criterion 3.4 Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program

Sub-criterion 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

Sub-criterion 4.1 In general, preference should be given to measure types that address specific program needs

Sub-criterion 4.2 Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes

Sub-criterion 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

Sub-criterion 5.1 Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

Sub-criterion 5.2 Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives

Sub-criterion 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).

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

Sub-criterion 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.

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

Sub-criterion 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 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; a 2014 version followed. The table below lists the measures included in the Core Set along with their current NQF endorsement number and status.

States voluntarily collect the Medicaid Adult 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.

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	Recommendations and Rationale
0004 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Measure Steward: NCQA	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	18 states reported FFY 2013 Alignment: Meaningful Use Stage 2 – Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report
0006 Endorsed CAHPS Health Plan Survey - Adult questionnaire Measure Steward: NCQA	30-question core survey of adult health plan members that assesses the quality of care and services they receive.	16 states reported FFY 2013 (11 states reported using CAHPS 5.0H; 4 states reported using CAHPS 4.0H; 1 state used an agency-designed CAHPS-like survey) Alignment: Medicare Shared Savings Program, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Moderate levels of states reporting observed due to high costs of implementation Addresses NQS and CMS Quality Strategy priority area of Person- and Family-Centered Experience of Care

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	Recommendations and Rationale
0018 Endorsed Controlling High Blood Pressure Measure Steward: NCQA	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	15 states reported FFY 2013 Alignment: Meaningful Use Stage 2 – Eligible Professionals, Medicare Shared Savings Program, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report Addresses NQS and CMS Quality Strategy priority area Prevention and Treatment of Chronic Conditions
0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation Measure Steward: NCQA	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.	15 states reported FFY 2013 Alignment: PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	Recommendations and Rationale
0032 Endorsed Cervical Cancer Screening Measure Steward: NCQA	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	28 states reported FFY 2013 Reason states did not report: measure was not identified as a key priority; other Alignment: Meaningful Use Stage 2 – Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program
0033 Endorsed Chlamydia screening in women [ages 21-24 only] Measure Steward: NCQA	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	25 stated reported FFY 2013 Alignment: Meaningful Use Stage 2– Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program
0039 Endorsed Flu Vaccinations for Adults Ages 18 and Over Measure Steward: NCQA	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.	12 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review; as a result it is burdensome for states and other entities to report
0057 Endorsed Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing Measure Steward: NCQA	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	29 states reported FFY 2013 Alignment: PQRS, HEDIS, Marketplace Quality Rating System	Support for continued use in the program MAP recommended the addition of #0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) as a complement to address this high-impact condition in the Medicaid Adult population
0063 Endorsed Comprehensive Diabetes Care: LDL-C Screening Measure Steward: NCQA	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an LDL-C test during the measurement year.	29 states reported FFY 2013 Alignment: PQRS, HEDIS	Measure should be removed from the program because it is no longer consistent with clinical guidelines

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	Recommendations and Rationale
0105 Endorsed Antidepressant Medication Management (AMM) Measure Steward: NCQA	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	24 states reported FFY 2013 Alignment: Meaningful Use Stage 2 – Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program
0272 Endorsed Diabetes Short-Term Complications Admissions Rate (PQI 1) Measure Steward: AHRQ	The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	23 states reported FFY 2013 Alignment: N/A	Support for continued use in the program Disparities-sensitive measure for which there is a gap in care Addresses an important clinical condition for the Medicaid Adult population
0275 Endorsed Chronic obstructive pulmonary disease (PQI 5) Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	23 states reported FFY 2013 Alignment: Medicare Shared Savings Program	Support for continued use in the program
0277 Endorsed Heart Failure Admission Rate (PQI 8) Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	23 states reported FFY 2013 Alignment: Medicare Shared Savings Program	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	Recommendations and Rationale
0283 Endorsed Asthma in Younger Adults Admission Rate (PQI 15) Measure Steward: AHRQ	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.	23 states reported FFY 2013 Alignment: N/A	Support for continued use in the program MAP recommended the addition of #1799 Medication Management for People with Asthma as a complement to address this high-impact condition in the Medicaid Adult population
0418 Endorsed Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan Measure Steward: CMS	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.	5 states reported FFY 2013 4 states reported Adult Core Set specifications; 1 state reported PCMH measure (includes screening for 24 mo. but not follow-up plan) Alignment: MU Stage 2 – Eligible Professionals, Medicare Shared Savings Program, PQRS	Support for continued use in the program Addresses an important measurement gap in mental and behavioral health treatment and outcomes Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report
0469 Endorsed PC-01 Elective Delivery Measure Steward: The Joint Commission	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)	13 states reported FFY 2013 Alignment: Hospital Inpatient Quality Reporting, Meaningful Use Stage 2-Hospitals, CAHs	Support for continued use in the program MAP recommends the steward consider including the impact of psychosocial determinants (e.g., substance abuse, mental illness) in the measure Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	Recommendations and Rationale
0476 Endorsed PC-03 Antenatal Steroids Measure Steward: The Joint Commission	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	5 states reported FFY 2013 Alignment: N/A	Support for continued use in the program Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report
0576 Endorsed Follow-Up After Hospitalization for Mental Illness Measure Steward: NCQA	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	27 states reported FFY 2013 Alignment: PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program MAP encouraged use of a longer follow-up period (e.g., 3-6 months) Addresses NQS and CMS Quality Strategy priority area of Healthy Living and Well-Being Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	Recommendations and Rationale
0648 Endorsed Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	4 states reported FFY 2013 Alignment: N/A	Support for continued use in the program Addresses NQS and CMS Quality Strategy priority area of Effective Communication and Care Coordination Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report MAP recommends measures be implemented as endorsed and adding the paired measure: #0647 Transition Record with Specified Elements Received by Discharged Patients
1517 Endorsed Prenatal & Postpartum Care [postpartum care rate only] Measure Steward: NCQA	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	28 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	Recommendations and Rationale
1768 Endorsed Plan All-Cause Readmissions Measure Steward: NCQA	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/ Denominator) 5. Total Variance Note: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	18 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Conditional support for continued use in the program MAP recommends the development and application of a risk-adjustment model for the Medicaid population
1879 Endorsed Adherence to Antipsychotic Medications for Individuals with Schizophrenia Measure Steward: CMS	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).	18 states reported FFY 2013 Alignment: HEDIS	Support for continued use in the program Addresses the needs of vulnerable population at greater risk of readmissions and nonadherence to medications Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report MAP recommends the steward consider refining this measure to simplify the data collection methodology

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	Recommendations and Rationale
2082 Endorsed HIV Viral Load Suppression Measure Steward: HRSA	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.	Alignment: N/A	Support for continued use in the program. Measure addresses a high risk population and high priority gap area. MAP recommends careful consideration of the potential modifications required on the measure. As currently specified, the identification of the measure denominator and code sets pose feasibility challenges. An alternative HIV/AIDS measure may need to be considered in the future.
2371 Undergoing Endorsement Review Annual Monitoring for Patients on Persistent Medications Measure Steward: NCQA	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the four rates separately and as a total rate : Rates for each: Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), Digoxin, diuretics, or anticonvulsants Total rate (the sum of the four numerators divided by the sum of the four denominators)	22 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Conditional support for continued use in the program pending NQF endorsement Measure requires data linkage which does not currently exist and has some coding challenges; as a result it is burdensome for states to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	Recommendations and Rationale
2372 (formerly 0031) Undergoing Endorsement Review Breast Cancer Screening Measure Steward: NCQA	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	26 states reported FFY 2013 Alignment: Meaningful Use Stage 2 – Eligible Professionals, Medicare Shared Savings Program, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Conditional support for continued use in the program pending NQF endorsement Measure has been submitted with updated specifications to meet clinical guidelines, has been recommended for endorsement by the Steering Committee
Not Endorsed Adult Body Mass Index Assessment Measure Steward: NCQA	The percentage of Medicaid Enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	16 states reported FFY 2013 Alignment: Health Insurance Marketplace Quality Rating System	Support for continued use in the program MAP encourages the steward to submit this measure for NQF endorsement MAP recommends measure be maintained for stability of the set because of moderate levels of state implementation Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report MAP recommends improving the feasibility of data collection; ICD-10 implementation may assist

APPENDIX E:
Measures Associated with the Top 10 Conditions for Readmissions Among Adults in Medicaid

A recent analysis by the Healthcare Cost and Utilization Project (HCUP) found that nonelderly Adult Medicaid beneficiaries experienced a total all-cause, 30 day readmissions rate of 14.6 per 100 admissions, adding up to approximately 700,000 readmissions in 2011. These readmissions cost approximately $7.6 billion and the 10 conditions with the most all-cause, 30-day readmissions accounted for 34.1% of all Medicaid readmissions.

These 10 conditions and how they relate to current or potential measures are outlined below.

Top 10 Conditions for Readmission[1]	Current Measures in the Medicaid Adult Core Set	Potential Future Additions to the Medicaid Adult Core Set
Septicemia (except in labor)	None	#0351 Death among surgical inpatients with serious, treatable complications (PSI 4)
Congestive Heart Failure (nonhypertensive)	#0277 Heart Failure Admission Rate (PQI 8)	#0358 Congestive Heart Failure (CHF) Mortality Rate (IQI 16)
Diabetes Mellitus with complications	#0272 Diabetes Short-Term Complications Admission Rate (PQI 1) #0063 Comprehensive Diabetes Care: LDL-C Screening #0057 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	#0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) #0575 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Chronic Obstructive Pulmonary Disorder and Bronchiectasis	#0275 Chronic obstructive pulmonary disease (PQI 5)	#2020 Adult Current Smoking Prevalence
Other complications related to pregnancy	#1517 Prenatal & Postpartum Care	
Early or threatened labor	#0469 PC-01 Elective Delivery #0476 PC-03 Antenatal Steroids	
Schizophrenia and other psychotic disorders	Adherence to Antipsychotics for individuals with schizophrenia #0576 Follow-Up After Hospitalization for Mental Illness	#1927 Cardiovascular Screening For People With Schizophrenia Or Bipolar Disorders Who Are Prescribed Antipsychotic Medications #1932 Diabetes Screening For People With Schizophrenia Or Mood Disorders Who Are Using Antipsychotic Medications

Top 10 Conditions for Readmission[1]	Current Measures in the Medicaid Adult Core Set	Potential Future Additions to the Medicaid Adult Core Set
Mood disorders	#0576 Follow-Up After Hospitalization for Mental Illness #0105 Antidepressant medication management #0576 Follow-Up After Hospitalization for Mental Illness	#1880 Adherence to Mood Stabilizers for Individuals with Bipolar Disorder #0580 Bipolar animatic agent
Alcohol related disorders	#0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment #0576 Follow-Up After Hospitalization for Mental Illness	
Substance related disorders	#0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment #0576 Follow-Up After Hospitalization for Mental Illness	

ENDNOTE

1 Hines AL, Barrett ML, Jiang HJ, et al. Conditions with the largest number of adult hospital readmissions by payer, 2011. Rockville, MD: AAHRQ; 2014. Healthcare Cost and Utilization Project (HCUP) Statistical Brief #172. Available at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.jsp. Last accessed June 2014.

APPENDIX F:
NQF Member and Public Comments

State Experience Collecting and Reporting the Core Set

America's Health Insurance Plans

Carmella Bocchino

Industry experience has shown that the following measures were not reported in 2013 due to limitations with software systems used to calculate these measures: Flu Shots for Adults, Screening for Depression and Clinical Follow-up, PC-01 Elective Delivery, PC-03 Antenatal Steroids, and Care Transitions. We recommend re-evaluating the feasibility of reporting these measures.

GlaxoSmithKline

Deborah Fritz

GlaxoSmithKline recognizes the challenges the MAP Committee faces regarding data gaps, the voluntary nature of reporting Adult Medicaid measures and the need for states to focus on their particular priority areas. We appreciate the summary highlights of State experience collecting and Reporting Adult Medicaid measures. You have provided useful insights on why MAP is committed to minimizing drastic changes to the measures for the first two years of program implementation. We agree that focusing on known challenges in data collection, reporting and monitoring the program's continuing development are important for CY2015. Hopefully, this will encourage increased state participation and support for initiatives to improve quality of care and population health of the Adult Medicaid population.

MAP's Measure Specific Recommendations and Gaps

ActualMeds Corporation

Joseph Gruber

ActualMeds Corporation wishes to support the Pharmacy Quality Alliance comments regarding implementation of the PQA Adherence Measures to the Medicaid Core Set. Assessment of quality in medication use and management throughout the healthcare system is key to improving health. ActualMeds supports the inclusion of the PQA adherence measures and an important part of measuring quality for Medicaid members. These measures are already well accepted by Medicare Part D Star Ratings and other quality systems, and vendors and care providers are conversant with their application and use. Thanks in advance for considering PQA quality measures. Joseph Gruber RPh, CGP, FASCP Chief Clinical Officer, ActualMeds Corporation

American Heart Association

Madeleine Konig

The American Heart Association/American Stroke Association (AHA/ASA) is pleased to see that the NQF Measures Application Partnership suggests further review of issues related to medication management and we support the inclusion of the NQF-endorsed medication adherence measure 0541, Proportion of Days Covered (PDC): 3 rates by Therapeutic Category. There is significant potential for improving the quality of care through careful medication management. Including medication adherence measures as part of the Medicaid core set would also be consistent with the recent findings of a National Quality Forum Task Force that ranked medication management in the top 5 high-leverage opportunities for measurement. Chronic conditions account for the great majority of the health burden to patients and costs to our health care system,

and for most of these conditions, medications are a first line of therapy. Poor adherence to medications is a widely recognized factor in failure of therapy, contributes substantially to increased costs, and has been recognized as America's "other drug problem."

America's Essential Hospitals

Ashley Ferguson

America's Essential Hospitals is pleased to see that the MAP suggests review with its conditional support of issues related to hospital readmission and NQF #1768 Plan All-Cause Readmissions (PCR). In line with the report, we also urge the use of NQF endorsed measure #1789 Hospital-Wide All-Cause Unplanned Readmission rather than NQF endorsed #1768 because it is more actionable and impactful. Additionally, before MAP moves to support the use of either NQF #1768 or #1789 as a measure in the Adult Core Set, NQF should develop a sufficient risk-adjustment methodology around socioeconomic (e.g., income, education, occupation)and sociodemographic (e.g., age, race, ethnicity, primary language) factors to ensure essential hospitals are not disproportionately penalized. Reducing preventable readmissions is of paramount concern to America's Essential Hospitals, but any program directed at reducing readmissions must target readmissions that are preventable and must also include appropriate risk-adjustment methodology.

There is a large body of emerging evidence that socioeconomic and sociodemographic factors can influence health outcomes. These studies have shown the impact adjusting for sociodemographic factors has on readmissions rates. One of the most compelling bodies of evidence that supports the use of risk adjustment for socioeconomic factors in performance measures, such as NQF #1768 and NQF #1789, is a technical report by an NQF expert panel in July 2014. Results on certain measures, such as readmissions measures, can be skewed by socioeconomic and sociodemographic factors and does not allow for comparable performance measures. Not risk-adjusting for these factors could cause an even further injustice to an already vulnerable population.

We appreciate the opportunity to comment on the above-captioned report. If you have any questions, please contact Ashley Henske at ahenske@essentialhospitals.org.

America's Health Insurance Plans

Carmella Bocchino

The report should be revised to recognize that the burden of medical record review applies not only to states, but to all entities collecting and reporting such data including health plans, providers, etc. To minimize burden of data collection measures collected via administrative methodologies should be prioritized over measures that require hybrid data sources.

0039: This measure could be subject to recall bias that may affect its reliability. Sample size may also be too small for meaningful health plan comparison. We recommend requiring all practitioners that administer immunizations to report vaccinations to state immunization registries, and also be required to release such data to hospitals, health plans, providers, etc.

0648: This measure is important for the Medicaid population, as it is highly dependent on communication among facilities, providers, and families or caregivers. Our experience shows that some plans use this measure in pay-for-performance programs. This measure is a hospital measure that is burdensome and difficult to collect as it may require EHR data extraction or chart review. Accurate information regarding whether the discharge record was sent within 24 hours may not be recorded and thus not available. Hospitals must be required to collect the exact transmission times of the transition record before this measure should be adopted.

0418: This measure is burdensome for health plans to collect as data are captured only through medical record review. It is difficult to obtain complete and consistent data due to providers using a variety of adult screening tools (e.g. PHQ-9), etc.) and follow-up plans are not captured by administrative data.

0476: This measure is burdensome for health plans to collect as it is not captured by administrative claims and complete data are difficult to obtain due to patients receiving antenatal steroids before delivery at a variety of locations (e.g. birthing center, hospital, etc.).

America's Health Insurance Plans

Carmella Bocchino

1517: This measure is burdensome to report not only for states, but also for health plans and providers, as it requires medical record review. We are concerned that some states recommend using the global obstetric billing code. Global billing allows for the bundling of the provision of antepartum care, delivery, and postpartum care into one billing code. Therefore, identifying post-partum care will be challenging under this type of environment as it would require a separate billing process.

0105: We recommend replacing this measure with #1879. Industry experience has shown that appropriate use of antipsychotics and drugs for bipolar disorder (e.g. Lithium and Lamictal) have a greater impact on the Medicaid population than antidepressants.

AstraZeneca

Kathy Gans-Brangs

In Appendix D, Measure 0039 (Page 30), we suggest changing title from " Flu Shots for Adults Ages 18 and Older" to "Flu Vaccinations for Adults Ages 18 and Older". This suggested edit would make the title consistent with the measure title in Exhibit 3 (page 6).

AstraZeneca

Kathy Gans-Brangs

Reference is made to Appendix D, Measure 0063 (Page 30). We do not support the removal of NQF#0063, Comprehensive Diabetes Care: LDL-C Screening, without the replacement of the measure to evaluate appropriate treatment to manage lipids. Removing the current measure without a replacement does not support current treatment recommendations and monitoring. We support a measure that includes an appropriate use of a statin: The use of high- or moderate-intensity statin therapy based on patient risk factors.

CVS/caremark

Kristin Garnett

CVS/caremark appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) Expedited Review of the Medicaid Adult Core Set of Measures. As a member of the Pharmacy Quality Alliance (PQA) organization, we echo and support their comments.

Assessment of quality in medication use and management throughout the healthcare delivery continuum leads to improved health. CVS/caremark values the MAP's consideration to include this measure in the Medicaid Adult Core Set of Measures. We support the inclusion of the NQF-endorsed medication adherence measure 0541, Proportion of Days Covered (PDC): 3 rates by Therapeutic Category in the Medicaid Adult Core Set of Measures. Specifically, we support the inclusion of adherence to renin-angiotensin system antagonists, diabetes medications and statins.

