NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership
Medicaid Task Force In-Person Meeting

June 5-6, 2014

NQF Conference Center at 1030 15th Street NW, 9th Floor, Washington, DC 20005

Remote Participation Instructions:

Streaming Audio Online

- Direct your web browser to: http://nqf.commpartners.com
- Under "Enter a meeting" type in the meeting number for Day 1: **828441** or for Day 2: **598904**
- In the "Display Name" field, type in your first and last name and click "Enter Meeting"

Teleconference

- Dial **(888) 802-7237** for workgroup members or **(877) 303-9138** for public members and use conference ID code for Day 1: **42876591** and for Day 2: **42883308** to access the audio platform.

Meeting Objectives:

- Develop deep understanding of current use of Medicaid Adult Core Set of measures
- Consider States' experiences implementing the Medicaid Adult Core Set
- Develop recommendations to remove or add measures to the set
- Formulate strategic guidance to CMS about strengthening the measure set over time to meet program goals

Day 1: June 5, 2014

8:30 am **Breakfast**

9:00 am **Welcome, Task Force Charge, Meeting Objectives, and Timeline**

Harold Pincus, Task Force Chair
Sarah Lash, Senior Director, NQF
Karen LLanos, Centers for Medicare & Medicaid Services (CMS)

- Task force introductions
- Recap key themes from April teleconference and web meeting
- CMS vision and goals for MAP and Medicaid Adult Core Set

9:30 am **Initial Year of Reporting the Medicaid Adult Core Set**

Megan Duevel Anderson, Project Manager, NQF

Karen Johnson, Senior Director, NQF

- Consideration of variations in State Medicaid populations and programs
- Evaluation of the Medicaid Adult Core Set against the MAP Measure Selection Criteria (MSC) and MAP's prior recommendations
- Summary of feedback on measure implementation, including modifications and potential reporting burden

10:30 am **State Experience Panel – New Hampshire**

Doris Lotz, Medicaid Chief Medical Officer, New Hampshire Department of Health and Human Services

- State presentation on worked well, significant challenges, and how the Core Set is helping to drive improvement
- State recommendations to the task force on addressing state priorities, specific measures within the set, and options for gap filling
- Task force questions and discussion

11:15 am **State Experience Panel – Virginia**

Cheryl Roberts, Deputy Director, Program, Virginia Department of Medical Assistance Services
Carol Stanley, Quality Improvement Supervisor, Virginia Department of Medical Assistance Services

- State presentation on worked well, significant challenges, and how the Core Set is helping to drive improvement
- State recommendations to the task force on addressing state priorities, specific measures within the set, and options for gap filling
- Task force questions and discussion

12:00 pm **Opportunity for Public Comment**

12:10 pm **Lunch**

12:30 pm **State Experience Panel – Louisiana**

Rebecca Gee, Medicaid Medical Director and Assistant Professor, Louisiana State University Schools of Public Health and Medicine
Rebekah Gurvich, Program Manager, Medicaid Quality Improvement
Eddy Meyers, Health Data Analyst/Quality Coordinator, University of Louisiana at Monroe

- State presentation on worked well, significant challenges, and how the Core Set is helping to drive improvement
- State recommendations to the task force on addressing state priorities, specific measures within the set, and options for gap filling
- Task force questions and discussion

1:15 pm **Non-Participating State Feedback**

Allison Ludwig, Senior Project Manager, NQF

- Summary of potential reasons for non-participation
- Strategies to overcome barriers to participation
- Task force discussion

1:45 pm **Discussion of Key Themes from State Experience**

Harold Pincus

- Task force discussion of how state experience should inform decisions about measures to add to or remove from the set

2:30 pm **Break**

2:45 pm **Measure by Measure Review**

Harold Pincus
Megan Duevel Anderson

- Measure specific recommendations
- Measures with significant barriers to implementation

4:45 pm **Opportunity for Public Comment**

5:00 pm **Summarize Progress and Adjourn for the Day**

Harold Pincus

Day 2: June 6, 2014

8:30 am **Breakfast**

9:00 am **Review Highlights from Previous Day**

Harold Pincus

9:15 am **Measure by Measure Review (continued)**

Harold Pincus
Megan Duevel Anderson

- Measure specific recommendations
- Measures with significant barriers to implementation

10:15 am **Strategy for Filling High-Priority Measure Gaps**

Harold Pincus
Sarah Lash
D.E.B. Potter, Senior Survey Statistician, Agency for Healthcare Research and Quality

- Prioritize measure gaps
- Measures available to address noted measure gaps
- Measure development needs

11:15 pm **Opportunity for Public Comment**

11:30 am **Lunch**

12:00 pm **Strategic Guidance for Strengthening the Medicaid Adult Core Set**

Harold Pincus

- Task force discussion of major strategic themes
- Develop recommendations to strengthen the measure set over time to meet program goals

1:30 pm **Round-Robin Discussion of Themes to Emphasize in Report and Coordinating Committee Review**

2:00 pm **Opportunity for Public Comment**

2:30 pm **Next Steps and Adjourn**

Harold Pincus

Measure Applications Partnership

Medicaid Task Force In-Person Meeting

@NatQualityForum
#NQFMAP

June 5-6, 2014

NATIONAL QUALITY FORUM

Welcome, Task Force Charge, Meeting Objectives, and Timeline

Medicaid Task Force Membership

Workgroup Chair: Harold Pincus, MD

Organizational Members

American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
Humana, Inc.	George Andrews, MD, MBA, CPE
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

Medicaid Task Force Membership

Subject Matter Experts

Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
Medicaid ACO	Ruth Perry, MD
Mental Health	Ann Marie Sullivan, MD
State Medicaid	Marc Leib, MD, JD

Federal Government Members

Centers for Medicare & Medicaid Services (CMS)	Marsha Smith, MD, PhD, FAAP

MAP Medicaid Task Force Charge

- The charge of the MAP Medicaid Task Force is to advise the MAP Coordinating Committee on recommendations to CMS for strengthening and revising measures and the identification of high priority measure gaps in the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set).
- 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 2014, with a report due to CMS by August 2014.

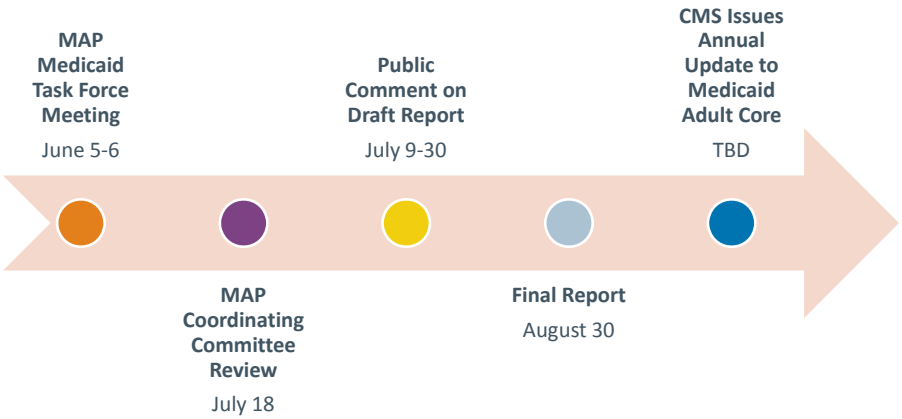
Themes from Previous Task Force Meetings

- MAP can assist CMS in identifying ways to strengthen the Medicaid Adult Core Set through incremental annual updates
  - Adding measures to fill gaps
  - Retiring current measures
  - Aligning with other CMS/HHS programs
- Strong interest in hearing directly from states about how to encourage participation
- Recognition of diversity across states: populations and benefit packages
- Trade-off between measure alignment across programs and fit-for-purpose of state level program

Meeting Objectives

- Develop deep understanding of current use of Medicaid Adult Core Set of measures
- Consider States' experiences implementing the Medicaid Adult Core Set
- Develop recommendations to remove or add measures to the set
- Formulate strategic guidance to CMS about strengthening the measure set over time to meet program goals

Timeline

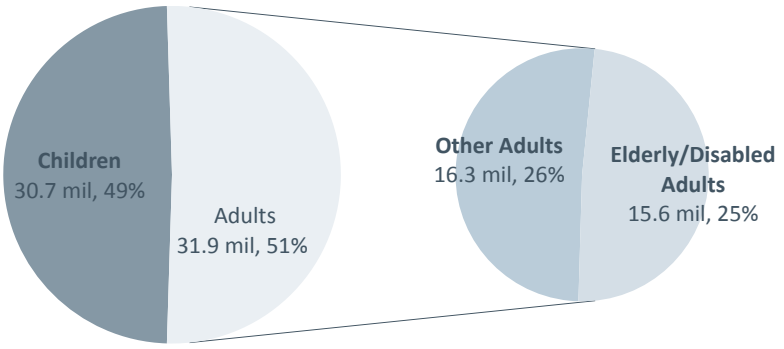


CMS Opening Remarks

Initial Year of Reporting the Medicaid Adult Core Set

Medicaid-Eligible Adult Population Overview

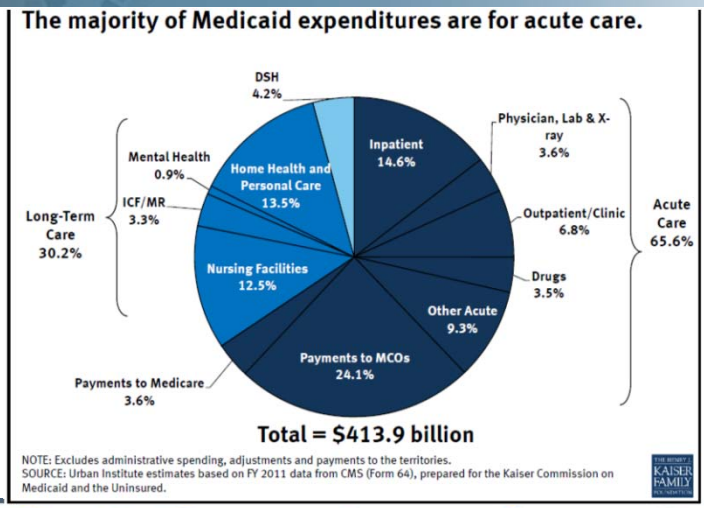
Medicaid Enrollees
(2009, in millions)



Since 1965, Medicaid has been the source of health coverage for low-income adults and children.