Our organization supports the continued use of PQA endorsed measures due to their rigorous consensus-driven process to develop, test, and endorse high-priority measures of medication-use quality. This measure has been thoroughly tested, and is calculated using prescription claims data, thus decreasing the burden of data collection. Additionally, the measure has been used as part of the Medicare Part D Star Ratings program for public reporting, plan comparison, and provision of quality bonus payments. Alignment of measurement sets across the healthcare delivery systems allows for consistency in quality assessments.

Thank you in advance for your consideration of these comments. If you have any questions, please contact our organization via the individuals below.

Eli Lilly and Company

Dawn Blank

Lilly USA appreciates the opportunity to comment on the Measure Application Partnerships recommendation. Lilly USA supports the inclusion of Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category (NQF 0541), as this measure evaluates medication adherence for treatments of prevalent chronic conditions. This measure is already

in use the Medicare Part D Star Ratings program, and including it in the Medicaid Adult Core Set would be an appropriate alignment of measures within the two programs.

GlaxoSmithKline

Deborah Fritz

GSK strongly supports the recommendation to phase in #0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%). Given the high prevalence of diabetes and state interest in improving risk factors, we agree that adding this measure of control is needed to move to the next step toward improved patient outcomes. It also provides States better data to evaluate the impact of Diabetes programs. GSK strongly supports the recommendation to phase in a measure of asthma management as a complement to the admission rate measures. We agree with adding #1799 Medication Management for People with Asthma. However, we suggest the Committee consider #1800 instead. This asthma medication ratio is a measure of control not just treatment and would have a bigger impact on appropriate treatment and patient health.

GSK strongly supports adding care coordination measures to the Medicaid Adult Measure set. We agree with adding #0647. To further address care coordination and patient outcomes, we recommend adding a Comprehensive Medication Management (CMM) measure such as the PQA (Pharmacy Quality Alliance) endorsed measure "Comprehensive Medication Review (CRM)." This is a patient focused measure not tied to a particular setting of care to improve transitions of care.

GSK agrees with MAP that medication management is critical to achieving high quality care and positive health outcomes and supports continued use of #2371 if it is re-endorsed. GSK agrees with the Committee and would also prefer the inclusion of measure of adherence or shared decision-making about medication choices. We suggest considering Comprehensive Medication Management (CMM) measure such as the PQA (Pharmacy Quality Alliance) endorsed measure "Comprehensive Medication Review (CRM)." This is a patient focused measure not tied to a particular setting of care to improve transitions of care. CRM is not dependent on a single point in time, or condition, or prescription fail to reflect he overall quality of medication management.

Highmark

Christine Pozar

NQF #0039: Flu Shots for Adults Ages 50-64 – This measure is burdensome to health plans as it is difficult to obtain complete data due to patients receiving vaccinations from a variety of sources that are not captured by administrative claims data.

Recommendations: Alternative to removing measure is to require all sources to document injections in state immunization registries to be eligible to order and receive payment for vaccines

State immunization registries should be required to release the data for both adults and pediatrics as requested by hospitals, insurance companies, schools, etc.

(These recommendations would be applicable to multiple immunizations [pneumococcal, HPV, hepatitis, etc.])

MedHere Today

Richard Logan

MedHere Today appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) Expedited Review of the Medicaid Adult Core Set of Measures.

Assessment of quality in medication use and management throughout the healthcare delivery continuum leads to improved health. MedHere Today is pleased to see that the MAP suggests further review of issues related to medication management and we support the inclusion of the NQF-endorsed medication adherence measure 0541, Proportion of Days Covered (PDC): 3 rates by Therapeutic Category. This measure, as recently submitted to the NQF measure maintenance process is focused on renin-angiotensin system antagonists, diabetes medications and statins. As an active PQA member organization, we know that the Pharmacy Quality Alliance uses a rigorous consensus-driven process to develop, test, and endorse high-priority measures of medication-use quality. The measure has been thoroughly tested, and is calculated using

prescription claims data, so adds little to the burden of data collection.

MedHere Today is a community pharmacist led, medication adherence consulting group designed to help community pharmacies implement and grow their adherence initiatives. Our consultants work every day with community pharmacies to help them focus on these three adherence measures within their pharmacies to improve medication adherence, and thus clinical outcomes. The utilization of these same three PDC measures within the Medicare Part D space resulted in a sense of urgency for many community pharmacies to adopt a more pro-active, patient centered approach to pharmacy practice. We feel that inclusion of these measures will push more of our colleagues to adopt creative, positive outcome producing, patient care models in their pharmacies.

Merck

Patrick Liedtka

Merck appreciates the opportunity to provide input on the Measure Application Partnership's (MAP) Expedited Review of the Medicaid Adult Core Set of measures.

There is growing recognition among US health care system stakeholders that assessing and improving the quality of medication management and appropriate use throughout the healthcare delivery continuum leads to improved health outcomes. Merck specifically supports the inclusion of the NQF-endorsed medication adherence measure, Proportion of Days Covered (PDC): 3 rates by Therapeutic Category, in the Medicaid adult measure set. This measure focuses on renin-angiotensin system antagonists, diabetes medications and statins, which are prevalent chronic conditions in the US. This measure is already in use in the Medicare Part D Star Ratings program, was recently designated for inclusion in the HIE QRS beta measure set, and is used by employer coalitions nationwide as part of the National Business Coalition on Health's eValue8 program. Incorporating this measure into the Medicaid Adult Core Set better aligns quality reporting across multiple programs. As a PQA member, Merck is aware that PQA uses a rigorous, consensus-driven process to develop, test, and endorse high-priority measures of medication-use quality.

In addition, research indicates the Medicaid population has generally lower medication adherence rates than other insured populations, so beginning to measure and improve medication management and use in this population offers the potential to deliver significant benefits to the country and states with respect to improved population and individual health.

NACDS

Alex Adams

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) Expedited Review of the Medicaid Adult Core Set of Measures.

The tracking of medication management and quality metrics are an essential part of improving health among populations and holds great promise to foster transparency and accountability. NACDS applauds the MAP's decision to further review issues related to medication management and supports the inclusion of the medication adherence 0541, Proportion of Days Covered (PDC): 3 rates by Therapeutic Category.

Proposed measure 0541 has been subjected to significant review. This measure has been: (1) developed by Pharmacy Quality Alliance (PQA) using insurance plan prescription claims data; (2) rigorously tested to ensure minimal burden and appropriate applicability; and (3) included in several quality platforms and metrics that have been shown to improve quality and safety.

Importantly, the inclusion of the measure will ensure consistency and harmonization across federal programs. Medication adherence metrics have been embraced and included in the Medicare Star Ratings program and as part of the beta-measure set of the Quality Rating System for health plans operating in the Exchanges. The importance of medication measures within the Medicare Part D program is reflected in the overall weight of the measures. Specifically, the medication-related measures account for nearly half of the overall weighting for PDP plans and 20% of the weighting for MA-PD plans.

NACDS

Alex Adams

Providing meaningful and transparent information around medication adherence is critically important to improve outcomes within Medicaid plans. Poor medication adherence is reported to cost $290 billion annually – 13% of total healthcare expenditures. Substantial evidence links improved medication adherence to reduced hospitalizations, delayed progression of disease, improved treatment outcomes, and cost savings. The Congressional Budget Office has estimated that for each one percent increase in the number of prescriptions filled by beneficiaries, there is a corresponding decrease in overall medical spending.

Medicaid patients face additional barriers to medication adherence, including cost issues, transportation barriers, and health literacy challenges, among others. Thus efforts to raise awareness and transparency around medication adherence are needed in to create incentives for significant health improvement within this vulnerable population. NACDS submits that the inclusion of the medication adherence measure (0541) is essential to (1) improve patient outcomes and achieve healthcare savings within the Medicaid population; (2) align priority measures with those currently implemented in federal, state and private sector programs; and (3) generate meaningful and actionable information to help consumers make more informed decisions.

National Partnership for Women & Families

Alison Shippy

We applaud the identification of maternal/reproductive health as a key area for inclusion in the initial core set, support those measures, and additionally, appreciate the attention from the MAP Medicaid Task Force to maternal health as it continue to have significant gaps in quality measures. Advancing maternity care performance measurement is a high priority for consumers and purchasers. We encourage the Task Force to consider adding the following maternal health measures, many of which are currently endorsed by NQF and already in use in many states.

1. PC-02 Cesarean Section (NQF #0471): This outcome 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. Stewarded by The Joint Commission (TJC), it is currently in the Medicaid Child Core Set and we feel it is critical to closely align both the Child and Adult sets to ensure continuity of evaluation as there are some facilities that may only use the Adult Set. Although TJC requires it for all facilities with 1,100+ births beginning this year, inclusion in the Adult set could also extend to facilities with fewer than 1,100 births. This could be the pathway to Hospital Compare or an alongside public reporting interface. Approximately one in three women have a cesarean section and experts agree that is too many – by tracking this outcome, hospitals are able to monitor whether various improvement activities are successful in lowering cesarean sections. Quality improvement activities include improving diagnostic and treatment approaches for labor disorders, reducing admissions for patients presenting in latent labor, and encouraging patience during the active phase of labor and the second stage of labor (pushing). Cesarean sections are much more costly than vaginal births and it is important to track a hospital's progress on this measure.

2. PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice (NQF #0480): 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 process measure is also a part of the set of five nationally implemented measures that address perinatal care from TJC. Breast feeding is associated with reduced hypertension, heart disease, diabetes, and breast and ovarian cancer in women. Also, there are significant postpartum hormonal contributions to maternal adaptation to parenting and life in the postpartum period through the continued surges of oxytocin (offers "calm and connection") and prolactin associated with breastfeeding.

3. Vaginal Birth After Cesarean Delivery Rate, Uncomplicated – IQI # 22:– This AHRQ measure evaluating Vaginal Birth After Cesarean (VBAC) rates is well established and used, but not NQF

endorsed. Similar to the rationale for including the Cesarean measure, it is important to evaluate this outcome. Despite widespread use, there has been a plateau in the performance results, reflecting a persistent performance gap that indicates the need for continued attention to improvement.

4. Healthy Term Newborn (NQF #0716):This outcome measure evaluates the percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care. The measure, stewarded by California Maternal Quality Care Collaborative, is currently endorsed with NQF and undergoing specification refinement as Unexpected Newborn Complications. While focused on the baby's outcome, we believe it is important to acknowledge that it includes outcomes influenced by the birth process and care of mother and also by the facility after the birth, which make it appropriate for the Adult Set.

While there are many other existing measures that could be recommended for inclusion, we recognize the relatively new reporting of this core set and acknowledge the limited resources Medicaid providers have dedicated to standardized measure collection. We look forward to future opportunities to submit measures for expanded Medicaid reporting. Medicaid plays a key role in child and maternal health, financing almost half of all births in the United States. Our ability to influence maternal outcomes is critically important in improving the health of our nation's moms and babies, as well as strengthening the financial health of our system.

OutcomesMTM

Jessica Frank

OutcomesMTM appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) Expedited Review of the Medicaid Adult Core Set of Measures.

OutcomesMTM is pleased to see the MAP suggests further review of issues related to medication therapy management, and we support the inclusion of the NQF-endorsed medication adherence measure 0541, Proportion of Days Covered (PDC): 3 rates by Therapeutic Category in the Medicaid Adult Core Set of Measures.

This measure is focused on renin-angiotensin system antagonists, diabetes medications and statins. As an active member of the Pharmacy Quality Alliance (PQA), our organization can attest to the rigorous consensus-driven process PQA uses to develop, test, and endorse high-priority measures of medication-use quality. The measure has been thoroughly tested, and is calculated using prescription claims data, so adds little to the burden of data collection.

Further, the measure is currently used as part of the Medicare Part D Star Ratings program for public reporting, plan comparison, and a factor contributing to quality bonus payments. It has been included in the HIE QRS beta-measure set; is used by employer coalitions nationwide as part of the National Business Coalition on Health's eValue8 program; and is incorporated into many medication therapy management (MTM) programs across the nation.

OutcomesMTM has included these medication adherence measures within our nationwide MTM programs across multiple market segments, including Medicare, Medicaid, and Commercial markets, for a number of years. The OutcomesMTM service model leverages the local relationship between the patient and the pharmacist to drive improvements in adherence. Therefore, over 100,000 pharmacists trained in the OutcomesMTM program across the nation are already familiar with these measures and are working to improve adherence in these three therapeutic areas, making it a natural fit to harmonize the measurement systems for Medicaid with that of Medicare and the other markets. We welcome further dialogue with the MAP, if desired.

Parata Systems

Gayle Tuttle

Parata Systems appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) Expedited Review of the Medicaid Adult Core Set of Measures. On behalf of Parata, we would like to comment in support of the inclusion of the NQF-endorsed medication adherence measure 0541, Proportion of Days Covered (PDC): 3 rates by Therapeutic Category.

We endorse and echo the comments submitted by Pharmacy Quality Alliance (PQA) of which Parata is a member. Assessment of quality in

medication use and management throughout the healthcare delivery continuum leads to improved health. Further, the measure is used as part of the Medicare Part D Star Ratings program for public reporting, plan comparison, and provision of quality bonus payments; has been included in the HIE QRS beta-measure set; is used by employer coalitions nationwide as part of the National Business Coalition on Health's eValue8 program; and is incorporated into EQuIPP, a national, standardized electronic Quality Improvement Platform for Pharmacies and Plans."

PerformRx

Erica Potter

1. They use ICD-9 codes, they should also list out ICD-10 codes due to the impending conversion

2. The opioid measure lists cancer as exclusion. I think there are other disease states that require higher doses of opioids. Specifically thinking of Sickle Cell Disease.

3. I liked how the measures are framed and my comment on the last one DRAFT QUALITY IMPROVEMENT INDICATOR: Persons in a Patient-Centered Medical Home or Other Integrated Care Team Model Receiving a Timely Comprehensive Medication review:

4. I would like to have threshold percentage of completion in case there is a large population identified for MTM service it might not be possible to complete reviewing all the members within the specified 30, 60, 90 days.

Pharmacy Quality Alliance

Woody Eisenberg

The Pharmacy Quality Alliance (PQA) appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) Expedited Review of the Medicaid Adult Core Set of Measures.

Assessment of quality in medication use and management throughout the healthcare delivery continuum leads to improved health. PQA is pleased to see that MAP suggests further review of issues related to medication management and we support the inclusion of the NQF-endorsed medication adherence measure 0541, Proportion of Days Covered (PDC): 3 rates by Therapeutic Category. This measure, as recently submitted to the NQF measure maintenance process is focused on renin-angiotensin antagonists, diabetes medications and statins. PQA uses a rigorous consensus-driven process to develop, test, and endorse high-priority measures of medication-use quality. The measure has been thoroughly tested, and is calculated using prescription claims data, so adds little to the burden of data collection.

Further, the measure is used as part of the Medicare Part D Star Ratings program for public reporting, plan comparison, and provision of quality bonus payments; has been included in the HIE QRS beta-measure set; is used by employer coalitions nationwide as part of the National Business Coalition on Health's eValue8 program; and is incorporated into EQuIPP, a national, standardized electronic Quality Improvement Platform for Pharmacies and Plans.

PhRMA

Jennifer Van Meter

PhRMA supports MAP's encouragement to include relevant outcome measures in the Medicaid Adult Core Set. Ultimately, achievement of improved clinical outcomes and quality of life is the desired goal, so measure sets should progress toward evaluating outcomes. Regarding specific measures, PhRMA supports the phased addition of Comprehensive Diabetes Care: HbA1c Poor Control and Medication Management for People with Asthma; both of these measures determine if medications are being used optimally in order to control chronic conditions. We also support addition of Transition Record with Specified Elements Received by Discharged Patients because care coordination is critical to ensuring a patient is receiving optimal care post-discharge. Further, we support inclusion of Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category (NQF 0541), as this measure evaluates medication adherence for treatments of prevalent chronic conditions. This measure is already in use in the Medicare Part D Star Ratings program, and including it in the Medicaid Adult Core Set would be an appropriate alignment of measures within the two programs. We believe that the addition of

these measures will aid in evaluating medication management in the adult Medicaid population.

RxAnte

Aaron Mckethan

At RxAnte we believe CMS should include the NQF-endorsed adherence measure 0541 into the Medicaid Core Set. We urge CMS to recognize the disproportionate value of improved performance on these measures relative to process or access measures, as they have recognized in the Medicare population through adherence measure 0541, for the following reasons:

Medication adherence improves health outcomes and lowers costs. Many recent studies such as Roebuck and colleagues (2011) provide evidence that patient adherence to medications used to treat congestive heart failure, hypertension, diabetes, and dyslipidemia can be associated with reductions in medication utilization and preventable costs.

CMS policy has resulted in increasing adherence rates among Medicare beneficiaries, and these improvements can be made in Medicaid as well. According to data supplied to health plan sponsors by a CMS contractor (Acumen), adherence to medications for cholesterol, diabetes, and blood pressure have improved nationally for Medicare beneficiaries since adherence measure 0541 was included in the Star Ratings.

Improving quality underserved populations can be difficult, but Medicare proves it works and it is worth the resources. Working with a particular national health plan serving a 55% low-income status (LIS) population, we have seen a dramatic increase in performance on adherence measure 0541 over the past two years, nearly triple the industry average.

Adherence measures will fuel new industry innovation in Medicaid as they have done in Medicare. Since CMS included adherence measure 0541 in the Star Ratings and implemented bonus payments linked to Star Ratings performance in 2011, we have seen countless examples of Medicare health plans investing in innovative new approaches to improve adherence at a population level and encouraging new provider collaboration as well as innovative care models.

Adherence measure 0541 reinforces other federal health care improvement priorities. Medication adherence is an important aspect of CMS's resolve to pursue the three-part aim of better health, better care, and lower costs. Other federal health care priorities can be reinforced with better adherence to safe and effective prescription medications such as the HHS's "Million Heart's" Initiative the Partnership for Patients, and the immediate past Surgeon General's health care initiatives.

For the above reasons, we urge CMS to include NQF-endorsed adherence measure 0541, as medication adherence is one of the few clear levers in health care that has been demonstrated to improve health outcomes and lower costs.

VoicePort LLC

Jeffery Maltese

VoicePort LLC appreciates the opportunity on comment in support of the MAP review of Medicaid Adult Core Set of Measures.

It is firmly established that the Assessment of quality in medication use and management throughout the healthcare delivery continuum leads to better treatment outcomes and improved health. We support a common set of clinical measures across all government funded health programs to ensure that quality care is provided consistently. VoicePort is pleased to see that the MAP suggests further review of issues related to medication management and we support the inclusion of the NQF-endorsed medication adherence measure 0541, Proportion of Days Covered (PDC): 3 rates by Therapeutic Category. This measure, as recently submitted to the NQF measure maintenance process is focused on renin-angiotensin system antagonists, diabetes medications and statins. PQA uses a rigorous consensus-driven process to develop, test, and endorse high-priority measures of medication-use quality. The measure has been thoroughly tested, and is calculated using prescription claims data, so adds little to the burden of data collection.