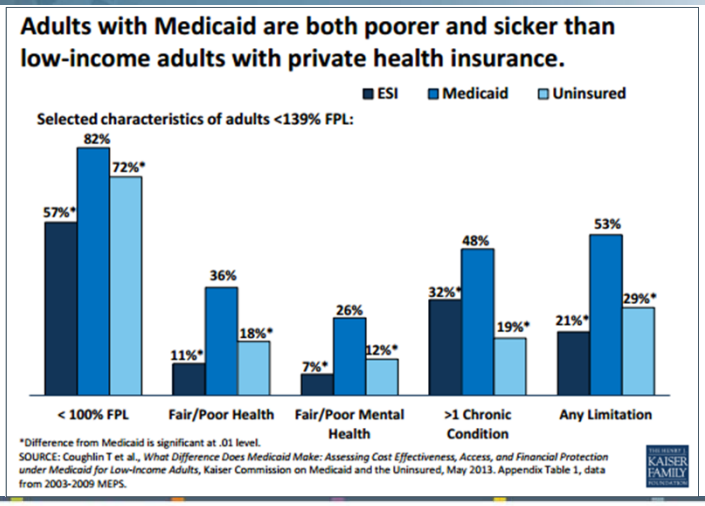
Kaiser Commission on Medicaid and the Uninsured. *Medicaid Primer: Key Information on the Nation's Health Coverage Program for Low-Income People.* March 2013.

Medicaid Spending by Type of Care



Kaiser Commission on Medicaid and the Uninsured. *Family Medicaid and its Role in State/Federal Budgets & Health Reform*. April 2013. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8162-03.pdf. Last accessed May 2014.

The Impact of Medicaid on Access to Care, Health Outcomes, and Quality of Care



Kaiser Commission on Medicaid and the Uninsured. *What is Medicaid's impact on Access to Care, Health Outcomes, and Quality of Care? Setting the record straight on the evidence.* August 2013.

Health Status of Current Adult Medicaid Enrollees

Health conditions and risks of adult enrollees under 65

- An estimated 57% of adults ages 21-64 covered by Medicaid are overweight, diabetic, hypertensive, have high cholesterol, or a combination of these conditions.
- Overall morbidity is estimated at more than 50% greater than the privately insured population.
- Nearly two of three adult women on Medicaid are in their reproductive years (19-44).
  - An estimated 48 percent of births were covered by Medicaid in 2010 (from a high of nearly 70 percent in Louisiana to less than 30 percent in New Hampshire and Massachusetts).
  - Medicaid covers approximately two of every three publically-funded family planning services including: prenatal and postpartum care, gynecological services, and testing/treatment of sexually transmitted infections.

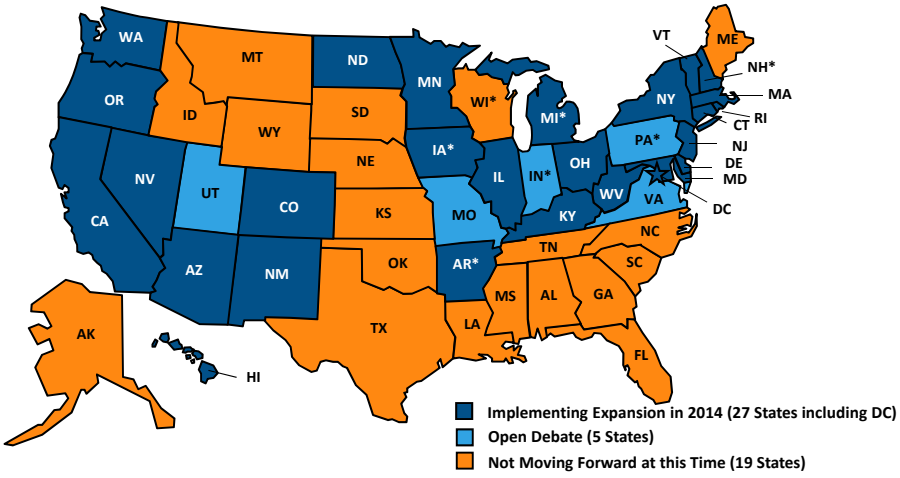
Kaiser Family Foundation: Low-Income Adults Under Age 65-Many are Poor, Sick, and Uninsured, June 2009.
Government Office on Accountability: Study on Medicaid Preventive Services, August 2009.
Damler, R. Medicaid Expansion under the Affordable Care Act. Health Watch. Issue 73. October, 2013.

Diversity of Adult Medicaid Population

- Racial and ethnic minority populations are disproportionately represented among Medicaid enrollees
- Across geographic regions, approximately 21% of the population is enrolled in Medicaid
- An additional 4.8 million adults have enrolled in Medicaid as of March 2014, compared to the same time last year
  - Medicaid expansion decisions and eligibility levels as a percent of the Federal Poverty Level (FPL) vary by State (0%-215%)
  - Disparities in growth of the Medicaid population observed between states that have and have not expanded Medicaid coverage (12.9% vs. 2.6%)
- Half of States with majority rural populations are expanding Medicaid coverage

Kaiser Family Foundation. *Health Coverage and Care in the South: A Chartbook. KFF: Washington, DC. April 2014. Available at* http://kaiserfamilyfoundation.files.wordpress.com/2014/04/8578-health-coverage-and-care-in-the-south-a-chartbook1.pdff
Bailey, J. *Medicaid Expansion as a Rural Issue: Rural and Urban States and the Expansion Decision* . Lyons, NE: Center for Rural Affairs; 2013. Available at http://files.cfra.org/pdf/medicaid-expansion-a-rural-issue.pdf. Last accessed May 2014.

Current Status of State Medicaid Expansion Decisions, 2014



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SOURCES: States implementing in 2014 and not moving forward at this time are based on data from CMS here. States noted as "Open Debate" are based on KCMU analysis of State of the State Addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of a Medicaid expansion bill in at least one chamber of the legislature.

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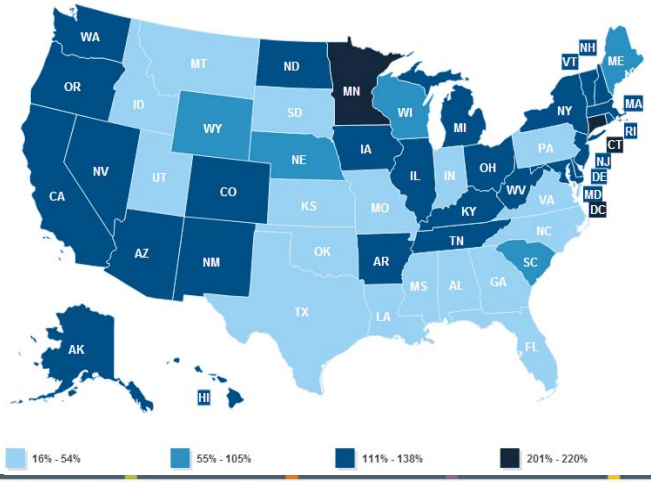
Medicaid Income Eligibility Limits



Medicaid Income Eligibility Limit	Number of States (and DC)
10-54% FPL	17
59-105% FPL	5
111-138%	26
201-220%	3

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Sources: Kaiser Family Foundation. http://kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-adults-at-application-effective-january-1-2014/ based on data from the Centers for Medicare and Medicaid Services (CMS), State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014.

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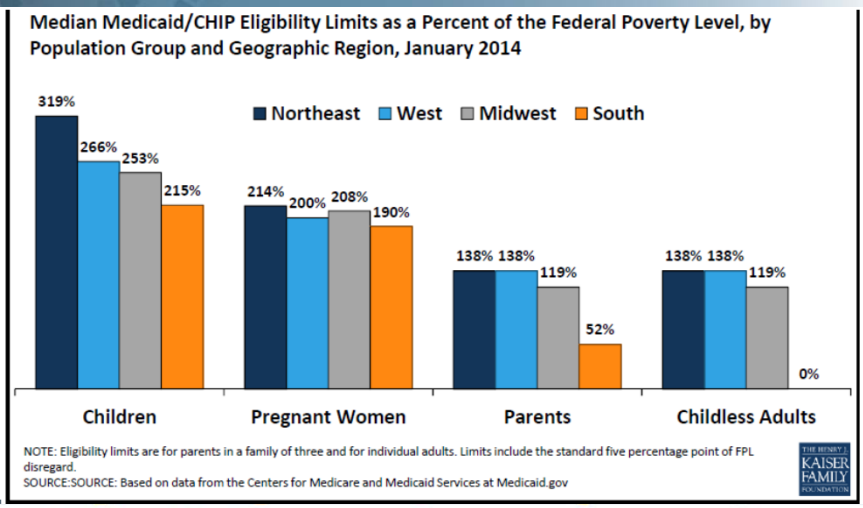
Median Medicaid/CHIP Eligibility as a Percent of Federal Poverty Level, by Population Group and Geographic Region



Kaiser Family Foundation. *Health Coverage and Care in the South: A Chartbook. KFF: Washington, DC. April 2014. Available at http://kaiserfamilyfoundation.files.wordpress.com/2014/04/8578-health-coverage-and-care-in-the-south-a-chartbook1.pdf*

Properties of the Medicaid Adult Core Set

Current Medicaid Adult Core Set Measures

NQF #	Measure Name	Measure Steward
0039	Flu Shots for Adults Ages 50-64	NCQA
n/a*	Adult BMI Assessment	NCQA
0031*	Breast Cancer Screening	NCQA
0032	Cervical Cancer Screening	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA
0418	Screening for Clinical Depression and Follow-Up Plan	CMS
1768	Plan All-Cause Readmission	NCQA
0272	PQI 01: Diabetes, Short-Term Complications Admission Rate	AHRQ
0275	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	AHRQ
0277	PQI 08: Congestive Heart Failure (CHF) Admission Rate	AHRQ
0283	PQI 15: Adult Asthma Admission Rate	AHRQ
0033	Chlamydia Screening in Women Ages 21-24	NCQA

NQF #	Measure Name	Measure Steward
0576	Follow-Up After Hospitalization for Mental Illness	NCQA
0469	PC–01: Elective Delivery	Joint Commission
0476	PC–03 Antenatal Steroids	Joint Commission
2082	***HIV Viral Load Suppression***	***HRSA***
0018	Controlling High Blood Pressure	NCQA
0063	Comprehensive Diabetes Care: LDL–C Screening	NCQA
0057	Comprehensive Diabetes Care: Hemoglobin A1c Testing	NCQA
0105	Antidepressant Medication Management	NCQA
1879	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA
2371	Annual Monitoring for Patients on Persistent Medications	NCQA
0006	CAHPS Health Plan Survey v 4.0—Adult Questionnaire	AHRQ, NCQA
0648	Care Transition—Transition Record Transmitted to Health Care Professional	AMA-PCPI
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA
1517	Prenatal and Postpartum Care: Postpartum Care Rate	NCQA

*Not NQF Endorsed

Medicaid Adult Core Set Properties: National Quality Strategy

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	2
Healthy Living and Well-Being	8
Affordability	1

Medicaid Adult Core Set Properties: Measure Characteristics

Medicaid Adult Core Set Characteristics		# of Measures
NQF Endorsement	Endorsed	24
	Not Endorsed	2
Measure Type	Structure	0
	Process	19
	Outcome	6
	Patient Experience of Care	1
Population Sensitivity	Disparities-Sensitive	6
	Risk Adjusted	4
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	15
	In the Medicaid Children's Core Set	3
	Health Insurance Marketplace Quality Rating System Beta Test Measure Set	12

Medicaid Adult Core Set Properties: Conditions

Clinical Conditions in Current Medicaid Adult Core Set	Number of Measures (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

Current MAP Measure Selection Criteria

1. NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2. Program measure set adequately addresses each of the National Quality Strategy's three aims
3. Program measure set is responsive to specific program goals and requirements
4. Program measure set includes an appropriate mix of measure types
5. Program measure set enables measurement of person- and family-centered care and services
6. Program measure set includes considerations for healthcare disparities and cultural competency
7. Program measure set promotes parsimony and alignment

MAP's Prior Recommendations on the Medicaid Adult Core Set

MAP Assessment of the Core Set – Fall 2013

- MAP recognized the investment made in the initial version of the core set measures and the need for States and CMS to gain experience with their use
- Sufficient attention to the three aims and six priorities of the National Quality Strategy
- Adequate to advance CMS' stated goals for the program
- Satisfactory share of outcome measures
- Strong in its alignment with other program sets and its parsimonious number of measures

MAP Recommendations – Fall 2013

Measure Specific Recommendation Summary:

- Measures should be used in their endorsed form, when possible, to maintain their scientific validity and reliability.
- Paired and composite measures should be used as designed to maintain their integrity and prevent data collection challenges.
- Measures that have lost endorsement should be re-evaluated for their use in the Core Set.
  - In cases when a measure has lost endorsement but the steward intends to resubmit an updated version, use of the most current version should proceed.
  - In cases when a measure has lost endorsement but the steward has no intention to provide an update, use of the measure should stop and a suitable replacement on the same topic be identified.

Strengthening the Measure Set – Fall 2013

- MAP recommended that the measure set be strengthened over the long term by the addition of measures in key areas:
  - Mental health screening (potential to develop a composite)
  - Access to services, particularly for reproductive health services and for individuals with disabilities
  - Wrap-around services to mitigate social determinants of health (e.g., transportation)
  - Individual goals for care (e.g., functional status, quality of life)
- MAP suggested that CMS consult the Family of Measures for Dual Eligible Beneficiaries for additional measures or measure concepts.

Implementing the Medicaid Adult Core Set

Medicaid Adult Core Set

Background

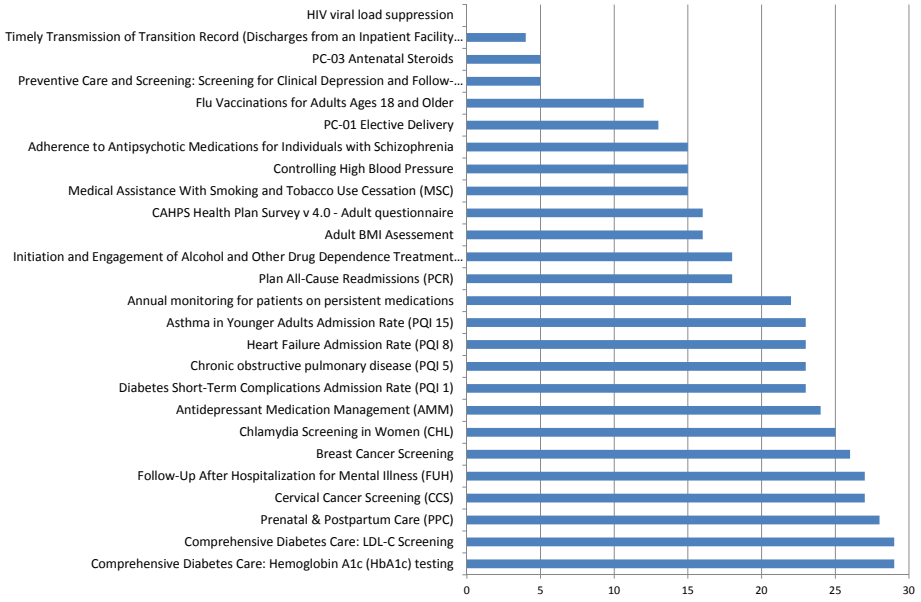
- Requirement of the Affordable Care Act to identify a parsimonious core set of measures that is reflective of the diverse health care quality needs of adults in Medicaid
  - Initial core set identified through multistakeholder process, annual improvements to strengthen core set are required
  - Voluntary reporting began FFY 2013, with technical assistance program
- 2-year grant program began Dec 2012 to support Medicaid agencies in collecting and reporting the core set
  - 26 states required to report at least 15 measures in 2014
  - In the future, CMS will make information reported by the states publicly available

Medicaid Adult Core Set

CMS Goals

- As with any new reporting program, CMS has spent the past year working with states to understand the Core Set measures and to refine the reporting guidance provided.
- Three-part goal for Core Set:
  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

Number of States Reporting Measures in Medicaid Adult Core Set FFY 2013



Summary Feedback on the Implementation of Measures

Modifications to Measure Specifications

Staff observations

- Most measures are modified in that they are "rolled up" to the Medicaid program level, even though they are specified for health plans, facilities, etc.
  - Guidance allows calculation of weighted average (based on size of eligible population) if developed from aggregated data (e.g., across multiple managed care organizations)
  - Reliability and validity of measure scores unknown because testing not conducted at program level of analysis
- Several "adaptations" for the measures are actually instructions for reporting
  - Most often, for particular age groups (e.g., 18-64; 65-74)
  - These instructions for reporting do not constitute a material change to the measure

Modifications to Measure Specifications

Staff observations

- A few modifications do constitute a material change to the measure
  - Allowing different methods of risk-adjustment or no risk-adjustment
- Most other modifications would not constitute a material change to the measure
  - Use of a more restricted age range
  - Providing date for age calculation (e.g., as of 12/31)
  - Changing denominator from enrollees to member-months*

Modifications to Measure Specifications

Staff observations

- Some modifications retain the intent of the specifications, but may affect comparability across states
  - Identification of those transferred to another institution
  - Use of vital records (instead of medical records) to obtain gestational age

Feedback on the Implementation of Measures

Staff Observations

- Implementation information obtained from FFY 2013 reporting to the Medicaid Adult CARTS reports
- Most of the measures in the Medicaid Adult Core Set have been "adapted"
  - The most common adaptation is stratification for particular groups
- Relatively few Technical Assistance (TA) requests for most measures
  - Often 1-4 requests per measure
  - More 10+ requests for those where denominator was member-months

Feedback on the Implementation of Measures

Staff Observations

- Reporting "population" varied across states
  - Medicaid only
  - Medicaid and CHIP
  - Medicaid and duals
  - Medicaid, CHIP, and duals
  - Other (e.g., "managed care population")

Questions?

State Experience Panel
New Hampshire

New Hampshire Adult Medicaid Quality Measures Application Experience

June 5, 2014
Doris Lotz MD, MPH
Medicaid Chief Medical Officer
New Hampshire Department of Health and Human Services

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NH Measures Application Experience

- Opportunities and Challenges
  - Measure Generation
  - Measuring Quality
  - Measurement for the Future

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NH AMQ Reported Measures

1. Flu Shots for Adults Ages 50-64
2. Breast Cancer Screening
3. Cervical Cancer Screening
4. Medical Assistance With Smoking and Tobacco Use Cessation
5. PQI 01: Diabetes, Short-term Complications Admission Rate
6. PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
7. PQI 08: Congestive Heart Failure Admission Rate
8. PQI 15: Adult Asthma Admission Rate
9. Follow-Up After Hospitalization for Mental Illness
10. PC-01: Elective Delivery
11. Comprehensive Diabetes Care: LDL-C Screening
12. Comprehensive Diabetes Care: Hemoglobin A1c Testing
13. Antidepressant Medication Management
14. Annual Monitoring for Patients on Persistent Medications
15. CAHPS Health Plan Survey v 5.0 - Adult Questionnaire with CAHPS Health Plan Survey v 5.0H - NCQA Supplemental
16. Prenatal and Postpartum Care: Postpartum Care Rate

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Rationale for the Chosen Measures

- Feasibility: What measures can we generate?
- Synergy or Efficiency: What measures must we generate as part of some other deliverable, such as the manage care program, another grant, etc.?
- Capacity Building: Where should we grow our understanding of measure generation and quality improvement?

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Feasible Measures

- What measures could be generated from administrative claims?
  - Flu Shots for Adults Ages 50-64
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Medical Assistance With Smoking and Tobacco Use Cessation
  - PQI 01: Diabetes, Short-term Complications Admission Rate
  - PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
  - PQI 08: Congestive Heart Failure Admission Rate
  - PQI 15: Adult Asthma Admission Rate
  - Comprehensive Diabetes Care: LDL-C Screening
  - Comprehensive Diabetes Care: Hemoglobin A1c Testing
  - Antidepressant Medication Management
  - Annual Monitoring for Patients on Persistent Medications

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Synergistic or Efficient Measures

- Where was there synergy between the grant and other measure generation activities?
  - CAHPS Health Plan Survey v 5.0 - Adult Questionnaire with CAHPS Health Plan Survey v 5.0H - NCQA Supplemental

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Capacity Building

- What measure(s) would require linking data sets?
  - Follow-Up After Hospitalization for Mental Illness
  - PC-01: Elective Delivery
- What hybrid measures would give experience with chart review and abstraction?
  - Prenatal and Postpartum Care: Postpartum Care Rate

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Rationale for Measures Not Chosen

- Too Expensive
- Uncertainty regarding the measure definition
- Unique NH concerns

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Required Chart Abstraction

- Adult BMI Assessment
- Screening for Clinical Depression and Follow-Up Plan
- Controlling High Blood Pressure
- Care Transition – Transition Record Transmitted to Health care Professional
- PC-03 Antenatal Steroids

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Measure Definition Uncertainty

- Plan All-Cause Readmission
- Chlamydia Screening in Women age 21-24
- Adherence to Antipsychotics for Individuals with Schizophrenia

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Unique NH Circumstances

- Impact of NH fiscal policy
  - Plan All-Cause Readmission
    - NH does not pay for readmission within 30 days
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
    - NH does not have a Substance Use Disorder Benefit
- Challenges of small populations
  - Annual HIV/AIDS medical visit

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Measure Generation Successes

- Claims-based measures
  - Previously
    - Generated and reported claims-based measures
  - New!
    - Aggregate multiple data types (e.g., claims, CAHPS, HEDIS), real time, automated data surveillance, preserve human analysis for outliers and other data requests, expanded number of measures reported, easier web interface with user customizable reports, improved subpopulation analysis, presenting different types of data, blended analysis to generate statewide/Medicaid wide data elements (e.g., HbgA1c from 3 MCOs and FFS, MQIS will create Medicaid rate)
  - Notable
    - Medicaid must be capable of handling multiple, diverse data types and develop the capacity to blend multiple data sources for analysis

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Slide 53

DHL9 READ AHRQ READMISSION BRIEF
Doris.H.Lotz, 5/29/2014

Measure Generation Successes, cont.