Further, the measure is used as part of the Medicare Part D Star Ratings program for public reporting, plan comparison, and provision of quality bonus payments; has been included in the HIE QRS beta-measure set; is used by employer coalitions nationwide as part of the National Business Coalition

on Health's eValue8 program; and is incorporated into EQuIPP, a national, standardized electronic Quality Improvement Platform for Pharmacies and Plans.

Our thanks in advance for your continued efforts and support.

Strategic Issues

America's Health Insurance Plans

Carmella Bocchino

We strongly agree that it is necessary for states to continue to increase their capacity and ability to use measures to advance quality improvement. Developing linkages to vital records systems to calculate some measures will be critical and will also benefit population health monitoring efforts. Health plans are currently exploring the use of data from state health information networks to improve reporting capabilities. The use of such a database would also need to be approved by NCQA as a supplemental database in order to greatly reduce the need for medical record review and duplication of efforts by providers and health plans.

We also support coordinating the Adult Core Set measures with the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP. This alignment will reduce burden on providers, states, and health plans.

Finally, since some of the measures included in the report are burdensome not only for states, but also health plans, providers, etc., data linkages necessary to support these measures need to be developed. For example, we would be supportive of the Adult BMI measure once ICD-10 is deployed and evidence of treatment for an elevated BMI can be captured, rather than just assessing the documentation of BMI in the medical record.

GlaxoSmithKline

Deborah Fritz

GSK strongly agrees that measures of beneficiary perspectives should be added, in particular use of CHAPS and PROs.

General Comments on the Report

American Association on Health & Disability

E. Clarke Ross

Recommendations to Address High Priority Gaps

We suggest that the Medicaid adult gaps and phrasing be aligned as closely as possible with the gaps and phrasing proposed to CMS by the NQF workgroup on persons dually eligible for Medicare and Medicaid reports. While the characteristics of the entire Medicaid adult population are different than the persons dually eligible for Medicare and Medicaid, the challenges and needs addressed by the two workgroups and populations are very similar. Consistency of gaps and phrasing would help all policymakers and stakeholders to better understand these concepts. The NQF "duals" gaps and phrases can serve as a minimum core in the larger adult Medicaid population.

National Quality Forum – MAP (Measures Application Partnership)

July 12, 2013 NQF (persons dually eligible work group) to CMS Preliminary Findings report and February 28, 2014 NQF Interim Report to CMS – 7 High Priority Measure Gaps

1. Goal-directed, person-centered care planning and implementation

2. Shared decision-making

3. Systems to coordinate healthcare with non-medical community resources and service providers

4. Beneficiary sense of control/autonomy/ self-determination

5. Psychosocial needs

6. Community integration/inclusion and participation

7. Optimal functioning (e.g., improving when possible, maintaining, managing decline)

These are appropriate for the entire adult Medicaid population.

Beneficiary Experience and Beneficiary-Reported Outcomes

We agree with the page 17 observation: MAP "members are not confident that the measures

would reflect the issues that matter most to Medicaid enrollees." We agree with the further observation that the "scope of CAHPS items was felt to be limited." We suggest that the Medicaid adult report reference the CMS-AHRQ pilot on the Medicaid home and community-based services (HCBS) experience survey.

On page 5, the chart categorizes the 26 measures in the adult core set by NQS and CMS quality strategy priorities. Only one of the 26 measures is "person and family-centered experience of care." This reinforces the high priority gap of beneficiary-reported outcomes.

Building state capacity

We endorse the observation of the need to build state capacity (page 15).

Thank you for considering our views.

American Optometric Association

Kara Webb

The American Optometric Association appreciates the opportunity to comment on the 2014 Report on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid. As doctors of optometry provide care for patients covered by Medicaid, the AOA is very interested in the progress of implementing the core measure set across the states.

The AOA understands that the implementation of Medicaid quality measures requires time and resources. As the MAP looks towards the future, the AOA recommends that the MAP continue to encourage a focus on measures related to diabetes care for the core measure set. As the MAP well knows, diabetes disproportionately affects low-income populations and Medicaid plays a critical role in supporting care for patients with diabetes. The AOA encourages the MAP to consider recommending the Comprehensive Diabetes Care: Eye Exam measure (NQF 0055) for inclusion in the core measure set. People with diabetes are at a significantly higher risk for developing eye diseases including glaucoma, cataracts and diabetic retinopathy, one of the most serious sight-threatening complications of diabetes. Additionally, those with diabetes are 40 percent more likely to suffer from glaucoma than people without diabetes. Many people without diabetes will get cataracts, but those with the disease are 60 percent more likely to develop this eye condition. People with diabetes also tend to get cataracts at a younger age and have them progress faster. For these reasons it is critical for patients with diabetes to receive annual eye exams. Including this measure in the core set would help to ensure that diabetic patients are getting necessary care that has a tremendous impact on future health care costs and quality of life.

America's Essential Hospitals

Ashley Ferguson

America's Essential Hospitals appreciates the opportunity to comment on the National Quality Forum's (NQF) draft report, Measure Applications Partnership: 2014 Report on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Our members provide a disproportionate share of the nation's uncompensated care and devote more than half of their inpatient and outpatient care to uninsured or Medicaid patients. Last year our members treated over 3.6 million Medicaid patients. Our members serve diverse communities—more than half of patients receiving care at our hospitals are racial or ethnic minorities. To best care for these populations, our members offer culturally and linguistically appropriate care. They also establish generous financial assistance programs, invest in care coordination and quality improvement, and provide specialized services that would otherwise be lacking in their community.

Essential hospitals demonstrate their commitment to improving quality of care and reducing disparities through their work in their communities, as evidenced by the participation of 23 hospitals in the Essential Hospitals Engagement Network (EHEN). The EHEN, funded by CMS through the Partnership for Patients, is the leading hospital network in the areas of health equity, patient and family engagement, and sustainability. Through the EHEN, essential hospitals are focused on reducing

preventable hospital-acquired conditions and 30-day readmissions.

For the above reasons, America's Essential Hospitals strongly supports the aim to standardize and align measurement efforts so that there is a core set of health care quality measures used across states to assess quality of care for adults enrolled in Medicaid. America's Essential Hospitals is a partner of the Partnership for Medicaid whose goal is to support the development of a comprehensive, standardized quality measurement and reporting program to promote improvement in the quality of care for our nation's most vulnerable populations.

We are grateful that MAP has taken action into looking at potential gap areas in the Adult Core Set. The topics of particular interest are: access to care, cultural competency, poor birth outcomes, primary care and behavioral health integration and treatment outcomes for behavioral health conditions and substances use disorders.

We appreciate the opportunity to comment on the above-captioned report. See our additional comments regarding specific recommendations in item 2 in these comments on the Medicaid Draft Report. For any questions please contact Ashley Henske at ahenske@essentialhospitals.org

America's Health Insurance Plans

Carmella Bocchino

In general, this report captures a balance of cross-cutting measures that assess areas of importance for the Medicaid population; however, it is limited to the measures that states can collect. The measure set needs to evolve to reflect the changing needs of the population and improvements to data collection systems.

We also recommend that CMS adopt measures that take into account social determinants of health (e.g. education and income) as these factors are important for the Medicaid population. Measures for future use in the Medicaid Adult Core Set could include adherence to medications for patients with chronic conditions.

Additionally, as the Medicaid Adult Core Set moves towards outcome measures, reporting of CPT Category II codes will be necessary to efficiency collect outcomes for lab tests, body mass index, blood pressure, and other biometric information.

Lastly, due to the Medicaid population having different subgroups (e.g. women, children, disabled, etc.), we recommend the MAP further consider the need to adjust for socioeconomic status and to monitor for any unintended consequences.

National Partnership for Women & Families

Alison Shippy

The Consumer-Purchaser Alliance (C-P Alliance) is pleased to provide input on this draft report. We wholly support a core set's ability to standardize and align measures across various reporting programs – streamlining providers' effort and focusing on measures best suited for improving outcomes. Medicaid is an area ripe for renewed focus considering the expansion of Medicaid coverage to adults under the Affordable Care Act (ACA). The measures in the Adult Core Set were originally compiled to address quality issues related to general adult health, maternal/reproductive health, complex health care needs, and mental health and substance use (26 measures in total).

We strongly support the overarching recommendation to include relevant outcome measures. Process and structural measures can miss the mark for what consumers and purchasers find most relevant – namely, whether or not the care provided is effective and efficient. We also support maintaining a parsimonious measure set and aligning with other programs, as long as alignment improves the meaningfulness of the measure set.

Parata Systems

Gayle Tuttle

Parata Systems appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) Expedited Review of the Medicaid Adult Core Set of Measures. On behalf of Parata, we would like to comment in support of the inclusion of the NQF-endorsed medication adherence measure 0541, Proportion of Days Covered (PDC): 3 rates by Therapeutic Category.

We endorse and echo the comments submitted by Pharmacy Quality Alliance (PQA) of which

Parata is a member. Assessment of quality in medication use and management throughout the healthcare delivery continuum leads to improved health. Further, the measure is used as part of the Medicare Part D Star Ratings program for public reporting, plan comparison, and provision of quality bonus payments; has been included in the HIE QRS beta-measure set; is used by employer coalitions nationwide as part of the National Business Coalition on Health's eValue8 program; and is incorporated into EQuIPP, a national, standardized electronic Quality Improvement Platform for Pharmacies and Plans."

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2015 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

NQF #	Measure Steward	Measure Name
Preventive Care		
0032	NCQA	Cervical Cancer Screening (CCS)
0033	NCQA	Chlamydia Screening in Women (CHL)
0039	NCQA	Flu Vaccinations for Adults Age 18 and Older (FVA)
0418	CMS	Screening for Clinical Depression and Follow-Up Plan (CDF)
2372	NCQA	Breast Cancer Screening (BCS)
NA	NCQA	Adult Body Mass Index Assessment (ABA)
Maternal and Perinatal Health		
0469	TJC	PC-01: Elective Delivery (PC01)
0476	TJC	PC-03: Antenatal Steroids (PC03)
1517	NCQA	Prenatal & Postpartum Care: Postpartum Care Rate (PPC)
Behavioral Health and Substance Use		
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)
0105	NCQA	Antidepressant Medication Management (AMM)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)
NA	NCQA	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA)
Care of Acute and Chronic Conditions		
0018	NCQA	Controlling High Blood Pressure (CBP)
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)*
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01)
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08)
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05)
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15)
1768	NCQA	Plan All-Cause Readmissions (PCR)
2082	HRSA	HIV Viral Load Suppression (HVL)
2371	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM)
Care Coordination		
0648	AMA-PCPI	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR)
Experience of Care		
0006	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, Version 5.0 (Medicaid) (CPA)

* This measure was added to the 2015 Medicaid Adult Core Set.

AHRQ = Agency for Healthcare Research & Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CMS = Centers for Medicare & Medicaid Services; HRSA = Health Resources and Services Administration; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; TJC = The Joint Commission.

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: December 30, 2014

FROM: Cindy Mann
Director
Center for Medicaid and CHIP Services

SUBJECT: **2015 Updates to the Child and Adult Core Health Care Quality Measurement Sets**

This informational bulletin describes the 2015 updates to the core set of children's health care quality measures for Medicaid and the Children's Health Insurance Program (CHIP) (Child Core Set) and to the core set of health care quality measures for adults enrolled in Medicaid (Adult Core Set).

Background

The Center for Medicaid and CHIP Services (CMCS) has worked with stakeholders to identify two core sets of health care quality measures that can be used to assess the quality of health care provided to children and adults enrolled in Medicaid and CHIP. The core sets are tools states can use to monitor and improve the quality of health care provided to Medicaid and CHIP enrollees. The goals of this effort are to:

1) encourage national reporting by states on a uniform set of measures; and
2) support states in using these measures to drive quality improvement.

Part of implementing an effective "quality measures reporting program" is to periodically re-assess the measures that comprise it since many factors, such as changes in clinical guidelines and challenges with reporting, may warrant modifying the measure set. In addition, CMCS continues to prioritize working with federal partners to promote quality measurement alignment across programs recognizing that this reduces burden on states reporting data to multiple programs and helps to drive quality improvement across payers and programs.

For the 2015 updates to the Child and Adult Core Sets, CMCS worked with the National Quality Forum's (NQF)[1] Measure Applications Partnership (MAP), a public-private partnership that reviews measures for potential use in federal public reporting,[2] to review and identify ways to improve the core sets. Collaborating with NQF's MAP process for core set updates promotes measure review alignment across CMS since NQF also updates measures for other CMS reporting programs.

[1] http://www.qualityforum.org/story/About_Us.aspx
[2] http://www.qualityforum.org/map/

CMCS is encouraged by state reporting on the core measures. For the Child Core Set, all states voluntarily reported two or more of the measures for federal fiscal year (FFY) 2013, with a median of 16 measures reported by states. For the Adult Core Set, 30 states reported a median of 17 measures and 25 states reported on at least 8 core set measures in FFY 2013. Additional information on state reporting for each core set can be found in the respective *2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP* and *the 2014 Annual Report on the Quality of Care for Adults Enrolled in Medicaid*.[3,4] CMCS looks forward to working with states on the core measures reporting now underway for FFY 2014.

2015 Child Core Set

Since the release of the initial Child Core Set in 2011, CMCS has collaborated with state Medicaid and CHIP agencies to voluntarily collect, report, and use the measures to drive quality improvements. Section 1139A of the Social Security Act provides that, beginning annually in January 2013, the Secretary shall publish recommended changes to the core measures.[5]

For the 2015 Child Core Set update, CMCS will:

- retire one measure, Percentage of Eligibles that Received Dental Treatment Services;[6]
- add two measures:
  - Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk;[7] and
  - Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment.[8]

In addition, CMS will pilot a reporting process for FFY 2015 for the child version of the hospital Consumer Assessment of Healthcare Providers and Systems survey (Child HCAHPS) in order to determine whether or not to include HCAHPS in the Core Set.[9] Since the Child HCAHPS is a survey conducted by hospitals, CMS will work with CMS hospital reporting programs and states to obtain the survey data. CMS views the Child HCAHPS as an important tool for monitoring a family's experiences and satisfaction with hospital-based pediatric care. This measure was recommended to help address gaps noted in the measure set in three areas: inpatient care; patient experience, and care coordination. Additional information about the Child Core Set MAP review process and their recommendations to CMS can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html

[3] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf

[4] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-adult-sec-rept.pdf

[5] The first update was issued via a State Health Official Letter "2013 Children's Core Set of Health Care Quality Measures," SHO #13-002. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf The second update was issued via a CMCS Informational Bulletin "2014 Updates to the Child and Adult Core Health Care Quality Measurement Sets." http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf

[6] Measure steward: CMS, Not NQF Endorsed

[7] Measure steward: American Dental Association on behalf of the Dental Quality Alliance, NQF#2508

[8] Measure steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI), NQF#1365

[9] Measure steward: Center for Quality Improvement and Patient Safety-Agency for Healthcare Research and Quality, Underdoing NQF Endorsement Review NQF#2548

2015 Adult Core Set

In January 2012, CMCS released its initial core set of health care quality measures for adults enrolled in Medicaid (Adult Core Set). Section 1139B of the Social Security Act, as amended by Section 2701 of the Affordable Care Act, notes that the Secretary shall issue updates to the Adult Core Set beginning in January 2014 and annually thereafter.[10]

For the 2015 Adult Core Set update, CMCS will:

- retire the Comprehensive Diabetes Care: LDL-C Screening measure;[11] and
- add the Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) measure.[12]

The replacement of the diabetes screening measure allows CMCS and states to expand the measurement of health care outcomes in Medicaid. Additional information about the Adult Core Set MAP review process and their recommendations to CMS can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html

Next Steps

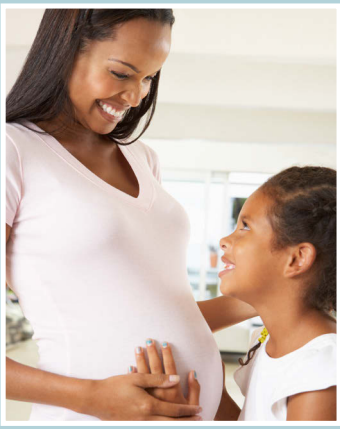
The updates to the Core Sets will take effect in the FFY 2015 reporting cycle, which will begin no later than December 2015. To support states in making these changes, CMCS will release updated technical specifications for both Core Sets in spring 2015 and make them available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html. States with questions or that need further assistance with reporting and quality improvement regarding the Child and Adult Core Sets can submit questions or requests to: MACQualityTA@cms.hhs.gov.

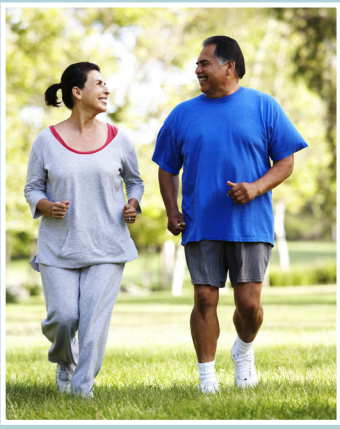
If you have questions about this bulletin, please contact Marsha Lillie-Blanton, Children and Adults Health Programs Group, at marsha.lillie-blanton@cms.hhs.gov

[10] The first update was issued via a CMCS Informational Bulletin "2014 Updates to the Child and Adult Core Health Care Quality Measurement Sets." http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf

[11] Measure steward: National Committee for Quality Assurance, NQF#0063

[12] Measure steward: National Committee for Quality Assurance, NQF#0059





The Department of Health and Human Services

2014 Annual Report on the Quality of Health Care for Adults Enrolled in Medicaid

Health and Human Services Secretary

Sylvia Mathews Burwell

November 2014

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CONTENTS

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EXHIBITS

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), required the Secretary of the U.S. Department of Health and Human Services (HHS) to establish a comprehensive adult health care quality measurement program to standardize the measurement of health care quality across state Medicaid programs and facilitate the use of the measures for quality improvement. This report, required by Section 1139B of the Social Security Act, as added by Section 2701 of the Affordable Care Act, summarizes information on the quality of health care furnished to adults covered by Medicaid.

Medicaid served 32 million adults in 2010, representing about half of the beneficiaries currently enrolled in the program. Adults ages 21 to 64 accounted for 37 percent of all Medicaid enrollees and the elderly (age 65 and over) accounted for 9 percent of the total.[1] The Centers for Medicare & Medicaid Services (CMS), the HHS agency responsible for ensuring effective health care coverage for Medicaid beneficiaries, plays a key role in promoting quality health care for adults enrolled in Medicaid. CMS works collaboratively with states to strengthen systems for measuring and collecting data on access and quality.

To promote a better understanding of health care quality efforts targeting adults enrolled in Medicaid, this report discusses the status of quality measurement and reporting efforts using the Medicaid Adult Core Set and summarizes information on managed care performance measures and performance improvement projects (PIPs) reported in external quality review (EQR) technical reports submitted to CMS by states. Key findings from these information sources are summarized below.

Status of Medicaid Adult Core Set Quality Measurement and Reporting

- In federal fiscal year (FFY) 2013, 30 states reported a median of 16.5 Medicaid Adult Core Set measures.
- Eight measures were reported by at least 25 states, with the most frequently reported measures focused on diabetes care management, postpartum care visits, mental health treatment, and women's preventive health care.
- Since this was the first year of state reporting on the Medicaid Adult Core Set measures, CMS is not publicly reporting findings on the measures but using the data as an opportunity to learn about the challenges states faced in uniformly reporting the measures. The findings will also be used to improve guidance for reporting that CMS provides to states.
- Medicaid health plan performance was highest on measures focused on diabetes care and medication management and lowest on measures related to behavioral health care access and use. Analysis of National Committee for Quality Assurance benchmarking data was conducted to determine these findings.

[1] Mathematica analysis of 2010 Medicaid Analytic eXtract data. Includes full-benefit and non-full-benefit enrollees (e.g., enrollees for family planning, breast cancer, and Medicare cost-sharing only).

Managed Care External Quality Review Findings

- Of the 42 states that currently contract with managed care plans, 39 submitted EQR technical reports to CMS for the 2013–2014 reporting cycle. The most frequently reported adult performance measures in the EQR reports are similar to those in the Medicaid Adult Core Set.
- Through their managed care entities, states are engaged in various types of improvement projects for adults. This report profiles PIPs in four areas: (1) adults with diabetes, (2) hospital readmissions, (3) hospital emergency department (ED) visits, and (4) substance use disorders.
- During this reporting cycle, 17 states reported a total of 62 adult diabetes PIPs, 14 states reported a total of 93 PIPs aimed at reducing hospital readmissions, 14 states reported 81 PIPs aimed at reducing hospital ED visits, and 5 states reported 22 PIPs with a focus on improving care for substance use disorders.

Conclusion

This report documents the foundation developed by CMS and states for measuring and improving the quality of health care for adults enrolled in Medicaid, irrespective of the delivery system in which they receive their health care. CMS plans to publicly report Medicaid Adult Core Set state-specific data in the 2015 Secretary's Report. These data will support CMS's future goals to: (1) increase the number of states reporting on the Medicaid Adult Core Set measures, (2) increase the number of measures reported by each state, (3) improve the completeness of the data reported, and (4) use the measures as part of state quality improvement initiatives, including for managed care EQR PIPs.

CMS and states will continue to work together to measure performance and use data collected to drive improvements in the quality of health care. As the momentum to pay for value rather than volume of services grows, state-specific performance data will be critical in guiding efforts to transform the systems of care that provide services to Medicaid enrollees.

I. INTRODUCTION

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), established the National Quality Strategy for Quality Improvement in Health Care (National Quality Strategy), which serves as the national blueprint to improve the health care delivery system and health outcomes by pursuing three goals: better care, healthy people/healthy communities, and affordable care.[2] These three goals are reflected in the activities undertaken by the Centers for Medicare & Medicaid Services (CMS) and other agencies of the U.S. Department of Health and Human Services (HHS) to improve care for adults enrolled in Medicaid.

The Affordable Care Act also required the Secretary of HHS to establish a comprehensive adult health care quality measurement program to standardize the measurement of health care quality across state Medicaid programs and facilitate the use of the measures for quality improvement. As required by section 1139B of the Social Security Act (as added by section 2701 of the Affordable Care Act), this report summarizes the status of state annual reporting on:

- a core set of health care quality measures for adults enrolled in Medicaid, and
- the quality of health care furnished to adults covered by Medicaid, including information collected through external quality reviews of managed care organizations (MCOs).

The HHS Secretary is required to "collect, analyze, and make publicly available the information reported by States" by September 30, 2014, and annually thereafter.[3] This is the Secretary's first annual report on the quality of health care for adults enrolled in Medicaid, and complements the Secretary's report on the quality of care for children in Medicaid and the Children's Health Insurance Program (CHIP), which has been published annually since 2010.[4]

A. Profile of Adults Enrolled in Medicaid

Of the 69 million Medicaid enrollees in 2010, about half (32 million) were adults ages 21 and older. [5] Adults ages 21 to 64 accounted for 37 percent of all Medicaid enrollees and the elderly (ages 65 and over) accounted for 9 percent of all enrollees (Exhibit 1).

Medicaid and CHIP are also critically important for population subgroups that disproportionately have lower-incomes, including racial and ethnic minority groups, people with limited English proficiency (LEP), and people who have historically suffered disparate health care access and health outcomes (e.g., rural population groups, women with young children). Women in their

[2] U.S. Department of Health and Human Services. "2013 Annual Progress Report: The National Quality Strategy Improvement in Health Care." Washington, DC: HHS, 2013. Available at: http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm.

[3] Section 1139B(d)(2) of the Social Security Act (42 U.S.C. §1320b-9b(d)(2)). Available at: http://www.ssa.gov/OP_Home/ssact/title11/1139B.htm.

[4] Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.

[5] Mathematica analysis of 2010 Medicaid Analytic eXtract data. Includes full-benefit and non-full-benefit enrollees (e.g., enrollees for family planning, breast cancer, and Medicare cost-sharing only).

reproductive years (ages 18 to 44) comprise a sizable share of adult Medicaid enrollees.[6] For this group, Medicaid provides coverage for a range of services including preventive services such as pap smears and mammography, family planning, and pregnancy-related services. Medicaid financed nearly 48 percent of all births in the United States in 2010, ranging from 24 percent of births in Hawaii to 69 percent of births in Louisiana.[7]

Medicaid also provides coverage for low-income people with disabilities and/or who are elderly, as well as supplemental coverage for Medicare enrollees (often called dually eligible beneficiaries). In 2010, about 12 percent (7.2 million) full-benefit, non-elderly adults with disabilities were enrolled in Medicaid (Exhibit 1). People with disabilities are a heterogeneous group, consisting of individuals with physical, mental, and intellectual impairments. Both the dually eligible and people with disabilities have complex health care needs and are high users of long-term services and supports.[8]

Adults covered by Medicaid generally are in poorer health than privately insured adults with similar income.[9] Analysis of 2003 to 2009 data from the Medical Expenditure Panel Survey found that, low-income adults ages 19 to 64 covered by Medicaid, compared with privately insured adults had statistically significantly higher rates of (1) an activity limitation during the year (53 percent versus 21 percent), (2) more than one chronic condition (48 percent versus 32 percent), and (3) self-reported fair or poor mental health (26 percent versus 7 percent).

Medicaid spending on services varies substantially across subsets of adult Medicaid enrollees, due in part to differences in the need for services. In 2012, average Medicaid spending per full-year equivalent enrollee was $4,100 for adults without disabilities, $17,300 for non-elderly people with disabilities, and $15,700 for the elderly.[10]

The Affordable Care Act established new health coverage options for Americans, including the expansion of Medicaid eligibility to low-income individuals such as adults without dependent children. Coverage expansions, combined with the changing demographics of our country, create an even more urgent need for robust quality measurement programs to better understand and address the health needs of new and historically served Medicaid population groups.

In sum, adult Medicaid enrollees have diverse health care needs. As a result, HHS's efforts to measure and improve the quality of health care provided to adults enrolled in Medicaid are designed to address these diverse needs.

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[6] Kaiser Family Foundation. "Medicaid's Role for Women Across the Lifespan: Current Issues and the Impact of the Affordable Care Act." Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7213-04.pdf.

[7] Markus, A.R., et al. "Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform." Women's Health Issues, vol. 23, no. 5, 2013, pp. e273–e280.

[8] Kaiser Family Foundation. "State Health Facts: Dual Eligibles." Available at: http://kff.org/state-category/medicare/dual-eligibles/.

[9] Coughlin, T. et al. "What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection Under Medicaid for Low-Income Adults." Kaiser Family Foundation, May 2013. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf.

[10] U.S. Department of Health and Human Services. "2013 Actuarial Report on the Financial Outlook for Medicaid," Table 2. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf.

II. FEDERAL AND STATE EFFORTS RELATED TO QUALITY MEASUREMENT AND REPORTING STATEWIDE

Section 1139B of the Social Security Act, as added by section 2701 of the Affordable Care Act, requires the Secretary to identify and publish a core set of health care quality measures for adults enrolled in Medicaid (Medicaid Adult Core Set). State reporting of the Medicaid Adult Core Set is voluntary, similar to the Core Set of Children's Health Care Quality Measures (of which states just completed their fourth year of reporting).[11]

A. Background on the Medicaid Adult Core Set

In January 2012, CMS published the Medicaid Adult Core Set (see Appendix A).[12] The initial core set of 26 health care quality measures was identified in partnership with a subcommittee to the Agency for Healthcare Research and Quality's (AHRQ's) National Advisory Council. This multi-stakeholder group composed of state Medicaid representatives, health care quality experts, representatives of health professional organizations, and patient advocacy groups, reviewed and evaluated approximately 1,000 measures from nationally recognized sources. The subcommittee broke into four work groups to focus on four dimensions of health care: adult health, maternal/ reproductive health, complex health care needs, and mental health and substance use. Following extensive review and public comment, the subcommittee selected 26 measures across six domains: prevention and health promotion, management of acute conditions, management of chronic conditions, family experiences of care, care coordination/care transitions, and availability.

The legislation further requires that improvements to the initial core set of adult health care quality measures be issued annually beginning in January 2014. To meet this requirement, CMS worked with the National Quality Forum's (NQF's) Measure Applications Partnership (MAP) to conduct an expedited review of the Medicaid Adult Core Set in September 2013. The objectives of this review were to understand states' experience to date with collecting the Medicaid Adult Core Set measures, evaluate the Medicaid Adult Core Set against the MAP measurement criteria, and consider measure alignment opportunities and identify measure gaps. After reviewing MAP recommendations and potential updates through CMS's internal measurement review process, CMS replaced one measure, Annual HIV/AIDS Medical Visit, with HIV Viral Load Suppression in the 2014 Medicaid Adult Core Set.[13]

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[11] State performance on the Child Core Set measures is publicly reported in the 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP. The Report also contains finding on quality of care provided to pregnant women. The report is available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-child-sec-rept.pdf.

[12] "Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults." Federal Register Notice 77 FR 286. Washington, DC: HHS, January 4, 2012. Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-01-04/pdf/2011-33756.pdf.

[13] The 2014 Medicaid Adult Core Set is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/AdultCoreMeasures.pdf. For further information on the 2014 Medicaid Adult Core Set, see http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf.

The multi-stakeholder review of the 2014 Medicaid Adult Core Set is nearly complete. The NQF Medicaid Adult Task Force began meeting in spring to review the 2014 Medicaid Adult Core Set.[14] CMS will release updates to the 2015 Medicaid Adult Core Set based on the multi-stakeholder review feedback and after completing its internal measurement review process, by January 2015.

CMS views the annual updating process as a unique opportunity to meet its goal of continuing to fill measurement gap areas in the core set and apply states' feedback about implementing the measures. Over the next year, CMS will focus its measurement development efforts around managed long-term services and supports (LTSS) and the Health Home Program, as well as filling other key gap areas, such as measures for care coordination and patient-reported outcomes.

To address one of these gap areas, in the fall of 2014, CMS will be conducting the first ever nationwide Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey of adult Medicaid enrollees to obtain national and state-by-state measures of access, barriers to care, and satisfaction with care across financing and delivery models.[15] This survey, which is a modified version of the Adult CAHPS Medicaid 5.0H questionnaire, will be administered in both English and Spanish. It will collect baseline information on the experiences of low-income adults during the early stages of implementation of the Affordable Care Act and will be used to inform CMS and state efforts to improve health care delivery for Medicaid enrollees.[16]

B. CMS Federal-State Data Systems for Quality Reporting

Section 1139B of the Social Security Act, as added by the Affordable Care Act, requires the Secretary to develop a standardized reporting format for the Medicaid Adult Core Set. CMS has continued to make progress in moving toward a modernized and streamlined Medicaid and CHIP data infrastructure known as the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. In the future, information collected as part of MACBIS will serve as the primary data source for Medicaid/CHIP quality reporting and performance measurement.

In the interim, CMS is using the CARTS system as the vehicle for collecting data on the Medicaid Adult Core Set. CARTS is the web-based data submission tool that states use to report the Child and Adult Core Set measures, and will serve as the tool states use to report the Health Home Core Set measures beginning in FFY 2015. CMS believes that standardized reporting has the potential to strengthen quality reporting, reduce health care costs associated with inefficiencies in the health care delivery system, and ultimately facilitate better health outcomes for adults in Medicaid.

[14] http://www.qualityforum.org/MAP_Task_Forces.aspx.

[15] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[16] Nationwide CAHPS Survey of Adult Medicaid Enrollees. June 6, 2014. Available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CAHPS-Survey-of-Adult-Medicaid-Enrollees.pdf

C. CMS Activities to Support Quality Measurement

1. Technical Assistance and Analytic Support Program

To encourage and support states to report the Medicaid Adult Core Set measures, CMS implemented a Technical Assistance and Analytic Support (TA/AS) Program.[17] The overarching goals of the TA/AS Program are to increase the number of states consistently collecting and uniformly reporting the Medicaid Adult Core Set measures and to support state efforts to use these data to improve the quality of care. As part of this program, the TA/AS team operates a TA mailbox to respond to specific questions raised by states regarding the Core Set specifications or other technical issues. The TA/AS team also provides one-on-one assistance to states and has developed TA tools, such as a resource manual and technical specifications, issue briefs, and webinars. In the first year, the TA/AS team responded to more than 140 TA requests on the Medicaid Adult Core Set measures, from 33 states.

2. Adult Medicaid Quality Grant Program

To assist states in collecting and reporting the Medicaid Adult Core Set, CMS launched the Adult Medicaid Quality Grant Program in December 2012. Funded by the Affordable Care Act, CMS selected 26 states to participate in the two-year grant program.[18] Each state receives up to $1 million per year for the two-year project period. The program has three main goals:

- Test and evaluate methods for collecting and reporting the Medicaid Adult Core Set in varying care delivery settings and payment arrangements, ideally demonstrating alignment with existing methods and infrastructures for collection and reporting.
- Develop staff capacity to report, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid.
- Conduct at least two Medicaid quality improvement projects (QIPs) related to the core set measures; states are encouraged to consider alignment for QIPs with CMS or other federal quality improvement activities (such as Strong Start, Million Hearts, and Partnership for Patients).

The grant program is assisting CMS in understanding the value and potential issues in collecting data on Medicaid Adult Core Set measures, as grantees are evaluating the collection and reporting of these measures and sharing feedback with CMS. The primary mechanism for these activities is a series of monthly meetings between grantees, CMS staff, and the TA/AS Program. Additionally, to help further the understanding of how health care quality affects diverse

[17] The TA/AS contract is led by Mathematica Policy Research and supported by subcontracts with the National Committee for Quality Assurance (NCQA) and the Center for Health Care Strategies (CHCS). A fact sheet describing the TA/AS program is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/TAFactSheet.pdf.

[18] The states are Alabama, Arkansas, California, Colorado, Connecticut, Georgia, Indiana, Iowa, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Hampshire, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Vermont, Washington, and West Virginia. Texas withdrew from the second year of the grant program. For more information on the Adult Medicaid Quality Grant Program see: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Medicaid-Quality-Grants.html.

populations within Medicaid, states were asked to collect data and stratify at least three of four specified measures (Comprehensive Diabetes Care: Hemoglobin A1c Testing, Postpartum Care, Controlling High Blood Pressure, or Cervical Cancer Screening) by at least two demographic categories: race, ethnicity, gender, language, geography, and disability status.

3. Testing Experience and Functional Assessment Tools (TEFT)

Beneficiaries using community-based long-term services and supports (CB-LTSS) are another focus of improved measurement and quality improvement efforts at CMS. The Testing Experience and Functional Assessment Tools (TEFT) grant program focuses on leveraging innovation in health information technology by testing quality measurement tools and demonstrating e-health in Medicaid CB-LTSS for the first time at a national scale. In March 2014, CMS selected nine states to receive grants to enable them to (1) test and evaluate new measures of functional capacity and individual experience for populations receiving CB-LTSS, (2) identify and harmonize the use of health information technology, and (3) identify and harmonize electronic CB-LTSS standards. As part of this demonstration project, TEFT grantees will field test an experience survey and a modified set of Continuity Assessment Record and Evaluation (CARE) functional assessment measures, demonstrate use of personal health records, and create an electronic CB-LTSS record. The TEFT grant program will provide national measures and valuable feedback on how health information technology can be implemented in this component of the Medicaid system.[19]

[19] The states are Arizona, Colorado, Connecticut, Georgia, Kentucky, Louisiana, Maryland, Minnesota, and New Hampshire. The TEFT initiative includes contracts for technical assistance and evaluation and interagency agreements with the Department of Defense and the Office of the National Coordinator. For more information on the TEFT grant program, see: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/TEFT-Program-.html.

III. NATIONAL FINDINGS ON QUALITY AND ACCESS FOR ADULTS ENROLLED IN MEDICAID

Beginning in 2014, states voluntarily collected and reported data on the Medicaid Adult Core Set measures. Thirty states reported one or more of the measures for the FFY 2013 reporting year (Exhibit 2). Twenty-six of the 30 states were Adult Medicaid Quality Grant Program grantees and 4 states were non-grantees. States reported a median of 16.5 measures.

Eight measures were reported by at least 25 states, an encouraging start for the first year of voluntary reporting (Exhibit 3). The most frequently reported measures were focused on (1) diabetes care management (LDL screening and hemoglobin A1c testing); (2) women's preventive health care (cervical cancer screening, breast cancer screening, and Chlamydia screening); (3) postpartum care visits; and (4) mental health treatment (follow-up after hospitalization for mental illness and antidepressant medication management). All of these measures are part of the Healthcare Effectiveness Data and Information Set (HEDIS®), and are frequently included in Medicaid managed care contracts for monitoring the quality of care provided to Medicaid enrollees receiving care through MCOs.[20] In addition, these measures are calculated primarily using Medicaid administrative data and do not require medical record review.