- CAHPS
  - Previously
    - Fielded CAHPS
  - New
    - Oversampled for subpopulation analyses
    - Analysis indicated that there is little variation within and across the subpopulations
  - Notable
    - With little variation within and across subpopulations, when is subpopulation analysis needed and when is it not needed to avoid "sample fatigue"?
    - Should CMS continue to require a separate CAHPS for the CHIP population?
    - What is the additional value of a national CAHPS survey?

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Measure Generation Successes, cont.

- Linking Data Sets
  - Previously
    - Data linked for specific analysis requests
  - New
    - Vital Records: Improved the ease of vital statistics use, but did not formally link the two data sets primarily because there is little need; subsequent linking will be more efficient; continued to develop techniques which may help to connect to a new statewide vaccine registry
    - New Hampshire Hospital: Institute of Mental Disease- no Medicaid claiming, 50% of mental health admissions are excluded from the analysis, improved MMIS notification of both admission and discharge from NHH and are now able to calculated a modified F/U after MH hospitalizations
  - Notable
    - Should data linkages be part of MMIS required architecture?
    - HEDIS measures may require modifications for Medicaid use

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Measure Generation Successes, cont.

- Hybrid Measures
  - New!
    - Used vendor to develop the measure which was expensive, many records were missing data or the records could not be found which likely artificially lower the rate; NH allows provider to bill a global pregnancy payment masking detailed information
  - Notable
    - Hybrid measures are more costly for smaller states; the same sample size is needed for measure validity, but cost impact greater on a smaller state budget
    - What hybrid measures have the greatest "Quality ROI"?

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Measuring Quality

- Rationale for quality improvement project development
  - What type of State leadership was needed?
    - State as facilitation vs. State as sole owner of the project interventions
  - What operational logistics needed?
    - Time frame to complete, data available, human resources available
  - Did the project and/or intervention have merit?
    - Clever idea to test?
    - Was there notable or data driven burden of disease or clinical need?

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Early Elective Deliveries

- State role: Facilitation
  - Topic of interest to others, existing network (NHHA, NNEPQIN, MOD), resources (MOD, State Epidemiologist)
- Clever idea
  - Comprehensive chart review to assess the accurate of claims information and assess the impact of psychosocial concerns
  - Develop best practice for hospital hard stop policies
- Results
  - Reported 25% EED rate, modified to 4.6% after chart review
  - Of the EEDs, 65% had significant psychosocial issues (e.g., rural and high risk, lack of a care giver, significant mental illness, drug use, etc.)
- Notable
  - Chart abstraction is required for accurate data capture (JCAHO changed measure to include chart abstraction)
  - There is a need for psychosocial issue capture

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Anti-depressant Medication Management

- State role: Sole Ownership
  - MCO administer the pharmacy benefit, but State has (almost) exclusive ownership of pharmacy policy, benefit determination and management of pharmacy services
- Clever idea
  - Use pharmacy data as an early indication of new onset depression to encourage medication adherence
  - If successful, incorporate into managed care
- Results
  - Test group: approximately 20% of new prescriptions for antidepressants are for a new diagnosis of depression
  - Still pending…

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Future Measurement: Priorities and Gaps

- Emerging areas of importance
  - Long Term Care Services and Supports
  - Home and Community Based Care Outcomes
  - Substance Use Disorder Treatment and Outcomes
    - Neonatal Addition Syndrome
  - Access measures including emergency department use

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Future Measurement: Unmet Challenges

- Measurement Generation
  - Multiple types of data
    - claims, surveys, vital records, registries
  - Multiple source of data
    - FFS, MCO, Expansion population
  - Measure selection
    - Measures not being used more broadly in health insurance quality measurement
  - Measure definitions and technical detail
    - Measures requiring complex claims analysis
  - Costs

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Future Measure Application Solutions

- Measure Generation
  - Improve measurement infrastructure
    - Require and build MMIS capacity
      - For multiple data sources
      - Linking data into MMIS
    - Support for auditing measures
  - Continue to improve the technical specifications of measures
    - Additional technical specificity
    - Amend HEDIS measures to consider the Medicaid population
    - Standard approach to weighting multiple data sources
  - Discontinue CHIP CAHPS (for smaller states or states who have integrated it into Medicaid) and National CAHPS
- Costs
  - Carefully select hybrid measure for Quality ROI
  - Increase standardization
  - Address overlapping measure initiatives by allowing sampling or use of MCO measures
  - Develop quality infrastructure vs. claims payment infrastructure

63

Future Measurement Priorities

- Measuring Quality
  - Measure quality impact
    - E.g., is the medical home package critical or it is the care/case management what correlates with impact?
  - Measure outcomes
    - E.g., be flexible regarding the processes by which the outcome is achieved (quality companion to ACO)
  - Measure what is important to the consumer
    - What is the Beneficiary Experience of Care:
      - Care right away? Access to care ? Emergency Department use?
      - Shared decision making (currently limited to medications)?
      - Some CAHPS questions may be more important than others…pull those out of the list.

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Future Measurement Priorities, cont.

- Measure Medicaid Program Administration
  - Medicaid quality programs should define measurable goals for the Medicaid program
  - How will we know when we're been successful?
  - What value does the Medicaid program bring to it's population, beyond payment for medical services?
- Link measurement to improvement
  - How does measurement/data analysis translation/relate to barrier identification, causal link to problem?
  - Additional work is needed to link interim, process or proxy measures to outcomes
  - Barriers to optimum health outcomes may not be in current measure set
- Measure Medicaid as part of the health care system
  - Integrate Medicaid into population health improvement
  - Medicaid is more than "just" a payer of health services

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State Experience Panel
Virginia

Department of Medical Assistance Services

Prepared for the National Quality Forum,
Measure Applications Partnership,
Medicaid Task Force Meeting,
June 5-6, 2014

http://dmas.virginia.gov

BACKGROUND & SUMMARY

VIRGINIA MEDICAID BACKGROUND AND SUMMARY OF DELIVERY SYSTEM

QUALITY MEASUREMENT PROGRAMS

ADULT MEASURES

MEDALLION 3.0

700,000 Enrollees in Managed Care

MCOs Statewide
July 1, 2012

The Public/Private Partnership

The Department has a public/private partnership with health plans that cover the majority of the Medicaid population and are specifically designed to meet the unique interest of the Commonwealth

Anthem #2

CoventryCares #4

InTotal {INOVA}

Kaiser #3

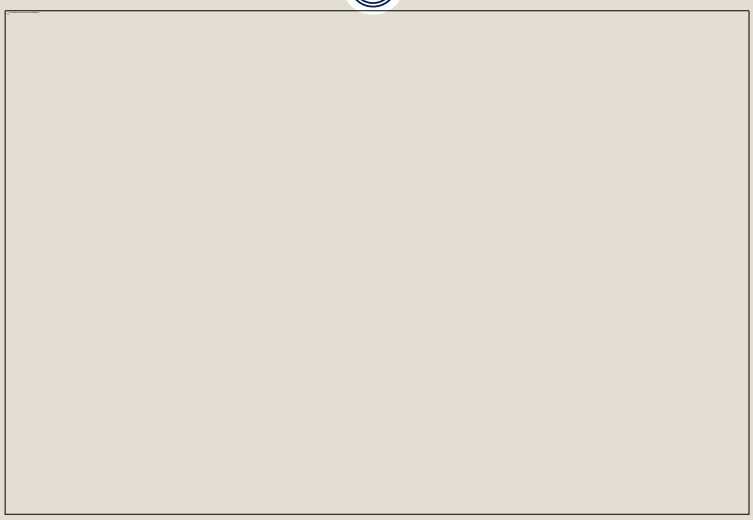
MajestaCare {Carilion}

Optima {Sentara}

Virginia Premier {VCU}

DMAS contracts with 3 of the largest health plans in the Commonwealth and country and 4 of the largest health systems in Virginia

Virginia Medicaid Managed Care



The Commonwealth's ROI

Health Plans provide the Commonwealth with healthcare , access and services

- Diverse practice models that compete and support the marketplace
- Capacity to recruit and leverage broader provider and specialty networks that are board certified
- Plans have flexibility to provide enhanced services and varied rate structure
- Predictive modeling and chronic care management
- Wellness programs
- Maternity program changes
- Technological advances
- Clinical and community partnership
- Full risk model provides budgetary certainty

The Commonwealth's ROI

Health Plans provide the Commonwealth with Innovation

Medallion Care Partnership System (MCSP) – New Payment/Delivery Model

- Each health plan is implementing at least two MCSPs to improve health outcomes for Medicaid members through a system designed to integrate primary, acute, and complex health services
- Supports medical homes, limited networks, pay for performance and regional pilots
- Supports integrated provider health care delivery systems participation, gain and/or risk sharing, performance-based incentives, and improvement of member health outcomes as measured through risk adjusted quality metrics, and alignment of administrative systems to improve efficiency and member experience

The Commonwealth's ROI

Health Plans provide the Commonwealth with measurable accountability

QUALITY

- Mandatory NCQA accreditation
- Sets of Quality measures
- Quality Collaborative
- Quality performance aligned with the population
- Annual managed care report focused on quality measures
- Quality measures are used to define program 's ROI with Governor 's staff and legislature.