Reasons for not reporting the Core Set measures vary by state. The least frequently reported measures include those that require states to conduct medical record review in order to collect the necessary data. These reviews can be resource intensive for states to conduct, and there are sometimes legal or technical barriers to collecting data from hospitals or individual providers. Of the 3 measures reported by fewer than 10 states (i.e., antenatal steroids, screening for clinical depression and follow-up, and care transition), data access and technical capacity were among the most often cited reasons for states not reporting on the measures.

CMS views the first year of reporting of the Medicaid Adult Core Set as an opportunity for learning and refinement of the Core Set measures. CMS is using the data reported by states to better understand the states' abilities (and challenges) to collect and report the measures. CMS plans to publicly report Medicaid Adult Core Set data in the 2015 Secretary's Report. As CMS moves into the second year of reporting, it will strive to meet four goals:

- Increase the number of states reporting on the Medicaid Adult Core Set measures
- Increase the number of measures reported by each state
- Improve the completeness of the data reported
- Use the measures as part of state quality improvement initiatives, including for managed care external quality review performance improvement projects

[20] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

A. Medicaid Health Plan Quality: NCQA Benchmarking Report

Seventeen of the 26 measures in the Medicaid Adult Core Set are Healthcare Effectiveness Data and Information Set (HEDIS) measures. Since CMS has decided to forgo public reporting of data submitted by states during the first year of collecting data on the Adult Core Set measures, this report includes performance data on measures in the Core Set reported to the National Committee for Quality Assurance (NCQA) by health plans providing services to Medicaid enrollees.[21]

In 2013, 213 Medicaid health plans in 37 states submitted performance data on Medicaid enrollees to the NCQA national database (Appendix B).[22] The health plan data reported to NCQA reflect a subset of the performance data in which states are reporting to CMS on the Medicaid Adult Core Set measures. States are asked to collect data on Core Set measures for enrollees of all delivery system types, including managed care and fee-for-service.

1. Methodology

Means, medians, and 25th and 75th percentiles were calculated from NCQA's HEDIS database for measures included in the 2013 Medicaid Adult Core Set. The data include performance measures submitted by health plans for HEDIS 2011 to 2013 based on services delivered in calendar years 2010 through 2012, respectively.[23] HEDIS data are reported to NCQA by product line (commercial, Medicaid, and Medicare) and lines of business (health maintenance organization [HMO] or preferred provider organization [PPO] plans). The data in this report include HMO results for both Medicaid and commercial product lines. Within the HEDIS database, HMO plans include HMOs, point-of-service (POS), and HMO/POS/PPO combination plans. (Standalone PPO plans are excluded from this analysis because this model is not used in the Medicaid program.)

Comparison over time provides an assessment of the direction and magnitude of the performance trend. A Wilcoxon Rank Sum Test was performed to test statistical significance. Numbers indicate statistically significant changes in median performance; 'NS' is used to denote no statistically significant change in median performance. The trend analysis is based on health plan submitted data, which do not necessarily include the same measures submitted by the same plans over the three-year period.

[21] Health plans submit their audited results to NCQA in June of each year for the previous calendar year. For example, HEDIS 2013 data reflect services delivered during measurement year 2012. All HEDIS data submitted to NCQA must undergo a HEDIS Compliance Audit to ensure adherence to HEDIS specifications and the processes used to calculate measure results.

[22] These plans covered an estimated 27.3 million child and adult Medicaid enrollees in 2013. Data are not separately available on the number of Medicaid health plan enrollees who are adults. For additional information, see Benchmarks for Medicaid Adult Health Care Quality Measures at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/AdultBenchmarkReport.pdf.

[23] The HEDIS nomenclature follows the reporting year. The measurement year is the year prior to the reporting year. For example, HEDIS 2013 includes measure results that were reported in June 2013. These results primarily assess health plan performance in calendar year 2012.

2. Findings

The number of plans reporting on each individual HEDIS measure varies due to (1) patient populations served (for example, plans may not have sufficient numbers of patients who meet demographic and diagnosis criteria for reliable and valid reporting of specific measures), (2) state contractual requirements for reporting HEDIS measures, and (3) whether the measure is required for NCQA accreditation.

Exhibit 4 shows Medicaid health plan performance on selected HEDIS 2013 measures included in the Medicaid Adult Core Set. Median Medicaid health plan performance was highest on the following three measures:

- Comprehensive Diabetes Care:
  - LDL-C Screening (76 percent); and
  - Hemoglobin A1c Testing (83 percent)
- Annual Monitoring of Patients on Persistent Medications: composite measure (85 percent) and individual measures of ACE inhibitors/ARBs (87 percent), digoxin (91 percent), and diuretic (87 percent)

Performance was mixed on the Smoking and Tobacco Cessation measure. The median rate was higher on the general guidance component and lower on the two components related to specific cessation strategies:

- Advising Smokers and Tobacco Users to Quit (76 percent)
- Medical Assistance With Smoking and Tobacco Use Cessation:
  - Discussing cessation medications (45 percent); and
  - Discussing cessation strategies (40 percent)

Performance was lowest on the following measures, all related to indicators of effective behavioral health care services:

- Follow-Up After Hospitalization for Mental Illness: follow-up within 7 days of discharge (45 percent)
- Antidepressant Medication Management: effective continuation phase treatment (35 percent)
- Alcohol and Other Drug (AOD) Dependence Treatment: initiation of AOD treatment (39 percent) and engagement of AOD treatment (9 percent)

CAHPS 5.0H measures of patient experience with health plans and providers are also collected by NCQA as part of its accreditation program. As shown in Exhibit 4, the CAHPS measures with the highest median rating among Medicaid enrollees in health plans were:

- How well doctors communicate (72 percent)
- Customer service (67 percent)

- Rating of specialist seen most often (64 percent)
- Rating of personal doctor (63 percent)

The two CAHPS measures with the lowest median ratings were for health promotion and education (28 percent), shared decision-making (51 percent), and rating of all health care (51 percent).

Between HEDIS 2011 and HEDIS 2013, median Medicaid health plan scores did not change substantially, with two exceptions: (1) the CAHPS measure for customer service increased by nearly 9 percentage points from 59 percent to 67 percent; and (2) performance on Adult Body Mass Index (BMI) Assessment increased by 24 percentage points from 48 percent to 72 percent (Exhibit 5). However, the change in the BMI Assessment rate was due in part to a shift from administrative to hybrid data collection methods to improve the accuracy of this measure.

B. Access to Care in Medicaid: Evidence from the Research Literature

Analysis of data from the 2003 to 2009 Medical Expenditure Panel Survey (MEPS), a nationally representative survey, found that most adults ages 18 to 64 covered by Medicaid report access to care that is fairly comparable to that of low-income Americans with employer-sponsored insurance (ESI).[24] Most Medicaid-enrolled adults reported having a usual source of care (84 percent) and a relatively small share reported having unmet medical needs (5 percent) or an unmet need for prescription drugs (4 percent). There were two indicators from the analysis of the 2003–2009 MEPS that warrant improvement: Medicaid enrollees compared to individuals with ESI had a higher likelihood of using emergency department services (26 percent versus 21 percent) and a lower likelihood of a specialty care visit (27 percent versus 54 percent).

[24] Coughlin, T. et al. "What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection Under Medicaid for Low-Income Adults. " Kaiser Family Foundation, May 2013. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf.

IV. MONITORING AND IMPROVING CARE IN MANAGED CARE SETTINGS

In 2010, 61 percent of adults enrolled in Medicaid, ages 21 to 64, obtained their health care through managed care plans (Exhibit 6). The rate of managed care enrollment varied widely across state Medicaid programs, with 16 states reporting 0 percent of adults enrolled in managed care to 100 percent of adults in Tennessee enrolled in managed care. States using a managed care delivery system must comply with certain federal requirements, including standards related to assessing and monitoring the quality of care provided by contracted managed care plans. This chapter of the report summarizes state activities related to monitoring and improving the quality of care for adults enrolled in managed care.

A. Overview

The Balanced Budget Act of 1997 created system-wide quality standards for states opting to use managed care for the delivery of health care in Medicaid.[25] Federal regulations implemented in 2003 require states to perform an annual external quality review (EQR) for each contracted managed care organization (MCO), prepaid inpatient health plan (PIHP), and health insuring organization (HIO).[26] These annual EQRs analyze and evaluate information on quality, timeliness, and access to the health care services that an MCO, PIHP, or HIO, and their contractors, furnish to Medicaid beneficiaries. Section 1139B(d) of the Social Security Act, as amended by section 2701 of the Affordable Care Act, requires the Secretary to include in this annual report the information that states collect through EQRs of MCOs and PIHPs participating in Medicaid.[27]

Federal managed care regulations at 42 CFR 438.310 et seq. lay out the parameters for conducting an EQR, including state responsibilities, qualifications of an external quality review organization (EQRO), federal financial participation, and state deliverable requirements. Per regulation, the state, its agent (not an MCO or PIHP), or an EQRO must perform three EQR-related activities:

[25] Codified at Section 1932(c) of the Social Security Act.

[26] See 42 CFR 438.2 for full definitions of MCO, PIHP, and HIO. HIOs are treated as MCOs for purposes of this analysis.

[27] Section 1139B(d) of the Social Security Act also requires the reporting of state-specific information on the quality of health care furnished to adults in benchmark plans under Section 1937 of the Act. There are currently no separate state reporting requirements for benchmark plans other than the EQR reporting process required for states contracting with MCOs and PIHPs. In other words, state EQR technical reports must include information related to benchmark plans that deliver care through MCOs or PIHPs; however, because this information is reported in the aggregate, which is allowable under EQR requirements, detailed data are not available for benchmark plans.

1. Validation[28] of performance measures[29]
2. Validation of performance improvement projects (PIPs)[30]
3. A review, at least every three years, to determine the managed care plan's compliance with state standards for access to care, structure and operations, and quality measurement and improvement[31]

The state may choose to perform up to five additional EQR-related activities.[32] A statutorily required set of CMS EQR Protocols provide instruction to states and EQROs on the process for conducting each of the eight EQR-related activities.[33] The state must contract with a qualified EQRO to produce an annual technical report that uses information from the EQR-related activities to assess the quality, timeliness, and access to care provided by each MCO and PIHP. The EQR technical report must also include an assessment of strengths and weaknesses with respect to quality, access, and timeliness and set forth recommendations for improving the quality of health care services furnished by each MCO or PIHP. Per regulation, the EQR technical report is a public document, available upon request to all interested parties.[34] Annually, CMS reviews each state's EQR technical report(s) for evaluation and follow-up.

[28] 42 CFR 438.320 defines validation as the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

[29] In accordance with 42 CFR 438.240(c), managed care states must require each MCO and PIHP to annually measure and report to the state its performance using standard measures required by the state. States are then required to annually ensure that performance measures reported by the MCO or PIHP during the preceding 12 months are validated.

[30] In accordance with 42 CFR 438.240(d), managed care states must require each MCO and PIHP to have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. States are then required to annually ensure that any MCO or PIHP performance improvement projects underway during the preceding 12 months are validated.

[31] 42 CFR §438.358(b)(3).

[32] Refer to 42 CFR 438.358(c) for a comprehensive list of optional EQR-related activities.

[33] In October 2012, CMS revised the EQR Protocols for the purpose of standardizing and strengthening managed care quality monitoring and improvement activities in Medicaid. The CMS EQR Protocols are available under "Technical Assistance Documents" at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

[34] See 42 C.F.R. § 438.364. EQR technical reports submitted to CMS and currently posted on State Medicaid web sites: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/External-Quality-Review-Technical-Reports.html.

B. External Quality Review Technical Reports Submitted to CMS for the 2013–2014 Reporting Cycle

Of the 42 states[35] that contracted with MCOs or PIHPs during the 2013–2014 reporting cycle, 39 states submitted EQR technical reports to CMS that provided information on the care furnished to adults covered by Medicaid.[36] These states contracted with 17 different EQROs to conduct the annual EQR, and six EQROs conducted reviews for multiple states during the 2013–2014 reporting cycle.[37] The majority of EQR technical reports focused on physical health services, but some included information on other types of managed care services, such as LTSS or behavioral health.

The 2013–2014 EQR technical reports provide insight into the strategies and efforts that states use to improve the quality of care for adults in Medicaid. The reports indicate that states and managed care entities engage in a variety of quality measurement and improvement efforts. Generally, the scope and focus of state initiatives are based on several factors, including the populations served by managed care, stakeholder and beneficiary feedback, and clinical areas in need of improvement.

EQR technical reports varied considerably in their structure, level of detail, and focus on quality, access, and timeliness of care. For example, some EQR technical reports contained a detailed analysis of how specific measurement and improvement efforts interface with state monitoring of quality, access, and timeliness of care. Other EQR technical reports did not explicitly discuss quality, access, and timeliness at all. Some provided substantial details related to the performance measure and PIP validation process, PIP interventions, and performance outcomes. This lack of uniformity across EQR technical reports is partly due to differences in state interpretation of regulatory language. While current regulations require states to annually validate performance measures and PIPs, they do not specifically require the inclusion of details on outcomes or interventions in the EQR technical reports. Despite this, the level of detail presented in the EQR technical reports has become more comprehensive over the past few years, following intensive CMS outreach and technical assistance efforts to that effect.

C. Reporting of Performance Measures in 2013–2014 External Quality Review Technical Reports

Of the 39 states that submitted EQR technical reports for the 2013–2014 reporting cycle, all states except two identified the types of performance measures reported by MCOs and PIHPs, and all states except D.C., North Carolina, and South Carolina identified the performance measures that were also validated by the EQRO.

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[35] For purposes of EQR, the term "states" includes the 50 states, the District of Columbia, and the territories.

[36] Utah and New Hampshire did not submit EQR reports before May 16, 2014, for inclusion in this analysis. North Dakota's managed care program was limited to the Children's Health Insurance Program (CHIP) population during the 2013-2014 reporting cycle; therefore, North Dakota's EQR technical report is not included in this analysis. Alabama, Alaska, Arkansas, Connecticut, Guam, Idaho, Maine, Montana, Oklahoma, South Dakota, the Virgin Islands, and Wyoming do not have MCOs or PIHPs that enroll adults covered by Medicaid.

[37] For a list of EQROs with current state Medicaid contracts in 2014, see Table EQR 1 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2013-2014.zip.

The most frequently reported performance measures for adults focused on diabetes care, behavioral health,[38] and asthma/COPD.[39] Other examples of performance measures states collected include those related to cardiac care, access to preventive/ambulatory services, and cervical and breast cancer screening. Many of the performance measures overlapped with measures from both the CMS Medicaid Adult Core Set and 2013 HEDIS, though the use of these measure sets is not required by CMS.

In the 2013–2014 reporting cycle:

- While 33 of the 39 states chose to include the performance rates achieved by each MCO or PIHP, only some provided additional information on the context for the performance rates achieved by the MCO or PIHP, as well as suggestions for improving future performance.
- Several states separated out the performance rates by subpopulations within their state. For example, Colorado and Iowa reported performance measure rates separately for their physical health and behavioral health programs while Florida and New York included performance rates for different geographic regions within the state.
- Thirty-one states compared performance in the 2013–2014 reporting cycle to performance in previous years. Twenty-one states also compared MCO and PIHP performance to national HEDIS Medicaid rates and 17 states included statewide managed care performance rates.

D. Description of Performance Improvement Projects in 2013–2014

All states that submitted an EQR technical report for the 2013–2014 reporting cycle included at least one PIP specific to the adult population and 38 of the 39 states included information on validation, as required by regulation.[40] Among these states, the topical focus and the number of PIPs per state varied considerably (Exhibit 7). Of the PIPs focused on the adult population, there were 147 PIPs related to behavioral health (19 states), 81 PIPs related to emergency department visits (14 states), 62 PIPs related to diabetes care (17 states), and 93 PIPs related to hospital readmissions (14 states). While most states conducted 20 or fewer PIPs during the reporting cycle, eight states had more than 20 PIPs. Texas, Florida, and California—states with large Medicaid managed care populations and a large number of MCOs and PIHPs—conducted the largest number of PIPs at 92, 87, and 79 PIPs, respectively.

Sixteen state EQR technical reports identified that the state either mandated a PIP topic or required its MCOs or PIHPs to participate in a collaborative PIP.[41] For example, four states

[38] Behavioral health performance measures include the subtopics of substance use disorders.

[39] Specific information related to state reported performance measures for adults can be found on Table EQR3 at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2013-2014.zip.

[40] Oregon's EQRO did not validate any PIPs for this reporting cycle because the state's Coordinated Care Organizations (CCOs) were in their first year of operation; the technical report instead provided information on the PIPs in development and outlined a protocol for validating PIPs in the next reporting cycle.

[41] States that mandated PIP topics for MCOs or PIHPs include: Arizona, California, Delaware, Florida, Georgia, Hawaii, Illinois, Louisiana, Maryland, Michigan, Nevada, Oregon, Pennsylvania, Rhode Island, Washington, and West Virginia.

(Florida, Maryland, Michigan, and Pennsylvania) mandated implementation of a PIP related to behavioral health. Other state-mandated PIP topics included: diabetes care, emergency department visits, hospital readmissions, Chlamydia screening for women, and use of imaging studies for low back pain. There were also a number of administrative PIPs, focusing on such topics as balance billing or call center timeliness.[42]

As mentioned previously, some EQR technical reports provided detailed intervention and outcomes information related to each PIP, as well as EQRO recommendations for improvement. Of the profiled PIP topics, education and outreach for members, providers, and communities were the most common interventions. Discussions of EQRO findings on the performance, progress, and limitations of each PIP differed greatly across reports, with descriptions of PIPs occasionally lacking key details. This lack of detailed intervention and outcomes information within the EQR technical reports has limited CMS's ability to conduct a comprehensive assessment on the efficacy of state quality improvement efforts for adults enrolled in managed care.

E. Focused Review of Performance Improvement Projects

This section presents findings from detailed abstractions of EQRO reporting on PIPs in four areas in which improvements in care could result in better health outcomes and lower cost: (1) care for adults with diabetes, (2) adult hospital readmissions, (3) adult emergency department visits, and (4) treatment of adults with substance use disorders.[43] An example of a state PIP is provided for each priority topic area. Criteria for selecting states to highlight below included whether the EQR technical report contained some information on interventions and outcomes, and an interest in ensuring geographic diversity of the states profiled.

1. Diabetes Care

Seventeen states reported a combined total of 62 adult diabetes PIPs during this reporting cycle (Exhibit 8). While the interventions of each PIP varied, common improvement aims included: controlling HbA1c (a measure of blood sugar), LDL-C (a measure of cholesterol), and/or blood pressure; increasing the percentage of members who had a diabetic retinal eye exam; and improving medication management.

Hawaii was one state in which all seven MCOs participated in PIPs aimed at improving care for members with diabetes.[44] The target indicators differed slightly by MCO, but included: (1) retinal eye exams for members with diabetes, (2) blood pressure, (3) HbA1c, and (4) LDL-C screening and control for members with diabetes. Interventions included: (1) mailing educational materials on diabetes to members to generate interest in disease management programs, (2)

[42] These administrative PIPs are reflected in the "other" column in Exhibit 7.

[43] Quality improvement efforts related to pregnant women are profiled in the "2014 Annual 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/2014-child-sec-rept.pdf. Additional information on "Adult Findings from EQR Technical Reports, 2013-2014" is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2013-2014.zip.

[44] Five of the seven MCOs were not yet in the re-measurement phase for the diabetes care PIPs.

provider and staff education and distribution of HEDIS toolkits, (3) the introduction of a care gap program, and (4) a pay-for-performance program for providers. The EQRO recommended that, in order to improve PIP performance, MCOs should have processes in place for conducting annual evaluations of the effectiveness of each intervention implemented, as well as annual barrier and drill-down analyses. Results varied by performance measure and MCO. In three of the seven HMOs, there was improvement on at least one measure.

2. Hospital Readmissions

Fourteen states reported a combined total of 93 PIPs aimed at reducing adult hospital readmissions during this reporting cycle (Exhibit 9). In three of those states, California, Hawaii, and Arizona, hospital readmissions PIPs were mandated for all health plans. Interventions often focused on implementing discharge planning and transitional care activities such as appointment reminder calls and mailings after discharge to ensure members' post-discharge needs were met.

Missouri had one PIP that was particularly successful in reducing member hospital readmissions at both 30 days and 90 days by two percent in 2011 and five percent in 2012. The PIP employed three major interventions: (1) the development and implementation of a disease management program for frequent causes of readmissions, including asthma and diabetes, (2) enhancement of a case management process to prevent readmissions, and (3) the development of an asthma home health program. The EQRO noted that the interventions implemented under this PIP were generally system wide and part of regular MCO operations, indicating that the improvements in hospital readmissions should continue in future years.

3. Emergency Department Visits

Fourteen states reported a combined total of 81 PIPs focused on reducing inappropriate use of the emergency department during this reporting cycle (Exhibit 10). Reducing the rate of avoidable emergency department utilization and increasing the rate of emergency department visits that do not result in an inpatient stay were the mostly frequently reported improvement aims in this area.

Louisiana required its three MCOs to conduct a PIP aimed at decreasing emergency department utilization, using the HEDIS Emergency Department Visits/1,000 Member Months measure as the target indicator. Each MCO set its own specific goals and designed its own interventions targeted to different stakeholders including members, providers, and the community. Interventions included (1) case management for "frequent flyers," (2) outreach calls to members, (3) mailing of educational materials, (4) quarterly emergency department reports for providers, and (5) outreach to high-volume hospital emergency department case management staff. While some performance data is available for all three MCOs, the EQRO recommended caution when interpreting the data for several reasons, including the structuring of the baseline and remeasurement periods. The EQRO identified the selection of interventions targeting both members and providers as a strength for all MCOs.

4. Substance Use Disorders

Nineteen states reported a combined total of 147 PIPs focused on behavioral health topics (Exhibit 11). These PIPs included improvement aims related to follow-up after hospitalization for a behavioral health or mental health diagnosis, depression care, and management of

antipsychotics. One of the most common topics within the broader category of behavioral health was substance use disorders, which was the focus of 27 PIPs in seven states (Arizona, California, Kentucky, Maryland, Massachusetts, New York, and Wisconsin).

Beginning in 2009 and continuing through this reporting cycle, Maryland required each of its seven MCOs to conduct a PIP aimed at increasing both the initiation of, and engagement in, alcohol and other drug dependence treatment.[45] The MCOs implemented a variety of interventions, including (1) the addition of a substance use consultant/Medical Director to conduct peer-to-peer discussions with providers, (2) engagement of pregnant members in group or individual counseling, (3) implementation of patient-centered medical homes, (4) revision of substance use provider contracts, and (5) improvements to information systems to better coordinate substance use care across settings. Performance, however, was mixed: across all MCOs, performance on the initiation of alcohol and other drug dependence treatment indicator declined by 5.6 percentage points, and performance on the engagement of alcohol and other drug dependence treatment indicator improved by 1.5 percentage points.[46]

[45] Both indicators were according to HEDIS measure specifications.

[46] The EQRO noted that the national HEDIS Medicaid rate for both of these measures declined during this time period. The EQRO also stated that Medicaid members who received substance use disorder treatment that is billed through a behavioral health entity, paid for by a grant or with cash, or received from a provider outside the Medicaid network would not be counted in the target HEDIS measures for these PIPs, which could be a factor in the lack of improvement on the initiation measure.

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V. CONCLUSION

This report documents the foundation developed by CMS and states for measuring and improving the quality of care for adults enrolled in Medicaid, whether they obtain services through fee-for-service or a managed care setting. Using the resources and the authorities of the Affordable Care Act, CMS has supported state efforts to report standardized quality metrics on adults covered by Medicaid.

During the first year of reporting on the Medicaid Adult Core Set, 30 states reported a median of 16.5 measures for FFY 2013. The Adult Medicaid Quality Grant Program has been instrumental in building state capacity to collect, report, and use the measures to improve the quality of care for adults enrolled in Medicaid. In addition, the TEFT grant program is testing quality measurement tools for Medicaid LTSS for the first time on a national scale.

This report also demonstrates efforts CMS and states are undertaking to enhance oversight of the annual EQR process required of states contracting with managed care plans. These efforts include providing feedback to states on the EQRs and making information abstracted from the EQR technical reports on performance measures and improvement projects publicly available in this annual report.

CMS and states will continue to work together to measure performance and use data collected to drive improvements in the quality of health care. As the momentum to pay for value rather than volume of services grows, state-specific performance data will be critical in guiding efforts to transform the systems of care that provide services to Medicaid enrollees.

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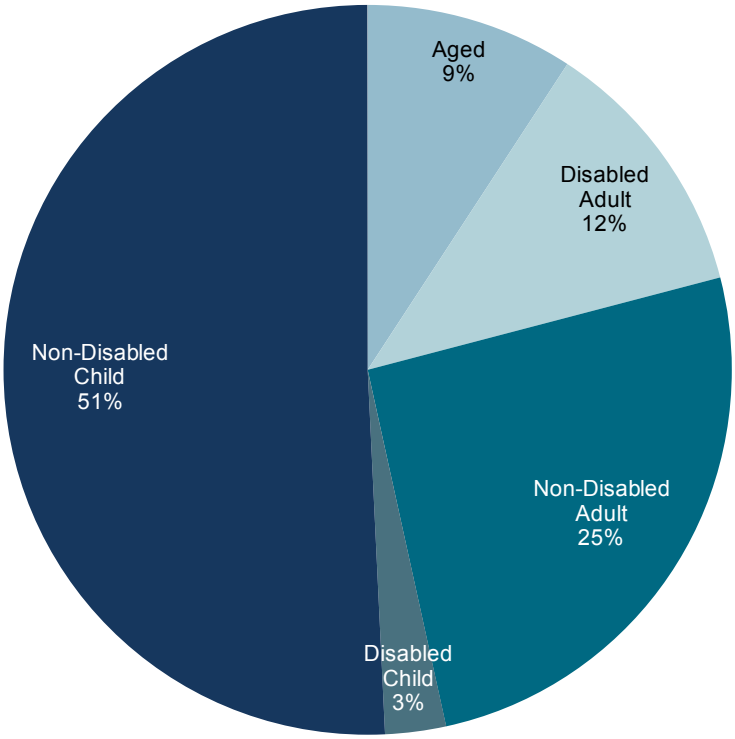
EXHIBITS

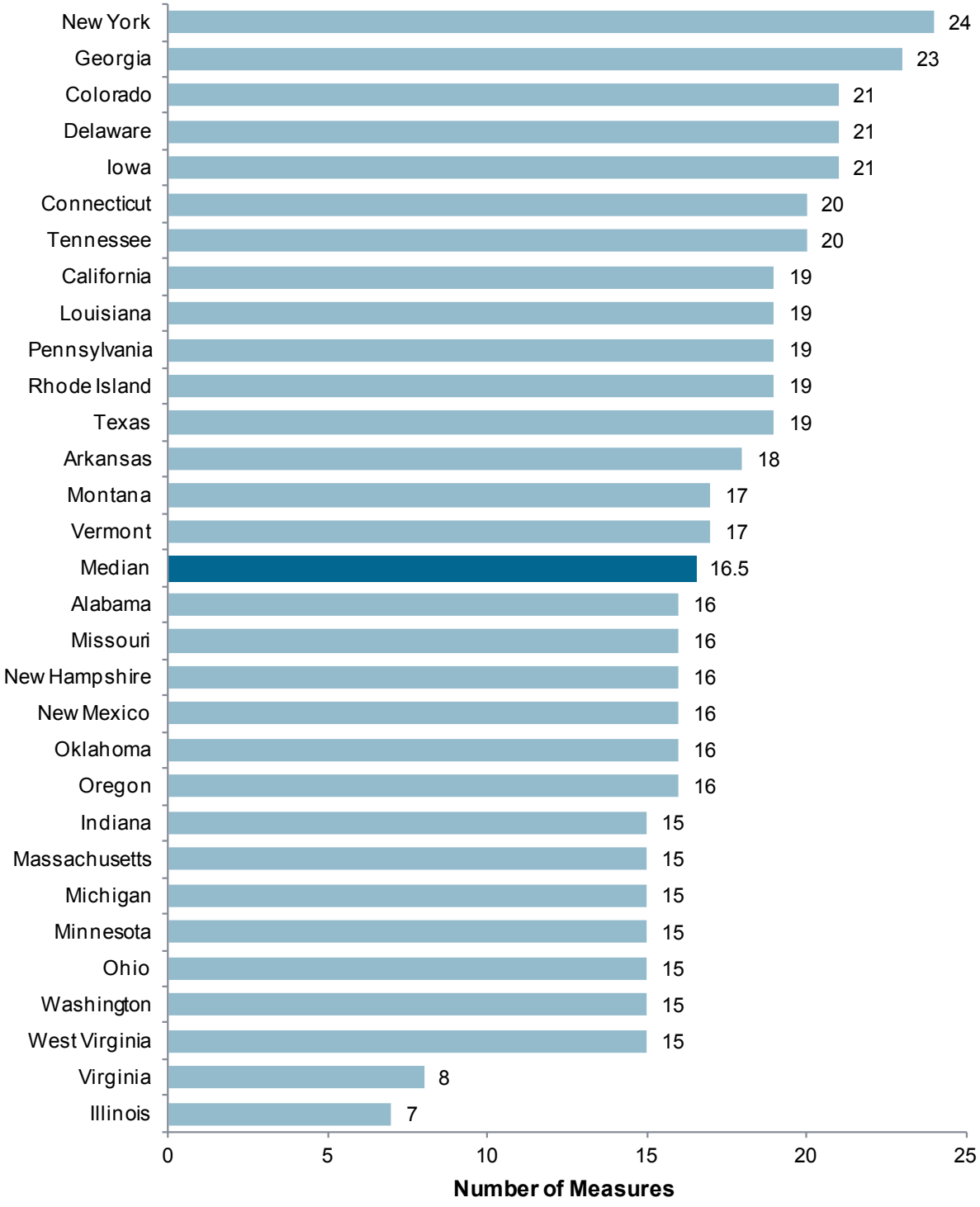
Exhibit 1. Distribution of Medicaid Enrollees, by Age and Disability Status, CY 2010



Source: Mathematica analysis of the 2010 Medicaid Analytic eXtract.

Notes: This analysis includes 69 million full-benefit and non-full-benefit enrollees (e.g., enrollees for family planning, breast cancer, and Medicare cost-sharing only). Adults are ages 18 to 64.

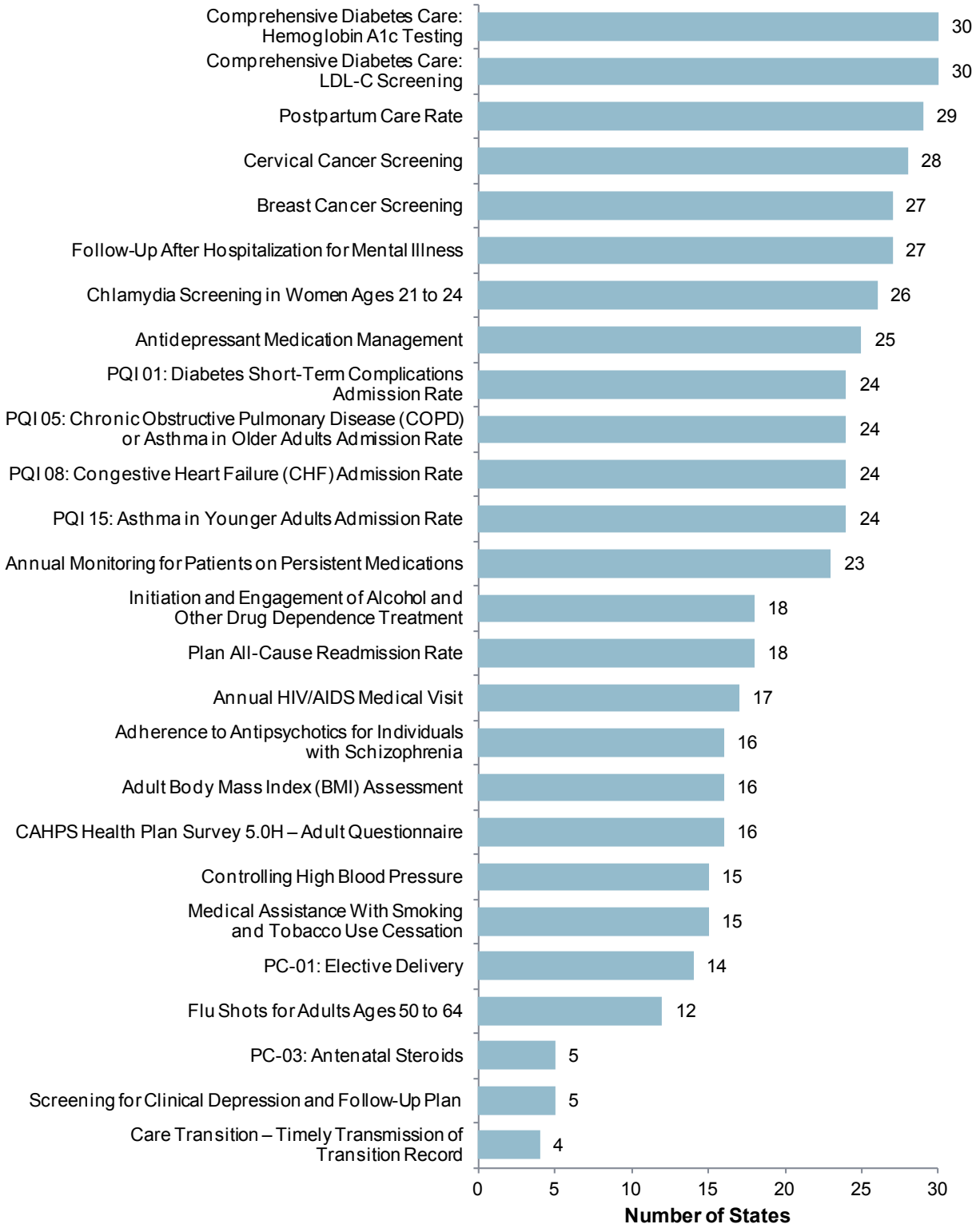
Exhibit 2. Number of Medicaid Adult Core Set Measures Reported, by State, FFY 2013



Source: Based on Mathematica analysis of FFY 2013 Adult CARTS reports.

Notes: This figure is based on state reporting of 26 Core Set measures for FFY 2013. The term "states" includes the 50 states and the District of Columbia.

Exhibit 3. Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2013



Source: Based on Mathematica analysis of FFY 2013 Adult CARTS reports.

Note: The term "states" includes the 50 states and the District of Columbia.

Exhibit 4. Medicaid Health Plan Performance on Selected HEDIS 2013 Measures in the Medicaid Adult Core Set

Measure	Required for Accreditation	Number of Medicaid Health Plans Reporting (n = 213)	Percentage of Plans Reporting	Mean	Median	25th percentile	75th percentile
Adult Body Mass Index (BMI) Assessment	Yes	153	72	67.5	72.0	62.5	78.7
Breast Cancer Screening	Yes	165	77	51.9	51.5	46.5	57.8
Cervical Cancer Screening	Yes	192	90	64.5	66.4	59.0	71.9
Medical Assistance With Smoking and Tobacco Cessation							
Advising smokers and tobacco users to quit	Yes	130	61	75.6	76.2	72.6	79.6
Discussing cessation medications	No	130	61	45.9	45.2	40.3	51.4
Discussing cessation strategies	No	130	61	41.2	40.4	36.7	44.9
Chlamydia Screening in Women Ages 21 to 24	Yes	169	79	63.6	64.3	59.0	70.7
Follow-Up After Hospitalization for Mental Illness							
Within 30 days of discharge	No	100	47	63.6	65.8	56.8	75.6
Within 7 days of discharge	Yes	102	48	43.7	44.7	31.3	54.8
Controlling High Blood Pressure	Yes	179	84	56.3	56.2	50.0	63.0
Comprehensive Diabetes Care: LDL-C Screening	Yes	201	94	75.5	76.3	71.0	80.5
Comprehensive Diabetes Care: Hemoglobin A1c Testing	Yes	201	94	83.0	83.2	79.2	87.3
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	No	94	44	58.5	61.3	55.1	66.7
Antidepressant Medication Management							
Effective acute phase treatment	Yes	142	67	52.8	51.5	48.3	56.2
Effective continuation phase treatment	Yes	142	67	36.7	35.3	32.1	40.2
Annual Monitoring for Patients on Persistent Medications							
Ace inhibitors/ARB	No	176	83	86.3	87.1	84.6	89.2
Digoxin	No	94	44	90.2	90.8	87.5	93.2
Diuretic	No	174	82	86.0	86.7	83.8	89.1
Anticonvulsants	No	136	64	65.8	66.0	61.8	70.7
Total	No	176	83	84.5	85.4	82.4	87.3

Exhibit 4 (continued)

Measure	Required for Accreditation	Number of Medicaid Health Plans Reporting (n = 213)	Percentage of Plans Reporting	Mean	Median	25th percentile	75th percentile
CAHPS 5.0H							
Rating of all health care	Yes	135	63	50.9	51.0	47.8	53.8
Rating of personal doctor	Yes	135	63	63.1	63.1	60.0	66.7
Rating of specialist seen most often	Yes	121	57	64.4	64.0	61.3	67.2
Rating of health plan	Yes	135	63	56.3	56.6	51.6	60.7
Customer service	Yes	114	54	66.7	67.4	63.1	70.2
Getting care quickly	Yes	135	63	59.0	59.7	56.1	62.4
Getting needed care	Yes	135	63	55.1	55.7	52.4	58.5
How well doctors communicate	Yes	135	63	71.5	71.9	69.6	74.1
Shared decision making	No	119	56	50.5	50.5	48.3	52.1
Health promotion and education	No	135	63	27.7	27.8	25.1	30.1.
Coordination of care	No	119	56	54.4	54.8	51.5	58.1
Alcohol and Other Drug Dependence Treatment							
Initiation of AOD treatment	No	93	44	39.4	39.3	35.0	43.4
Engagement of AOD treatment	No	93	44	10.2	9.0	5.1	15.5
Postpartum Care Rate	Yes	191	90	63.0	64.0	57.9	70.2

Source: National Committee for Quality Assurance (NCQA) analysis of the national HEDIS 2013 database. These results reflect health plan performance in 2012.