BACKGROUND & SUMMARY

VIRGINIA MEDICAID BACKGROUND AND SUMMARY OF DELIVERY SYSTEM

QUALITY MEASUREMENT PROGRAMS

ADULT MEASURES

Virginia's Managed Care Quality Measures Set is in the 2011-2015 Quality Strategy and the Contract with the MCOs

- DMAS maintains/tracks quality measures' stewards and supporting entities to enable efficiencies in quality improvement, benchmarking opportunities, and value

Unduplicated Menu of Quality Measures	Measure Steward	In Med. II 2011- 2015	CHIPRA Measure	CMS Adult Measure	Meaningful Use EHR-CMS
Antidepressant Medication Management - Effective Acute Phase Treatment	HEDIS Tech Spec	yes	no	yes	Yes, Non-Core
Antidepressant Medication Management - Effective Continuation Phase Treatment	HEDIS Tech Spec	yes	no	yes	No
Use of Appropriate Medications for People with Asthma - Total	HEDIS Tech Spec	yes	no	no	Yes, Non-Core
Use of Appropriate Medications for People with Asthma (12-50)	HEDIS Tech Spec	yes	no	no	Yes, Non-Core
Use of Appropriate Medications for People with Asthma (5-11)	HEDIS Tech Spec	yes	no	no	Yes, Non-Core
Breast Cancer Screening - Total	HEDIS Tech Spec	yes	no	yes	Yes, Non-Core
Controlling High Blood Pressure for members with hypertension - Total	HEDIS Tech Spec	yes	no	yes	Yes, Non-Core
Comprehensive Diabetes Care - HbA1c Testing	HEDIS Tech Spec	yes	yes	yes	No
Comprehensive Diabetes Care - Eye Exams	HEDIS Tech Spec	yes	no	no	No
Comprehensive Diabetes Care - LDL-C Screening	HEDIS Tech Spec	yes	no	yes	No
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	HEDIS Tech Spec	yes	no	no	Yes, Non-Core
Prenatal and Postpartum Care - Timeliness of Prenatal Care	HEDIS Tech Spec	yes	yes	yes	No
Prenatal and Postpartum Care - Postpartum Care	HEDIS Tech Spec	yes	no	yes	No
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	HEDIS Tech Spec	yes	no	no	Yes, Non-Core
Comprehensive Diabetes Care - HbA1c Control (<8%)	HEDIS Tech Spec	yes	no	no	Yes, Non-Core
FU After Hospitalization For Mental Illness - 7 days	HEDIS Tech Spec	yes	yes	yes	No
FU After Hospitalization For Mental Illness - 30 days	HEDIS Tech Spec	yes	yes	yes	No
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)	HEDIS Tech Spec	yes	no	no	Yes, Non-Core

Implementation of Performance Incentive Awards for MCOs

- Includes three HEDIS measures
- Two of the three HEDIS measures are CMS adult core measures:
  - blood pressure control; and,
  - timeliness of prenatal care

Next version of Virginia's Medicaid Managed Care Quality Strategy

- Current version covers CY 2011 – 2015
- Next version will cover CY 2016 – 2020
  - Brainstorming sessions have begun for the subset of quality measures that will be included in the quality strategy
  - DMAS will work in partnership with MCOs to establish logical criteria for selecting the set of quality measures
  - Measures will be decided by March 2015 to be included in the managed care contracts beginning July 1, 2015

State Recommendations

- Continue with voluntary reporting
- Be transparent with reporting (even if only one state reports their scores on a measure)
- **Recognize the need for efficiencies with regards to adult quality measures for Medicaid, Medicare, Exchanges, Expansion.**
  - Too many measures is over-burdening the providers and the MCOs
  - The more measures there are, the more diluted the quality improvement efforts
  - Identify regulatory and innovative efforts to combine improvement efforts for adult populations in order to create synergies for population health

Gaps

- Has a measure for sickle cell been considered?
- Publish an annual crosswalk of measures used by Federal/state health care delivery (for example, the flu shot measure is used by Medicare QIOs, CMS core measure set, NCQA for Medicare MCOs)

Questions?

- **More Information**
- Contract and Quality Reports on DMAS web site http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Managed Care Value Purchase Document http://www.dmas.virginia.gov/Content_atchs/atchs/wnew_f1.pdf
- 2013 Annual Managed Care Report http://www.dmas.virginia.gov/Content_atchs/mc/apr-f8.pdf

Opportunity for Public Comment

Lunch Break

State Experience Panel
Louisiana

Collecting and Reporting Medicaid Adult Core Set Measures in Louisiana

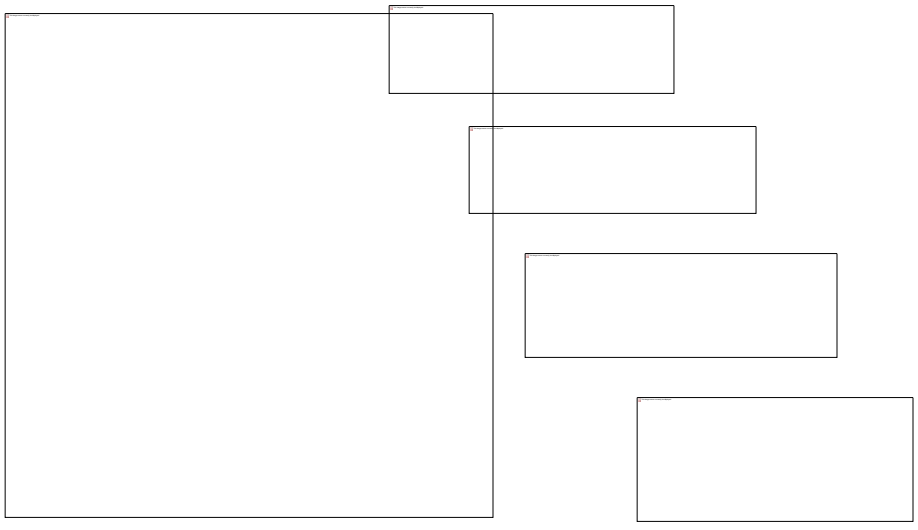
June 5, 2014

Rebekah Gee, MD, MPH, MS, FACOG
Medicaid Medical Director
Louisiana Department of Health and Hospitals
&
Eddy Myers, MBA, CPA
Quality Team Lead
University of Louisiana at Monroe
Office of Outcomes Research and Evaluation

Overview

- Adult Medicaid Quality Grant Selected Measures for the State of Louisiana
- Successes
- Challenges
- Driving Quality Improvement
- Recommendations
- Questions

Louisiana



Adult Medicaid Quality Grant 2013 Measures

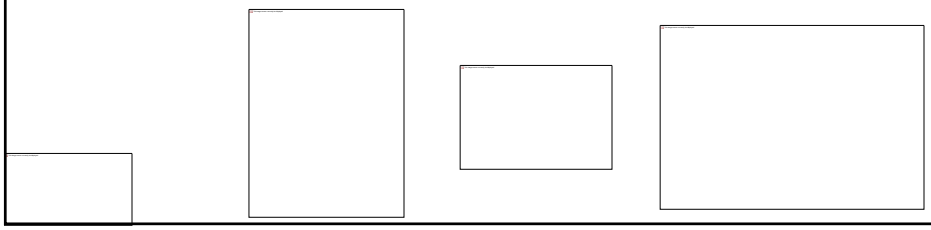
- Flu Shots for Adults Ages 50-64
- Breast Cancer Screening
- Cervical Cancer Screening
- Plan All-Cause Readmission
- Diabetes, short-term Complications Admission Rate
- Chronic Obstructive Pulmonary Disease Admission Rate
- Congestive Heart Failure Admission Rate
- Adult Asthma Admission Rate
- Chlamydia Screening in Women Ages 21-24
- Follow-Up After Hospitalization for Mental Illness
- Elective Delivery
- Antenatal Steroids
- Comprehensive Diabetes Care: LDL-C Screening
- Annual HIV/AIDS Medical Visit
- Comprehensive Diabetes Care: Hemoglobin A1C Testing
- Antidepressant Medication Management
- Annual Monitoring for Patients on Persistent Medications
- CAHPS Health Plan Survey
- Prenatal and Postpartum Care: Postpartum Care Rate

Successes

- **Prior to the Adult Medicaid Quality Grant, Louisiana Medicaid collected 18 HEDIS and 10 CHIPRA measures.**
- **CMS grant facilitated programming and reporting of 19 out of the 26 Core Set measures.**
- **Grant created an innovative and unique Medicaid/Vital Records matching procedure for Early Elective Deliveries (EED) measure to be able to collect data electronically.**
  - **Validated by the National Perinatal Information Center/Quality Analytic Services (NPIC/QAS).**
  - **Potential to eliminate need for chart reviews for EED Core Set measure.**

Successes

- Gained experience implementing the chart review process with Postpartum Care measure.
  - Partnered with Louisiana Office of Public Health nurses.
- Utilized administrative claims data measures to streamline data collection.



Challenges

- Identified initial measures of interest and revised list after assessing feasibility/data availability
  - e.g. Care Transition was replaced by Plan All-Cause Readmission because of data accessibility issues.
- Plan All-Cause Readmission risk adjustment method.
- Matching Medicaid data to Vital Records data.

Challenges

- Created and implemented chart review process.
  - Extremely labor intensive.
  - Provider claims contact information discrepancies.
- Required longer time than expected to program some measures while waiting on clarifications for specifications from CMS
  - e.g. HIV and EED measures.

How Collecting Core Set Data Can Drive Quality Improvement

- Enhance capacity for analyzing and reporting quality measures across all programs in Medicaid.
- Use of this data to drive Medicaid policy and interventions to improve health outcomes for Medicaid populations.
  - This is HUGE!
- Add capabilities that can be utilized in other measures, systems or initiatives (e.g. Vital Records matching and potential use of birth certificates to collect EED reason).

Recommendations

- Limit chart review burden by utilizing measures that use administrative claims or other accessible electronic health data where possible.
- Enhance process for obtaining clarifications about specifications to minimize programming delays (e.g. possible webpage with FAQs).
- Consider additional measures that impact large segments of the population (e.g. Asthma Medication Ratio measure and Adults' Access to Preventive/Ambulatory Health Services).

Recommendations

- Incorporate more electronic specifications for clinical quality measures (eCQMs) from Meaningful Use program into reporting set.
- Align the core measures where possible with the Physicians Quality Reporting System (PQRS) to avoid duplication of effort.
- Add a potentially avoidable emergency room visits measure.

Questions?

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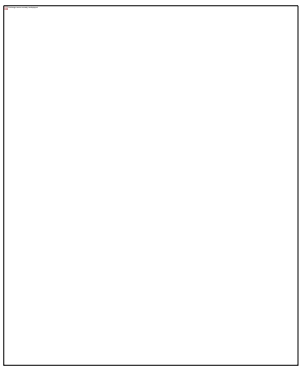
Website: www.dhh.la.gov



Kathy Kliebert, *Secretary*
Jeff Reynolds, *Undersecretary*
Ruth Kennedy, *Medicaid Director*

This document was published by the Louisiana Department of Health and Hospitals in May of 2014.
Please direct inquiries to Rebecca.Gurvich@LA.GOV.