Notes: Not all health plans submit the measures required for accreditation; reasons for not reporting a measure include insufficient denominators, non-reportable results, and not all health plans submitting data to the HEDIS database are accredited.

The 2013 national HEDIS database contains data for 213 Medicaid health plans (health maintenance organization [HMO] plans, point of service [POS] plans, and combination health plans) that voluntarily submitted HEDIS data to NCQA in June 2013. These health plans covered an estimated 27.3 million Medicaid beneficiaries in 37 states. This estimate includes Medicaid health plan enrollees of all ages, as these data are not separately available on the number of Medicaid health plan enrollees who are adults.

Exhibit 5. Change in Medicaid Health Plan Performance on Selected HEDIS Measures in the Medicaid Adult Core Set, 2011–2013

Measure	Number of Medicaid Health Plans Reporting 2011 (n =184)	Number of Medicaid Health Plans Reporting 2012 (n = 191)	Number of Medicaid Health Plans Reporting 2013 (n = 213)	HEDIS Median 2011	HEDIS Median 2012	HEDIS Median 2013	Percentage Point Change 2011–2013
Adult Body Mass Index (BMI) Assessment	117	130	153	47.6	57.9	72.0	24.4
Breast Cancer Screening	164	158	165	52.4	50.5	51.5	NS
Cervical Cancer Screening	172	173	192	69.7	69.1	66.4	-3.3
Medical Assistance With Smoking and Tobacco Cessation							
Advising smokers and tobacco users to quit*	118	116	130	74.8	75.1	76.2	n.a
Discussing cessation medications*	118	116	130	42.7	44.5	45.2	n.a
Discussing cessation strategies*	118	116	130	38.1	40.6	40.4	n.a
Chlamydia Screening in Women Ages 21 to 24	151	160	169	62.5	64.4	64.3	NS
Follow-Up After Hospitalization for Mental Illness							
Within 30 days of discharge	82	88	100	66.6	67.7	65.8	NS
Within 7 days of discharge	85	91	102	45.1	46.1	44.7	NS
Controlling High Blood Pressure	137	148	179	56.4	57.5	56.2	NS
Comprehensive Diabetes Care: LDL-C Screening	175	183	201	75.4	76.2	76.3	NS
Comprehensive Diabetes Care: Hemoglobin A1c Testing	175	183	201	82.2	82.4	83.2	NS
Adherence to Antipsychotic Medications for Individuals with Schizophrenia**	n.a.	n.a.	94	n.a.	n.a.	61.3	n.a.
Antidepressant Medication Management							
Effective acute phase treatment	90	97	142	50.1	49.4	51.5	1.4
Effective continuation phase treatment	90	97	142	32.7	32.4	35.3	2.6

Exhibit 5 (continued)

Measure	Number of Medicaid Health Plans Reporting 2011 (n =184)	Number of Medicaid Health Plans Reporting 2012 (n = 191)	Number of Medicaid Health Plans Reporting 2013 (n = 213)	HEDIS Median 2011	HEDIS Median 2012	HEDIS Median 2013	Percentage Point Change 2011–2013
Annual Monitoring for Patients on Persistent Medications							
Ace inhibitors/ARB	130	157	176	86.5	86.9	87.1	NS
Digoxin	59	75	94	90.3	91.0	90.8	NS
Diuretic	130	156	174	85.8	86.4	86.7	NS
Anticonvulsants	113	130	136	68.6	65.3	66.0	-2.6
Total	132	157	176	84.2	84.8	85.4	NS
CAHPS 5.0H							
Rating of all health care	129	128	135	49.2	50.0	51.0	NS
Rating of personal doctor	129	128	135	60.8	62.1	63.1	2.2
Rating of specialist seen most often	113	104	121	61.3	62.1	64.0	2.7
Rating of health plan	129	128	135	55.4	56.1	56.6	NS
Customer service	72	61	114	58.6	60.0	67.4	8.8
Getting care quickly	128	126	135	57.1	58.2	59.7	2.6
Getting needed care	125	120	135	50.2	49.8	55.7	5.5
How well doctors communicate	128	127	135	69.4	70.2	71.9	2.5
Shared decision making***	120	109	119	n.a.	n.a.	50.5	n.a.
Health promotion and education***	129	128	135	n.a.	n.a.	27.8	n.a.
Coordination of care	115	106	119	51.8	54.3	54.8	NS
Alcohol and Other Drug Dependence Treatment							
Initiation of AOD treatment	77	78	93	40.4	39.0	39.3	NS
Engagement of AOD treatment	77	78	93	13.3	11.4	9.0	-4.3
Postpartum Care Rate	165	180	191	64.6	65.0	64.0	NS

Source: National Committee for Quality Assurance (NCQA) analysis of the national HEDIS database.

Notes: The 2013 national HEDIS database contains data for 213 Medicaid health plans (health maintenance organization [HMO] plans, point of service [POS] plans, and combination health plans) that voluntarily submitted HEDIS data to NCQA in June 2013. These health plans covered an estimated 27.4 million adult Medicaid beneficiaries in 37 states. This estimate includes Medicaid health plan enrollees of all ages, as these data are not separately available on the number of Medicaid health plan enrollees who are adults.

NS = change in median performance from 2010 to 2012 was not statistically significant.

n.a. = not applicable; measure is either not reported by Medicaid health plans or there was a change in specification of the measure over time.

*Medical Assistance with smoking and tobacco cessation could not be compared between 2011 and 2013 due to a specification change in the measure.

**Adherence to Antipsychotic Medications for Individuals with Schizophrenia is a new measure for 2013.

***Indicator changed over time and could not be compared between 2011 and 2013.

Exhibit 6. Number and Percentage of Full-Benefit Adults, Ages 21–64, Enrolled in Medicaid by State and Service Delivery Type, CY 2010*

State	Total Number of Full-Benefit Adults	Managed Care		Fee-for-Service		Primary Care Case Management	
		Number	Percent	Number	Percent	Number	Percent
U.S. Total	12,922,368	7,880,635	61.0	1,660,247	12.8	3,381,486	26.2
Alabama	76,453	18	0.0	31,128	40.7	45,307	59.3
Alaska	26,031	0	0.0	0	0.0	26,031	100.0
Arizona	463,165	377,901	81.6	0	0.0	85,264	18.4
Arkansas	48,997	11	0.0	24,183	49.4	24,810	50.6
California	1,526,351	1,111,587	72.8	0	0.0	414,764	27.2
Colorado	132,941	9,326	7.0	2,923	2.2	120,692	90.8
Connecticut	246,061	144,543	58.7	0	0.0	101,518	41.3
Delaware	79,150	70,417	89.0	0	0.0	8,733	11.0
District of Columbia	80,067	69,491	86.8	0	0.0	10,576	13.2
Florida	702,045	237,127	33.8	100,561	14.3	364,357	51.9
Georgia	249,485	210,689	84.4	0	0.0	38,796	15.6
Hawaii	99,931	94,345	94.4	0	0.0	5,586	5.6
Idaho	30,743	0	0.0	18,384	59.8	12,359	40.2
Illinois	709,312	35,479	5.0	480,063	67.7	193,770	27.3
Indiana	240,268	211,245	87.9	126	0.1	28,897	12.0
Iowa	138,252	0	0.0	71,588	51.8	66,664	48.2
Kansas	47,031	31,967	68.0	714	1.5	14,350	30.5
Kentucky	129,968	27,796	21.4	85,485	65.8	16,687	12.8
Louisiana	145,657	0	0.0	76,757	52.7	68,900	47.3
Maine	114,941	0	0.0	64,871	56.4	50,070	43.6
Maryland	259,891	225,933	86.9	0	0.0	33,958	13.1
Massachusetts	315,207	157,572	50.0	126,161	40.0	31,474	10.0
Michigan	540,109	375,874	69.6	0	0.0	164,235	30.4
Minnesota	216,830	166,835	76.9	0	0.0	49,995	23.1
Mississippi	82,745	0	0.0	0	0.0	82,745	100.0

Exhibit 6 (continued)

State	Total Number of Full-Benefit Adults	Managed Care		Fee-for-Service		Primary Care Case Management	
		Number	Percent	Number	Percent	Number	Percent
Missouri	161,154	87,491	54.3	0	0.0	73,663	45.7
Montana	21,208	11	0.1	16,832	79.4	4,375	20.6
Nebraska	40,816	16,897	41.4	1,645	4.0	22,274	54.6
Nevada	61,386	44,213	72.0	0	0.0	17,173	28.0
New Hampshire	23,397	0	0.0	0	0.0	23,397	100.0
New Jersey	244,590	216,789	88.6	0	0.0	27,801	11.4
New Mexico	133,798	106,691	79.7	0	0.0	27,107	20.3
New York	2,157,903	1,771,401	82.1	6,436	0.3	380,066	17.6
North Carolina	304,368	0	0.0	200,697	65.9	103,671	34.1
North Dakota	16,727	0	0.0	11,511	68.8	5,216	31.2
Ohio	544,626	485,370	89.1	0	0.0	59,256	10.9
Oklahoma	105,340	0	0.0	50,121	47.6	55,219	52.4
Oregon	149,375	128,374	85.9	401	0.3	20,600	13.8
Pennsylvania	420,144	295,350	70.3	81,446	19.4	43,348	10.3
Rhode Island	59,260	46,150	77.9	0	0.0	13,110	22.1
South Carolina	145,026	85,264	58.8	14,621	10.1	45,141	31.1
South Dakota	20,748	0	0.0	13,655	65.8	7,093	34.2
Tennessee	308,319	307,876	99.9	0	0.0	443	0.1
Texas	369,526	161,479	43.7	94,056	25.5	113,991	30.8
Utah	84,418	12,094	14.3	15,621	18.5	56,703	67.2
Vermont	70,397	0	0.0	55,304	78.6	15,093	21.4
Virginia	144,695	102,207	70.6	11,323	7.8	31,165	21.5
Washington	192,482	136,049	70.7	2,173	1.1	54,260	28.2
West Virginia	58,098	36,459	62.8	1,461	2.5	20,178	34.7
Wisconsin	370,909	282,331	76.1	0	0.0	88,578	23.9
Wyoming	12,027	0	0.0	0	0.0	12,027	100.0

Source: Mathematica analysis of the 2010 Medicaid Analytic eXtract.

Notes: Managed care is defined in this context as enrollment in health maintenance organizations (HMOs) or health insuring organizations (HIOs) to provide a comprehensive set of services on a prepaid capitated risk basis. To protect privacy, state counts representing fewer than 11 people were recoded to 11 for the state count and for calculation of the state percentage.

*Adults include Medicaid enrollees ages 21 to 64 years as of December 31, 2010 who were not reported as eligible on the basis of disability. Individuals are reported in the service delivery system in which he or she was last covered for basic services in 2010.

Exhibit 7. Performance Improvement Projects (PIPs) Targeting Adults Included in External Quality Review (EQR) Technical Reports, by Topic Area, 2013–2014 Reporting Cycle

State	Number of PIPs for Adults	Years of Data	PIPs Validated[a]	Adult BMI	Asthma/ COPD	Behav. Health[b]	Cancer Screening	Cardiac Care	Care Transitions	Diabetes	ED Visits	Hospital Readmissions	Preventive/ Chronic Care	Other[c]
Total PIPs	608	.	.	10	9	147	16	12	15	62	81	93	24	139
Total States	39			7	5	19	9	8	7	17	14	14	9	15
Arizona	22	PH & BH: 2010-2011; LTC: CY 2011	All	-	-	13*	-	-	-	-	-	9*	-	-
California	79	2011-2012	All	-	2	28	2	1	-	-	24*	25*	-	-
Colorado	8	Varies by PIP	All	1	-	6	-	-	-	-	-	-	1	-
Delaware	2	Not Reported	Some	-	-	-	-	-	-	-	2*	-	-	-
D.C.	4	2013	All	-	-	-	-	-	-	-	-	-	4	-
Florida	87	2012-2013	Some	1	-	32*	-	-	3	1	2	2	3	43
Georgia[d,e]	6	SFY 2013	All	-	-	-	-	-	-	3*	-	-	-	3*
Hawaii	14	Varies by PIP	All[f]	2	-	-	-	-	-	7*	-	5*	-	-
Illinois	5	SFY 2011	All[f]	-	-	-	-	-	3*	-	-	-	-	2
Indiana	9	Varies by PIP	Some	-	-	3	-	-	-	6	-	-	-	-
Iowa	2	Varies by PIP	Some	-	-	1	-	-	1	-	-	-	-	-
Kansas	2	Varies by entity	Some	-	-	-	-	-	-	2	-	-	-	-
Kentucky	6	CY 2012	All	-	-	2	1	-	-	-	3	-	-	-
Louisiana	6	Varies by PIP	All[f]	-	-	-	3	-	-	-	3*	-	-	-
Maryland	6	CY 2012	All	-	-	6*	-	-	-	-	-	-	-	-
Massachusetts	11	CY 2012	All[f]	-	-	1	-	-	-	2	-	7	-	1
Michigan	18	2012-2013	All	-	-	18*	-	-	-	-	-	-	-	-
Minnesota	12	Not Reported	All	-	3	-	4	-	-	4	-	-	1	-
Mississippi[g,h]	8	2012	All	2	-	-	-	2	-	2	2	-	-	-
Missouri	2	2009-2012	All[f]	-	-	-	-	-	-	1	-	1	-	-

Exhibit 7 (continued)

State	Number of PIPs for Adults	Years of Data	PIPs Validated[a]	Adult BMI	Asthma/ COPD	Behav. Health[b]	Cancer Screen-ing	Cardiac Care	Care Trans-itions	Diabetes	ED Visits	Hospital Readmis-sions	Preven-tive/ Chronic Care	Other[c]
Nebraska	3	Varied by PIP	All	-	-	-	1	-	-	-	2	-	-	-
Nevada	3	2012-2013	All	-	-	-	-	-	-	1	2*	-	-	-
New Jersey	1	CY 2012	All	1	-	-	-	-	-	-	-	-	-	-
New Mexico	6	2012-2013	All[f]	-	1	2	-	-	1	1	-	1	-	-
New York[i]	15	2011-2012	All	-	2	1	-	-	-	-	-	10	-	2
North Carolina	4	2012	All	-	-	1	-	-	-	-	-	-	-	3
Ohio	4	CY 2010	All[f]	-	-	-	-	-	-	-	-	-	-	4*
Oregon[j]	33	N/A	N/A	-	1	1	1	1	-	15*	1	4	4	5
Pennsylvania	23	CY 2012	Some	-	-	7*	-	-	-	-	5	8	1	2
Puerto Rico	12	CY 2012-2013	All[f]	1	-	-	-	2	-	4	-	5	-	-
Rhode Island[k,l]	8	2011-2012	All	-	-	1	1	-	-	-	-	-	2	4*
South Carolina	7	Not Reported	All	-	-	-	1	1	-	-	1	-	-	4
Tennessee	11	CY 2012	All	-	-	-	-	1	1	2	-	-	-	7
Texas	92	FY 2011	All	-	-	-	-	-	-	-	29	5	3	55
Vermont	1	2010-2011	All	-	-	-	-	1	-	-	-	-	-	-
Virginia[m]	7	CY 2011-2012	All	-	-	7	-	-	-	-	-	-	-	-
Washington	33	Varies by PIP	Some	2	-	9	2	-	5*	1	2	9	-	3
West Virginia	6	2012	All[f]	-	-	-	-	-	-	3*	3	-	-	-
Wisconsin	27	MCOs: CY 2011; LTC: FY 2012-2013	Some	-	-	8	-	3	1	7	-	2	5	1

Exhibit 7 (continued)

Source: EQR technical reports submitted to CMS for the 2013-2014 reporting cycle as of May 16, 2014. Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Notes: During the 2013-2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Information about the EQR process is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

* PIP topic was mandated by the state.

[a] EQR validation rating is the overall validation rating assigned to the PIP in the EQR technical report. EQROs used different rating systems in the validation process. EQRO discussion and recommendations are summarized from the EQR technical report's discussion of the validation results for each PIP, including strengths, limitations, and recommendations for improvement.

[b] "Behavioral health" is used as an umbrella term that includes mental health, substance use disorders, and other behavioral conditions such as ADHD. AHRQ, SAMHSA, and HRSA all employ the term "behavioral health" in this manner. For more information, see: AHRQ 2013 Lexicon for Behavioral Health and Primary Care Integration: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf. HRSA FAQs issued March 10, 2014: http://www.hrsa.gov/grants/apply/assistance/bhi/bhifaqs.pdf. SAMHSA mission statement: http://beta.samhsa.gov/about-us/who-we-are.

[c] "Other" includes PIPs on topics such as: customer/member satisfaction (FL, SC), balance billing (FL, TN), call center timeliness (FL, NC), and language and cultural services (FL, TN, WA).

[d] Georgia has a mandated PIP on provider satisfaction (3 MCOs).

[e] Georgia's PIP on provider satisfaction, which is captured in the "Other" category, was for members of all ages.

[f] This state's EQRO validated all of the PIPs mentioned in the technical report; it was unclear whether any additional PIPs were conducted, but not validated or mentioned in the technical report.

[g] Focused studies were submitted in place of PIPs. Carolinas Center for Medical Excellence (the EQRO) was directed by the state to review the projects as focused studies.

[h] Mississippi's Cardiac Care PIP, which focused on hypertension, was not validated by the EQRO.

[i] New York conducted two asthma PIPs that included both children and adult populations. One of those PIPs is represented in this table and the other is accounted for in Table 4 of the 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP.

[j] Because this was the first full year of operation for Oregon's coordinated care organizations (CCOs), the 2013 report highlights results of the readiness reviews of the CCOs to evaluate their capacity to meet federal requirements.

[k] Rhode Island has mandated PIPs in Chlamydia screening for women (2 MCOs) and use of imaging studies for low back pain (2 MCOs); these are captured in the "Other" category. Rhode Island also has a mandated PIP in initial health screens for special populations, which is captured in the "Preventive/Chronic Care" category.

[l] Two of Rhode Island's PIPs, focused on Chlamydia screening for women and initial health screens for special populations, included some children in the target population as well as adults.

[m] Virginia's behavioral health PIPs, which are focused on follow-up after hospitalization for mental illness, include all members ages 6 and older.

Behav. = behavioral; BH = behavioral health; BMI = body mass index; COPD = chronic obstructive pulmonary disease; CY = calendar year; EQRO = external quality review organization; ED = emergency department; FY = fiscal year; LTC = long-term care; PH = physical health; SFY = state fiscal year.

Exhibit 8. Diabetes Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Florida	1	None reported	No intervention information; met validation ratings	None reported
Georgia	3	HbA1c control, LDL-C control, Blood pressure control	Some intervention information; did not meet validation rating	Mixed results
Hawaii	7	Varied by MCO: HbA1c control, LDL-C control, Blood pressure control, retinal eye exams	Some intervention information; mixed validation rating information	Mixed results
Indiana	6	Varied by MCO: HbA1c control, LDL-C control, retinal eye exams	Some intervention information; validation ratings not reported	Mixed results
Kansas	2	Diabetic screening rates	No intervention information; validation will be completed in 2014	None reported
Massachusetts	2	Varied by MCO: HbA1c control, LDL-C control, nephropathy, retinal eye exams	Some intervention information; validation ratings not reported	Mixed results; None statistically significantly
Minnesota	4	Blood pressure control for individuals with diabetes	Some intervention information; validation ratings not reported	Mixed results
Mississippi	2	Quality and longevity of life of diabetes patients, use of screenings among diabetic patients	No intervention information; met validation ratings	None reported
Missouri	1	HbA1c control, LDL-C control, nephropathy, retinal eye exams	Some intervention information; met validation ratings	No improvement
Nevada	1	HbA1c testing, LDL-C screening, nephropathy screening	Some intervention information; met validation rating	No statistically significant improvement
New Mexico	1	HbA1c screening, LDL-C screening	Some intervention information; met validation rating	Statistically significant improvement on both measures
Oregon	15	HbA1c and LDL-C testing for members with diabetes and either schizophrenia or bipolar disorder	Some intervention information; PIPS were not validated as part of the 2013 EQR	First year of PIP; no outcomes reported
Puerto Rico	4	Blood pressure, glycosylated hemoglobin, LDL-C, ACE inhibitors, medication adherence, and smoking among diabetic members	Detailed intervention information; validation ratings not reported	None reported

Exhibit 8 (continued)

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Tennessee	2	Diabetes monitoring in people with diabetes and schizophrenia	No intervention information; met validation ratings	None reported
Washington	1	Diabetes compliance	No intervention information; validation ratings not reported	None reported
West Virginia	3	Varies by entity; hemoglobin A1c control, retinal eye exam, HgBA1c testing, LDL-C level <100mg/dL	Some intervention information; validation ratings not reported	PIP in development stage; no outcomes reported
Wisconsin	7	None reported	No intervention information; validation ratings not reported	None reported

Source: EQR technical reports submitted to CMS for the 2013–2014 reporting cycle as of May 16, 2014. Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Notes: During the 2013–2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Because this was the first full year of operation for Oregon's coordinated care organizations (CCO), the 2013 report highlights results of the readiness reviews of the CCOs to evaluate their capacity to meet federal requirements.

Information about the EQR process is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Exhibit 9. Hospital Readmissions Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Arizona	9	Inpatient readmissions	No intervention information; validation ratings not reported	None reported
California	25	All-cause readmissions	Majority of the PIPs are in the design and implementation stage; one MCO reported focus group studies and team interventions; three MCOs "met" most of their reported sub-measures	Two MCOs reported results; one MCO found its consumers to have a lower 30-day readmission rate; one MCO reported baseline percentages for its first month of implementation
Florida	2	Varied by MCO: follow-up after discharge, behavioral health discharge planning, hospital readmission rates, inpatient psychiatric readmissions	No intervention information; two MCOs met validation ratings, 18 MCOs partially met validation ratings, three did not meet validation ratings	Collaborative PIP achieved statistically significant improvement; no results reported for other PIPs
Hawaii	5	Acute readmissions within 30 days	Some intervention information; met all validation ratings	No results reported; baseline rates reported for some MCOs
Massachusetts	7	Varied by MCO: readmission rates as a result of aftercare effectiveness, substance abuse services	Some intervention information; validation results varied; most met or partially met validation ratings or goals	Mixed results; one MCO showed statistically significant improvement
Missouri	1	Readmission rate	Some intervention information; met validation rating	Achieved reduction in readmission rate from baseline
New Mexico	1	Readmission rate	No intervention information; partially met validation rating	Achieved reduction in readmissions over a four-year period
New York	10	Varied by MCO; reduce readmission rates for all-cause and for behavioral health, obstetrical, and complex readmissions	Detailed intervention information; mixed validation results	Mixed results
Oregon	4	None reported	No intervention information; PIPs not validated in 2013 EQR	None reported

Exhibit 9 (continued)

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Pennsylvania	8	Readmission rate	Detailed intervention information; varied validation ratings	Mixed results; some MCOs have yet to report their results
Puerto Rico	5	Varied by MCO: hospital readmissions, medication adherence	Some intervention information; varied validation results	Mixed results; data pending for four MCOs; improvement for one MCO
Texas	5	None reported	No intervention information; validation ratings not reported	None reported
Washington	9	Readmission rate	Some intervention information; one MCO met validation ratings, three partially met validation ratings, five did report validation ratings	None reported
Wisconsin	2	Readmission rate	Some intervention information; validation ratings not reported	One MCO achieved reduction in readmission rate

Source: EQR technical reports submitted to CMS for the 2013–2014 reporting cycle as of May 16, 2014. Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Notes: During the 2013–2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

In addition to the PIPs represented here, AZ and IA conducted PIPs targeting hospital readmissions among children. Information on these PIPs is reflected in the 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP.

This table does not include PIPs focused on follow-up care after a hospitalization.

Because this was the first full year of operation for Oregon's coordinated care organizations (CCOs), the 2013 report highlights results of the readiness reviews of the CCOs to evaluate their capacity to meet federal requirements.

Information about the EQR process is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Exhibit 10. Emergency Department (ED) Visits Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
California	24	Avoidable ED visits among individuals 12+ years for non-emergent needs	Some intervention information; validation ratings not reported	Mixed results; statistically significant improvement for 14 MCOs; no improvement for 10 MCOs
Delaware	2	Rate of ED usage; no specific measures identified	No intervention information; low confidence validation ratings	Limited measurable improvement
Florida	2	Varied by MCO; ED use for non-emergency care, avoidable ED utilization	No intervention information; validation ratings not reported	None reported
Kentucky	3	Non-emergent/inappropriate ED utilization, ED care rates	Detailed intervention information; validation ratings not reported	Mixed results; no improvement for one MCO; no results reported for two MCOs
Louisiana	3	Percentage of ED visits per 1,000 member months that did not result in an inpatient stay	Detailed intervention information; validation ratings not reported	Baseline rate higher than the national average; no results reported
Mississippi	2	Rate of ED usage; no specific measures identified	No intervention information; partially met validation rating	No study question included in PIP documentation; no results reported
Nebraska	2	Varied by MCO; 30-day follow-up for non-emergent ED visits, ED overutilization	Detailed intervention information; validation ratings not reported	PIPs are in first year and results have not been reported
Nevada	2	Rate of ED usage; no specific measures identified	No intervention information; both received met validation ratings	None reported
Oregon	1	Rate of ED usage; no specific measures identified	Some intervention information; PIPs not validated for 2013 EQR	None reported
Pennsylvania	5	Rate of ED usage; no specific measures identified	Detailed intervention information; all MCOs met or partially met validation ratings	Mixed results; improvement for one MCO, no results reported for four MCOs
South Carolina	1	ED over-utilization; no specific measures identified	No intervention information; partially met validation rating	None reported

Exhibit 10 (continued)

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Texas	29	ED visits; no specific measures identified	No intervention information; validation ratings not reported	None reported
Washington	2	Varied by MCO; avoidable ED visits, improving the medical homes for emergencies	Detailed intervention information; all MCOs met or partially met validation rating	Mixed results for one MCO; no results reported for one MCO
West Virginia	3	Varied by MCO; rate of ED visits for members ages 20-44, rate of ED visits for patients with a back pain diagnosis	Detailed intervention information; validation ratings not reported	Mixed results; improvement for two MCOs, mixed results for one MCO

Source: EQR technical reports submitted to CMS for the 2013-2014 reporting cycle as of May 16, 2014. Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Notes: During the 2013-2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Analysis includes PIPs targeting adults from the submitted EQR technical reports.

In addition to the PIPs represented in this table, GA and MN also conducted PIPs targeting ER visits among children.

Because this was the first full year of operation for Oregon's coordinated care organizations (CCO), the 2013 report highlights results of the readiness reviews of the CCOs to evaluate their capacity to meet federal requirements.

Information about the EQR process is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Exhibit 11. Substance Use Disorders Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle

State	Number of MCOs/PIHPs Participating	Performance Measure(s) and/or Indicators	Intervention/Validation Ratings	Results
Arizona	12	Members admitted to an acute inpatient setting with a diagnosis of chronic pain, substance abuse, anxiety and/or depression; members with an ED visit with a diagnosis of chronic pain, substance abuse, anxiety and/or depression; member deaths classified as accidental, suicide, or unknown	Some intervention information; validation ratings not yet reported as PIPs are still in implementation	PIPs are still in the implementation phase; baseline data was reported for calendar year 2012
California	3	Promote wellness and recovery for increased independence and improved functioning; reduce the number of crisis visits and inpatient hospitalization and spending for unplanned services; "A New Start for Moms" program integrating mental health and substance use disorder services	Detailed intervention information; two MCOs "met" most of sub-measures and one MCO "partially met" most of sub-measures	Two of the PIPs are still in the implementation or early planning phases and have no data to report; one PIP reported "intake" data for an unspecified number of consumers.
Kentucky	1	Smoke-free status of members who completed smoking cessation program at 7 days, 30 days, 60 days, 3 months, 6 months, 9 months, and 1 year; smoking cessation program completion rate	Detailed intervention information; met validation rating	No quantifiable improvement in smoke-free status; program completion rates increased slightly
Maryland	7	Initiation of alcohol and other drug dependence treatment; engagement of alcohol and other drug dependence treatment	Detailed intervention information; partially met validation ratings	Improvement for all MCOs on engagement measure; decline for all MCOs on initiation measure
Massachusetts	1	Aftercare rates for members who receive inpatient substance abuse services	Detailed intervention information; met goals	Statistically significant improvement for both of the MCO's indicators
New York	1	Use of NYS Quitline; CAHPS measures associated with smoking	Some intervention information; did not meet validation rating	No quantifiable improvement
Wisconsin	2	Varies by MCO; percentage of members who report an attempt to quit tobacco, rate of smoking cessation counseling	Some intervention information; one entity met validation rating, one partially met validation rating	Improvement for both MCOs; statistical significance not reported

Exhibit 11 (continued)

Source: EQR technical reports submitted to CMS for the 2013-2014 reporting cycle as of May 16, 2014. Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Notes: During the 2013–2014 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ID, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. UT and NH did not submit an EQR technical report before May 16, 2014 for inclusion in this analysis.

Analysis includes PIPs targeting adults from the submitted EQR technical reports.

Information about the EQR process is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

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APPENDIX A

2013 CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS ENROLLED IN MEDICAID

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Exhibit A.1. 2013 Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid

NQF #	Measure	Measure steward	Data source	Alignment with other programs
0039	Flu Shots for Adults Ages 50 to 64	NCQA	Survey	HEDIS, NCQA Accreditation
NA	Adult Body Mass Index (BMI) Assessment	NCQA	Administrative or hybrid	HEDIS, Health Home Core Set
NA	Breast Cancer Screening	NCQA	Administrative	MU1, HEDIS, NCQA Accreditation, PQRS GPRO, Shared Savings Program
0032	Cervical Cancer Screening	NCQA	Administrative or hybrid	MU1, HEDIS, NCQA Accreditation
0027	Medical Assistance With Smoking and Tobacco Use Cessation	NCQA	Survey	MU1, HEDIS, Medicare, NCQA Accreditation
0418	Screening for Clinical Depression and Follow-Up Plan	CMS	Administrative and medical record	PQRS, CMS QIP, Health Home Core Set, Shared Savings Program
1768	Plan All-Cause Readmission Rate	NCQA	Administrative	HEDIS
0272	PQI 01: Diabetes Short-Term Complications Admission Rate	AHRQ	Administrative	None
0275	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	AHRQ	Administrative	Shared Savings Program
0277	PQI 08: Congestive Heart Failure (CHF) Admission Rate	AHRQ	Administrative	Shared Savings Program
0283	PQI 15: Asthma in Younger Adults Admission Rate	AHRQ	Administrative	None
0033	Chlamydia Screening in Women Ages 21 to 24	NCQA	Administrative	MU1, HEDIS, NCQA Accreditation, Child Core Set
0576	Follow-Up After Hospitalization for Mental Illness	NCQA	Administrative	HEDIS, NCQA Accreditation, Child Core Set, Health Home Core Set
0469	PC-01: Elective Delivery	TJC	Administrative and medical record	HOP QDRP, TJC's ORYX Performance Measurement Program
0476	PC-03: Antenatal Steroids	TJC	Administrative and medical record	TJC's ORYX Performance Measurement Program
NA	Annual HIV/AIDS Medical Visit	NCQA	Administrative	None
0018	Controlling High Blood Pressure	NCQA	Hybrid	MU1, HEDIS, NCQA Accreditation, PQRS GPRO, Shared Savings Program
0063	Comprehensive Diabetes Care: LDL-C Screening	NCQA	Administrative or hybrid	MU1, HEDIS, NCQA Accreditation, PQRS
0057	Comprehensive Diabetes Care: Hemoglobin A1c Testing	NCQA	Administrative or hybrid	MU1, HEDIS, NCQA Accreditation, PQRS
0105	Antidepressant Medication Management	NCQA	Administrative	MU1, HEDIS, NCQA Accreditation
NA	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA	Administrative	HEDIS, VHA
NA	Annual Monitoring for Patients on Persistent Medications	NCQA	Administrative	HEDIS, NCQA Accreditation
0007	CAHPS Health Plan Survey 5.0H – Adult Questionnaire	AHRQ NCQA	Survey	HEDIS, NCQA Accreditation, Shared Savings Program
0648	Care Transition – Transition Record Transmitted to Health Care Professional	AMA/PCPI	Administrative and medical record	Health Home Core Set
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA	Administrative	MU1, HEDIS, Health Home Core Set
1517	Postpartum Care Rate	NCQA	Administrative or hybrid	HEDIS

AHRQ = Agency for Healthcare Research and Quality; AMA/PCPI = American Medical Association-convened/Physician Consortium for Performance Improvement; HEDIS = Healthcare Effectiveness Data and Information Set; NCQA = National Committee for Quality Assurance; MU1= Meaningful Use Stage 1; PQRS = Physician Quality Reporting System; GPRO = Group Practicing Reporting Option; CMS QIP = Centers for Medicare & Medicaid Services Quality Improvement Program; HOP QDRP = Hospital Outpatient Quality Data Reporting Program; TJC ORYX = The Joint Commission ORYX; VHA = Veteran's Health Administration.

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APPENDIX B

NUMBER OF MEDICAID HEALTH PLANS REPORTING HEDIS OR CAHPS MEASURES FOR ADULTS TO NCQA

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Exhibit B.1. Number of Medicaid Health Plans Reporting HEDIS or CAHPS Measures for Adults to NCQA, by Region and State, HEDIS 2011–2013

Region and State	HEDIS 2011	HEDIS 2012	HEDIS 2013
Total number of plans reporting	184	191	213
Northeast (5 states)	20	18	22
Connecticut	3	0	2
Massachusetts	4	5	5
New Jersey	3	3	4
New York	8	8	9
Rhode Island	2	2	2
Mid-Atlantic (6 states)	27	29	29
Delaware	2	2	2
District of Columbia	3	3	2
Maryland	8	8	8
Pennsylvania	6	8	8
Virginia	5	5	6
West Virginia	3	3	3
South (9 states)	40	44	53
Florida	14	18	16
Georgia	3	3	3
Kentucky	1	1	4
Louisiana	0	0	2
Mississippi	0	0	2
New Mexico	6	6	6
South Carolina	4	4	4
Tennessee	7	7	7
Texas	5	5	9
Midwest (11 states)	61	63	64
Colorado	2	2	2
Illinois	2	2	4
Indiana	5	4	4
Kansas	1	2	1
Michigan	14	14	13
Minnesota	9	7	7
Missouri	7	6	2
Nebraska	1	2	3
Ohio	7	7	7
Utah	1	1	3
Wisconsin	12	16	18
West (6 states)	36	37	45
Arizona	1	1	1
California	24	23	30
Hawaii	1	3	6
Nevada	2	2	2
Oregon	1	1	1
Washington	7	7	5

Source: National Committee for Quality Assurance (NCQA) analysis of the national HEDIS database.

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APPENDIX C

GLOSSARY

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GLOSSARY

AHRQ	Agency for Healthcare Research and Quality
Affordable Care Act	The Patient Protection and Affordable Care Act
AMA/PCPI	American Medical Association-convened/Physician Consortium for Performance Improvement
AOD	Alcohol or Other Drug
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARE	Continuity Assessment Record and Evaluation
CB-LTSS	Community-based Long Term Services and Supports
CCO	Coordinated Care Organization
CHCS	Center for Health Care Strategies
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
ED	Emergency Department
EQR	External Quality Review
EQRO	External Quality Review Organization
EDI	Employer Sponsored Insurance
FFY	Federal Fiscal Year
GPRO	Group Practice Reporting Option
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIO	Health Insuring Organization
HMO	Health Maintenance Organization
HOP QDRP	Hospital Outpatient Quality Data Reporting Program
LEP	Limited English Proficiency
LTSS	Long-term Services and Supports
MACBIS	Medicaid and CHIP Business Information Solutions
MAP	Measure Applications Partnership

MCO	Managed Care Organization
MEPS	Medical Expenditure Panel Survey
MU1	Meaningful Use Stage 1
National Quality Strategy	National Quality Strategy for Quality Improvement in Health Care
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
POS	Point of Service Plans
PPO	Preferred Provider Organization
PQRS	Physician Quality Reporting System
QIP	Quality Improvement Project
TA/AS	Technical Assistance and Analytic Support
TEFT	Testing Experience and Functional Assessment Tools
TJC	The Joint Commission
VHA	Veteran's Health Administration