Non-Participating State Feedback

Discussion of Key Themes from State Experience

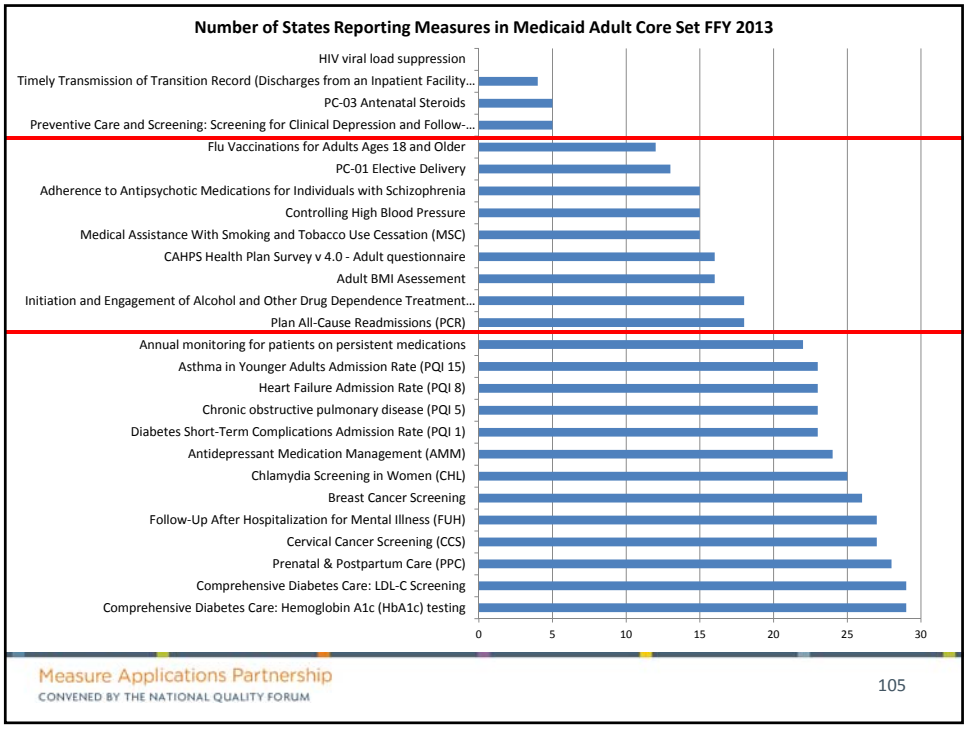
Key Themes from State Experience

- What are states' most notable successes related to quality measurement?
- What are states' most significant challenges and how could changes to the Core Set be helpful?
- Will any points of feedback from the states need to influence the decision process about specific measures?
- Have the states raised any policy-level issues that should be discussed during tomorrow's session on strategy?

Measure by Measure Review

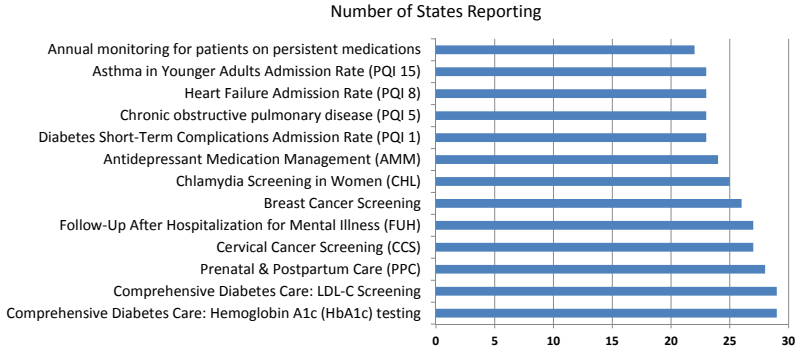
Top 10 Causes of Re-hospitalization in the Medicaid Population (based on HCUP data, ordered by frequency)

- Mood disorders
- Schizophrenia
- Diabetes
- Pregnancy complications
- Alcohol-related
- Early or threatened labor
- Congestive heart failure
- Septicemia
- Chronic Obstructive Pulmonary Disease
- Substance-related disorders



Measure by Measure Review: Measures with High Levels of Reporting (13)

- Should the measures be maintained in the Core Set?
- Are there suggested changes to the application of the measures?



Measure by Measure Review: Measures with High Levels of Reporting

Measures of Women's Health and Related Topics

- 1517 – Prenatal and Postpartum Care: Postpartum Care Rate
- 0032 – Cervical Cancer Screening
- 0031 – Breast Cancer Screening
- 0033 – Chlamydia Screening in Women Ages 21-24

- Related measures to be discussed in another section:
  - 0469 – PC-01 Elective Delivery
  - 0476 – PC-03 Antenatal Steroids

1517 – Prenatal and Postpartum Care: Postpartum Care Rate

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/1517

Description:	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.
Exclusions:	Exclude non-live births
Data Source:	Administrative claims, Electronic Clinical Data, Paper Medical Records
Type:	Process
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic
Alignment:	HEDIS, Health Insurance Marketplace Quality Rating System

1517 – Prenatal and Postpartum Care: Postpartum Care Rate

NQF Endorsed – Steward: National Committee for Quality Assurance

Implementation:

- Adaptation: None
- 28 states reported FFY 2013
  - All states reported the Medicaid Adult Core Set specifications, based on HEDIS 2013
- Challenges: Methodology
  - Underreported through administrative data because postpartum visits are included in global payments
  - Hybrid method to collect data is costly and can be burdensome
- Reasons states did not report (n=12):
  - Other (2)
  - Other reasons: Information was not collected because the measure was not identified as a key priority, budget constraints, staff constraints, requires medical record review, requires data linkage which does not currently exist

0032 – Cervical Cancer Screening

NQF Endorsed
Steward: National Committee for Quality Assurance

QPS Link: www.qualityforum.org/qps/0032

Description:	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: - Women age 21–64 who had cervical cytology performed every 3 years. - Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.
Exclusions:	Exclude: Women who had a hysterectomy with no residual cervix any time during their medical history through the end of the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data, Paper Medical Records
Type:	Process
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic
Alignment:	Meaningful Use Stage 2 - Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System

0032 – Cervical Cancer Screening

NQF Endorsed
Steward: National Committee for Quality Assurance

Implementation:

- Adaptation: None
- 27 states reported FFY 2013
  - All 27 states reported Medicaid Adult Core Set specifications
- Challenges: Determining eligible population
  - Denominator should include women ages 24-64 at the end of the measurement year to account for the 3-year look-back period
- Reasons states did not report (n=3):
  - Information was not collected because the measure was not identified as a key priority (2)
  - Other reasons: Other

0031 – Breast Cancer Screening

Not NQF Endorsed
Steward: National Committee for Quality Assurance

QPS Link: www.qualityforum.org/qps/0031

Description:	Percentage of women 42-69 years of age who had a mammogram to screen for breast cancer
Exclusions:	Women who had a bilateral mastectomy or for whom there is evidence of two unilateral mastectomies. Look for evidence of a bilateral mastectomy as far back as possible in the member´s history through Dec 31 of the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data, Electronic Health Record
Type:	Process
Level of Analysis:	Clinician: Group/Practice, Individual, Health Plan, Population: State
Care Setting:	Clinician Office/Clinic
Alignment:	Meaningful Use Stage 2 - Eligible Professionals, Medicare Shared Savings Program, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System

0031 – Breast Cancer Screening

Not NQF Endorsed

Steward: National Committee for Quality Assurance

Implementation:

- Prior MAP Recommendation: In cases when a measure has lost endorsement but the steward intends to resubmit an updated version, use of the most current version should proceed
- Adaptation:
  - Rates reported by two age groups: ages 42-64 and 65-69
- 26 states reported FFY 2013
  - All 16 states reported Medicaid Adult Core Set specifications
- Challenges: Age range and determining eligible population
  - Changes to HEDIS specifications: FFY 2014 denominator should include women ages 52-74 to account for the 2-year, 3-month look-back period
- Reasons states did not report (n=4):
  - Information was not collected because the measure was not identified as a key priority (1)
  - Other reasons (3)

0033 – Chlamydia Screening in Women Ages 21-24

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0033

Description:	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.
Exclusions:	Exclude patients who qualified for the denominator based on a pregnancy test alone and who meet either of the following: - A pregnancy test (Pregnancy Tests Value Set) during the measurement year followed within seven days (inclusive) by a prescription for isotretinoin. - A pregnancy test (Pregnancy Tests Value Set) during the measurement year followed within seven days (inclusive) by an x-ray (Diagnostic Radiology Value Set).
Data Source:	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy
Type:	Process
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic
Alignment:	Meaningful Use Stage 2- Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System

0033 – Chlamydia Screening in Women Ages 21-24

NQF Endorsed – Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - HEDIS 2013 specifications included 3 rates (2 age ranges and a summary rate)
    - » Rate for ages 21-24 reported in the Medicaid Adult Core Set, while 16-20 reported in the Child Core Set
- 25 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: Coding
  - Link to NCQA list of National Drug Codes for contraceptive medications
- Reasons states did not report (n=6):
  - Information was not collected because the measure was not identified as a key priority (3)
  - Other reasons: Budget constraints, staff constraints, data inconsistencies/accuracy, other

Measure by Measure Review: Measures with High Levels of Reporting

Measures of Mental and Behavioral Health Topics

- 0576 – Follow-Up After hospitalization for Mental Illness
- 0105 – Antidepressant Medication Management
- 0004 – Initiation and Engagement of Alcohol and Other Drug Related Dependence Treatment

- Related measures discussed in following sections:
  - 1879 -Adherence to Antipsychotics for Individuals with Schizophrenia
  - 0418 – Screening for Clinical Depression and Follow-Up Plan

0576 – Follow-Up After Hospitalization for Mental Illness

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0576

Description:	The percentage of discharges for patients 21 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. - Two rates are reported: The percentage of discharges for which the patient received follow-up within 30 and within 7 days of discharge.
Exclusions:	Three types of discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.
Data Source:	Administrative claims, Electronic Clinical Data
Type:	Process
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic, Urgent Care, Hospital/Acute Care Facility, Behavioral Health/Psychiatric: Inpatient and Outpatient
Alignment:	PQRS, HEDIS, Health Insurance Marketplace Quality Rating System

0576 – Follow-Up After Hospitalization for Mental Illness

NQF Endorsed – Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - HEDIS 2013 specifications ages 6 and older: Medicaid Adult Core Set does not include rate for ages 6-20
  - Reported rates in the Medicaid Adult Core Set: Ages 21-64, and 65 and older
- 27 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: None reported
- Reasons states did not report (n=3):
  - Requires data linkage which does not currently exist (1)
  - Information was not collected because the measure was not identified as a key priority (1)
  - Other reasons: Other

0105 – Antidepressant Medication Management

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0105

Description:	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: 12 weeks b) Effective Continuation Phase Treatment: 6 months
Exclusions:	Exclude members who filled a prescription for an antidepressant 90 days (3 months) prior to the IPSD.
Data Source:	Administrative claims, Electronic Clinical Data, Pharmacy
Type:	Process
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic
Alignment:	Meaningful Use Stage 2 - Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System

0105 – Antidepressant Medication Management

NQF Endorsed – Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - Rates reported in two age groups: Ages 18-64, and 65-74
- 24 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: Coding
  - Link to NCQA list of National Drug Codes for antidepressant medications
- Reasons states did not report (n=6):
  - Information was not collected because the measure was not identified as a key priority (4)
  - Other

0004 – Initiation and Engagement of Alcohol and Other Drug Related Dependence Treatment

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0004

Description:	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following: - Initiation: The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. - Engagement: The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Exclusions:	Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. Exclude from the denominator patients whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic, Urgent Care, Emergency Medical Services/Ambulance, Hospital/Acute Care Facility, Behavioral Health: Inpatient and Outpatient
Alignment:	Meaningful Use Stage 2 - Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System

0004 – Initiation and Engagement of Alcohol and Other Drug Related Dependence Treatment

NQF Endorsed – Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - Rates reported in two age groups: Ages 18-64, and 65 and older
- 18 states reported FFY 2013
  - All states reported the Medicaid Adult Core Set specifications
- Challenges: Data collection
  - For FFY 2014, any enrollee excluded from initiation rate must also be excluded from engagement rate
- Reasons states did not report (n=12):
  - Information was not collected because the measure was not identified as a key priority (8)
  - Other reasons: Entire population not covered, requires medical record review, requires data linkage which does not currently exist, other

Measure by Measure Review: Measures with High Levels of Reporting

Measures of Chronic Disease, Cardiovascular Disease and Diabetes

- 1768 – Plan All-Cause Readmission
- 0021 – Annual Monitoring for Patients on Persistent Medications
- 0063 – Comprehensive Diabetes Care: LDL-C Screening
- 0057 – Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
- PQI Measures
  - 0272 – Diabetes Short-Term Complications Admission Rate (PQI 01)
  - 0277 – Congestive Heart Failure (CHF) Admission Rate (PQI 08)
  - 0275 – Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (PQI 05)
  - 0283 – Adult Asthma Admission Rate (PQI 15)
- Related measures discussed in other sections:
  - 0018 – Controlling High Blood Pressure
  - N/A – Adult BMI Assessment
  - 0648 – Care Transition – Transition Record Transmitted to Health Care Professional

1768 – Plan All-Cause Readmission

NQF Endorsed
Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/1768

Description:	For patients 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* (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission *An acute inpatient stay with a discharge during the first 11 months of the measurement year
Data Source:	Administrative claims, Electronic Health Record, Paper Medical Records
Type:	Process
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic, Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility
Alignment:	HEDIS, Health Insurance Marketplace Quality Rating System

1768 – Plan All-Cause Readmission

NQF Endorsed
Steward: Centers for Medicare & Medicaid Services

Implementation:

- Prior MAP recommendations Workgroup strongly supported CMS' plans to work with the measure steward to develop a risk adjustment model for the Medicaid population.
- Adaptation:
  - Rates reported by two age groups: Ages 18-64, and 65 and older
- 18 states reported FFY 2013
  - 14 states reported Medicaid Adult Core Set specifications
  - 4 state used different specifications
- Challenges: Risk-adjustment methodology and denominator exclusions
  - States encouraged to report unadjusted readmission rates for FFY 2014, because there are no standardized risk-adjustment tables for Medicaid
- Reasons states did not report (n=12):
  - Information was not collected because the measure was not identified as a key priority (5)
  - Other reasons: Budget constraints, staff constraints, data inconsistencies/accuracy, data source not easily accessible, other

0021 – Annual Monitoring for Patients on Persistent Medications

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0021

Description:	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)
Exclusions:	For Members on Anticonvulsants: (optional) Members who had an inpatient (acute or nonacute) claim/encounter during the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data, Laboratory, Pharmacy
Level of Analysis:	Group/Practice, Individual, Team, Health Plan
Care Setting:	Ambulatory Surgery Center (ASC), Clinician Office/Clinic, Urgent Care, Laboratory, Pharmacy
Alignment:	HEDIS, Health Insurance Marketplace Quality Rating System

0021 – Annual Monitoring for Patients on Persistent Medications

NQF Endorsed – Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - Rates reported in two age groups: Ages 18-64, and 65 and older
- 22 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications, based on HEDIS 2013
- Challenges: Coding
  - Link to NCQA list of National Drug Codes for ACE inhibitors/ARB medications
- Reasons states did not report (n=8):
  - Information was not collected because the measure was not identified as a key priority (5)
  - Other reasons: Requires data linkage which does not currently exist, other

Medication Management Measures

- Prior MAP Recommendation: CMS should retain the measure in the set for the time being, monitor measure development in this topic area, and update or replace the measures as soon as a suitable alternative is available.
- Are any of the following preferred for use in the Core Set?
  - 0097 – Medication Reconciliation
  - 0419 – Documentation of Current Medications in the Medical Record
  - 0541 – Proportion of Days Covered (PDC)- 3 Rates by Therapeutic Category
  - 0546 – Diabetes: Appropriate Treatment of Hypertension

0097 – Medication Reconciliation

NQF Endorsed
Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0097

Description:	Percentage of patients aged 18 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days of discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist who had reconciliation of the discharge medications with the current medication list in the outpatient medical record documented. This measure is reported as two rates stratified by age group: 18-64 and 65+.
Exclusions:	N/A
Data Source:	Administrative claims, Electronic Clinical Data
Level of Analysis:	Clinician: Individual, Population: National
Care Setting:	Ambulatory Care: Clinician Office/Clinic, Home Health
Alignment:	Medicare Shared Savings Program, PQRS

0419 – Documentation of Current Medications in the Medical Record

NQF Endorsed – Steward: Centers for Medicare & Medicaid Services

QPS Link: http://www.qualityforum.org/qps/0419

Description:	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration
Exclusions:	For Members on Anticonvulsants: (optional) Members who had an inpatient (acute or nonacute) claim/encounter during the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data: Registry
Level of Analysis:	Clinician: Individual, Population: National
Care Setting:	Clinician Office/Clinic, Outpatient Behavioral Health/Psychiatric Facility, Dialysis Facility, Home Health, Other, Inpatient Rehabilitation Facility, Nursing, Home/Skilled Nursing Facility
Alignment:	Meaningful Use Stage 2 – Eligible Professionals, PQRS

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

NQF Endorsed – Steward: Pharmacy Quality Alliance

QPS Link: http://www.qualityforum.org/qps/0541

Description:	The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Beta-Blockers (BB), Renin Angiotensin System (RAS) Antagonists, Calcium-Channel Blockers (CCB), Diabetes Medications, Statins.
Exclusions:	Exclusion criteria for the PDC category of Diabetes medications: Patients who have one or more prescriptions for insulin in the measurement period.
Data Source:	Electronic Clinical Data: Pharmacy
Level of Analysis:	Clinician: Group/Practice, Team, Health Plan
Care Setting:	Ambulatory Care: Clinician Office/Clinic, Pharmacy
Alignment:	Meaningful Use Stage 2 – Eligible Professionals, PQRS

0546 – Diabetes: Appropriate Treatment of Hypertension

NQF Endorsed – Steward: Pharmacy Quality Alliance

QPS Link: http://www.qualityforum.org/qps/0546

Description:	The percentage of patients who were dispensed a medication for diabetes and hypertension that are receiving an angiotensin-converting – enzymeinhibitor (ACEI) or angiotensin receptor blocker (ARB) or direct renin inhibitor (DRI) renin-angiotensin-antagonist medication.
Exclusions:	N/A
Data Source:	Electronic Clinical Data: Pharmacy
Level of Analysis:	Clinician: Group/Practice, Clinician: Team, Health Plan
Care Setting:	Ambulatory Care: Clinician Office/Clinic, Pharmacy
Alignment:	

0063 – Comprehensive Diabetes Care: LDL-C Screening

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0063

Description:	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.
Exclusions:	Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes. Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data: Laboratory, Paper Medical Records
Type:	Process
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic, Pharmacy
Alignment:	PQRS, HEDIS

0063 – Comprehensive Diabetes Care: LDL-C Screening

NQF Endorsed – Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - Rates reported in two age groups: Ages 18-64, and 65 and older
- 29 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: Coding
  - Link to NCQA list of National Drug Codes for insulin or oral hypoglycemic/antihyperglycemic medications
- Reasons states did not report (n=1): Other

0057 – Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0057

Description:	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.
Exclusions:	Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes. Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records
Type:	Process
Level of Analysis:	Clinician: Group/Practice, Individual, Health Plan, Integrated Delivery System, Population: National, Regional, State
Care Setting:	Clinician Office/Clinic
Alignment:	PQRS, HEDIS, Health Insurance Marketplace Quality Rating System

0057 – Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

NQF Endorsed – Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - Rates reported by two age groups: Ages 18-64, and 65-75
- 29 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: Coding
  - Link to NCQA list of National Drug Codes for medications to treat diabetes
- Reasons states did not report (n=1): Other

0272 – Diabetes Short-Term Complications Admission Rate (PQI 01)

NQF Endorsed – Steward: Agency for Healthcare Research and Quality

QPS Link: http://www.qualityforum.org/qps/0272

Description:	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.
Exclusions:	Not applicable
Data Source:	Administrative claims
Type:	Outcome
Level of Analysis:	Population: County or City, State
Care Setting:	Hospital/Acute Care Facility
Alignment:	

0272 – Diabetes Short-Term Complications Admission Rate (PQI 01)

NQF Endorsed – Steward: Agency for Healthcare Research and Quality

Implementation:

- Adaptation:
  - Rates reported by two age groups: Ages 18-64, and 65 and older
  - Eligible population criteria reflect reporting per 100,000 member months for Medicaid enrollees ages 18 and older
- 23 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: Determining eligible population
  - Changes to numerator and denominator to account for part-year Medicaid enrollees
  - Update specifications late in reporting year
- Reasons states did not report (n=7):
  - Information was not collected because the measure was not identified as a key priority (6)
  - Other reasons: Other (1)

0277 – Congestive Heart Failure (CHF) Admission Rate (PQI 08)

NQF Endorsed – Steward: Agency for Healthcare Research and Quality

QPS Link: http://www.qualityforum.org/qps/0277

Description:	Percent of county population with an admissions for heart failure.
Exclusions:	None
Data Source:	Administrative claims
Type:	Outcome
Level of Analysis:	Population: County or City, State
Care Setting:	Clinician Office/Clinic, Hospital/Acute Care Facility
Alignment:	Medicare Shared Savings Program

0277 – Congestive Heart Failure (CHF) Admission Rate (PQI 08)

NQF Endorsed – Steward: Agency for Healthcare Research and Quality

Implementation:

- Adaptation:
  - Rates reported by two age groups: Ages 18-64, and 65 and older
  - Eligible population criteria reflect reporting per 100,000 member months for Medicaid enrollees ages 18 and older
- 23 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: Determining eligible population
  - Changes to numerator and denominator to account for part-year Medicaid enrollees
  - Update to specifications late in reporting year
- Reasons states did not report (n=7):
  - Information was not collected because the measure was not identified as a key priority (6)
  - Other reasons: Other (1)

0283 – Adult Asthma Admission Rate (PQI 15)

NQF Endorsed – Steward: Agency for Healthcare Research and Quality

QPS Link: http://www.qualityforum.org/qps/0283

Description:	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.
Exclusions:	None
Data Source:	Administrative claims
Type:	Outcome
Level of Analysis:	Population: County or City
Care Setting:	Clinician Office/Clinic
Alignment:	

0283 – Adult Asthma Admission Rate (PQI 15)

NQF Endorsed – Steward: Agency for Healthcare Research and Quality

Implementation:

- Adaptation:
  - Reported for ages 18-39
  - Eligible population criteria reflect reporting per 100,000 member months for Medicaid enrollees
- 23 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications, based on AHRQ
- Challenges: Determining eligible population
  - Changes to numerator and denominator to account for part-year Medicaid enrollees
  - Update specifications late in reporting year
- Reasons states did not report (n=7):
  - Information was not collected because the measure was not identified as a key priority (6)
  - Other reasons: Other (1)

Alternative Asthma Measures

- Are any of the following preferred for use in the Core Set?
  - 0548 – Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT)
  - 1799 – Medication Management for People with Asthma
  - 1800 – Asthma Medication Ratio

0548 – Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT)

NQF Endorsed – Steward: Pharmacy Quality Alliance

QPS Link: http://www.qualityforum.org/qps/0548

Description:	Rate 1 (SAC): The percentage of patients aged 5-50 years as of the last day of the measurement year with persistent asthma who were dispensed more than 3 canisters of a short-acting beta2 agonist inhaler during the same 90-day period. Rate 2 (ACT): The percentage of patients aged 5-50 years as of the last day of the measurement year with persistent asthma who were dispensed more than 3 canisters of short acting beta2 agonist inhalers over a 90-day period and who did not receive controller therapy during the same 90-day period.
Exclusions:	For rates 1 & 2, exclude any patient who filled: One or more prescriptions for a COPD medication during the measurement year; or One or more prescriptions for a cystic fibrosis medication during the measurement year; or One or more prescriptions for a nasal steroid medication during the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data: Pharmacy
Level of Analysis:	Health Plan
Care Setting:	Pharmacy
Alignment:	

1799 – Medication Management for People with Asthma

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/1799

Description:	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates : 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.
Exclusions:	1) Exclude patients who had any diagnosis of Emphysema (Emphysema Value Set, Other Emphysema Value Set), COPD (COPD Value Set), Chronic Bronchitis (Obstructive Chronic Bronchitis Value Set, Chronic Respiratory Conditions Due To Fumes/Vapors Value Set), Cystic Fibrosis (Cystic Fibrosis Value Set) or Acute Respiratory Failure (Acute Respiratory Failure Value Set) any time during the patient's history through the end of the measurement year (e.g., December 31). 2) Exclude any patients who have no asthma controller medications (Table AMR-A) dispensed during the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Ambulatory Care: Clinician Office/Clinic, Pharmacy
Alignment:	HEDIS, Health Insurance Marketplace Quality Rating System

1800 – Asthma Medication Ratio

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/1800

Description:	The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Exclusions:	1) Exclude patients who had any diagnosis of Emphysema (Emphysema Value Set, Other Emphysema Value Set), COPD (COPD Value Set), Chronic Bronchitis (Obstructive Chronic Bronchitis Value Set, Chronic Respiratory Conditions Due To Fumes/Vapors Value Set), Cystic Fibrosis (Cystic Fibrosis Value Set) or Acute Respiratory Failure (Acute Respiratory Failure Value Set) any time during the patient's history through the end of the measurement year (e.g., December 31). 2) Exclude any patients who have no asthma controller medications (Table AMR-A) dispensed during the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data, Paper Medical Records
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic, Inpatient Rehabilitation Facility, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility
Alignment:	HEDIS

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0275 – Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (PQI 05)

NQF Endorsed – Steward: Agency for Healthcare Research and Quality

QPS Link: http://www.qualityforum.org/qps/0275

Description:	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population. See Notes.
Exclusions:	Exclude cases: • transferring from another institution (SID ASOURCE=2) • MDC 14 (pregnancy, childbirth, and puerperium) • MDC 15 (newborn and other neonates)
Data Source:	Administrative claims
Type:	Outcome
Level of Analysis:	Population: County or City
Care Setting:	Hospital/Acute Care Facility
Alignment:	Medicare Shared Savings Program

0275 – Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (PQI 05)

NQF Endorsed – Steward: Agency for Healthcare Research and Quality

Implementation:

- Adaptation:
  - Rates reported by two age groups: Ages 18-64, and 65 and older
  - Eligible population criteria reflect reporting per 100,000 member months for Medicaid enrollees ages 18 and older
- 23 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: Determining eligible population
  - Changes to numerator and denominator to account for part-year Medicaid enrollees
  - Update to specifications late in reporting year
- Reasons states did not report (n=7):
  - Information was not collected because the measure was not identified as a key priority (6)
  - Other reasons: Other (1)

Review Highlights of from Previous Day

Highlights from Day 1

- Achieving CMS Goals for Participation in the Program
  - Strategic issues for the Medicaid Adult Core Set reporting
  - Provide ongoing TA support to enhance consistency
  - Use of measures for internal and external comparisons
- Presentations from States
  - Diverse state populations, programs, benefits, structures
  - Burden of reporting on strained budgets
  - Alignment with other state and federal reporting programs
  - Tension of using standardized measures for comparisons and specifying measures to the population

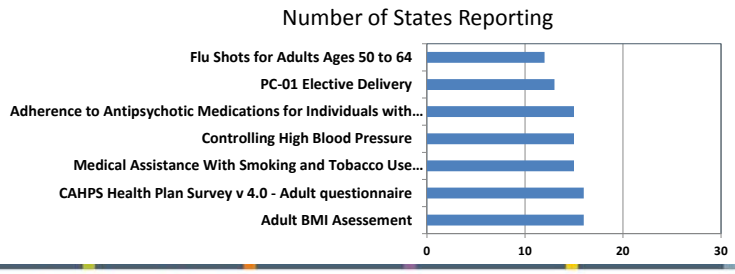
Highlights from Day 1

- Review of the Core Set measures
  - Feedback on existing measures to stewards
    - » Update measures with current guidelines
    - » Crosswalk with Child Core Set
  - Direction for the future of measurement
    - » Risk-adjustment
    - » Collection burden (hybrid measures, medical record review, registries)
    - » Return on Investment and identification of measures that drive improvement
    - » Understanding the beneficiary perspectives

Measure by Measure Review (continued from Day 1)

Measure by Measure Review: Measures with Moderate Levels of Reporting

- Some issues with measures, many are likely to be resolved in the new technical specifications manual
- Should the measures be maintained in the Core Set or is there concern about the use of the measure in the Core Set?
- Are there suggested changes to the application of the measures to increase reporting?



Measure by Measure Review: Measures with Moderate Levels of Reporting

Measures of Mental and Behavioral Health Topics

- 1879 -Adherence to Antipsychotics for Individuals with Schizophrenia

- Related measures discussed in other sections:
  - 0576 – Follow-Up After hospitalization for Mental Illness
  - 0105 – Antidepressant Medication Management
  - 0004 – Initiation and Engagement of Alcohol and Other Drug Related Dependence Treatment
  - 0418 – Screening for Clinical Depression and Follow-Up Plan

1879 -Adherence to Antipsychotics for Individuals with Schizophrenia

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/1879

Description:	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).
Exclusions:	Individuals with any diagnosis of dementia during the measurement period
Data Source:	Administrative claims, Electronic Clinical Data: Pharmacy, Other
Type:	Process
Level of Analysis:	Clinician: Group/Practice, Health Plan, Population: State
Care Setting:	Clinician Office/Clinic, Behavioral Health/Psychiatric: Outpatient
Alignment:	HEDIS

1879 -Adherence to Antipsychotics for Individuals with Schizophrenia

NQF Endorsed – Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - Rates reported in two age groups: Ages 18-64, and 65 and older
- 15 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: Coding
  - Link to NCQA list of National Drug Codes for antipsychotic medications
- Reasons states did not report (n=14):
  - Information was not collected because the measure was not identified as a key priority (11)
  - Other reasons: Requires medical record review, other

Measure by Measure Review: Measures with moderate levels of reporting

Measures of Chronic Disease and Care Coordination

- 0018 – Controlling High Blood Pressure
- N/A – Adult BMI Assessment

- Related measures discussed in other sections:
  - 1768 – Plan All-Cause Readmission
  - 0021 –Annual Monitoring for Patients on Persistent Medications
  - 0063 – Comprehensive Diabetes Care: LDL-C Screening
  - 0057 – Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
  - PQI Measures
    - 0272 – Diabetes Short-Term Complications Admission Rate (PQI 01)
    - 0277 – Congestive Heart Failure (CHF) Admission Rate (PQI 08)
    - 0275 – Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (PQI 05)
    - 0283 – Adult Asthma Admission Rate (PQI 15)
  - 0648 – Care Transition – Transition Record Transmitted to Health Care Professional

0018 – Controlling High Blood Pressure

NQF Endorsed
Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0018

Description:	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.
Exclusions:	Exclude all patients with evidence of ESRD on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD. Exclude all patients with a diagnosis of pregnancy during the measurement year. Exclude all patients who had an admission to a nonacute inpatient setting during the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data, Paper Medical Records
Type:	Outcome
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic, Urgent Care
Alignment:	Meaningful Use Stage 2 - Eligible Professionals, Medicare Shared Savings Program, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System

0018 – Controlling High Blood Pressure

NQF Endorsed
Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - Rates reported by two age groups: Ages 18-64, and 65 and older
- 15 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: None reported
- Reasons states did not report (n=15):
  - Requires medical record review (11)
  - Information was not collected because the measure was not identified as a key priority (4)
  - Other reasons: Budget constraints, not collected by provider

N/A – Adult BMI Assessment

Not NQF Endorsed
Steward: National Committee for Quality Assurance

Description:	The percentage of Medicaid Enrollees ages 18 to 74 who had an outpatient visit and whose body mas index (BMI) was documented during the measurement year or the year prior to the measurement year.
Exclusions:	Enrollees who had a diagnosis of pregnancy during the measurement year or the year prior to the measurement year.
Data Source:	Administrative Data, Electronic Clinical Data, Paper Medical Record
Type:	Process
Level of Analysis:	Clinician: Individual, Clinician: Group/ Practice, Health Plan, Population: National
Care Setting:	Clinician Office/ Clinic
Alignment:	HEDIS, Health Insurance Marketplace Quality Rating System

N/A – Adult BMI Assessment

Not NQF Endorsed
Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - Rates reported by two age groups: ages 18-64 and 65-74
- 16 states reported FFY 2013
  - All 16 states reported Medicaid Adult Core Set specifications
- Challenges: Data Source
  - Concerns that administrative data alone results in underreporting, BMI codes are not always reported in claims
  - Hybrid specifications address underreporting, but is more costly and burdensome to providers
- Reasons states did not report (n=14):
  - Information was not collected because the measure was not identified as a key priority (6)
  - Other reasons: Budget constraints, data source not easily accessible, medical record review, other

MAP Prior Recommendation

- The measure should be updated or replaced with an endorsed measure to address this important topic.
- MAP recommends NQF #0421 Preventive Care and Screening: BMI Screening and Follow-up as an alternative if the measure is not updated and submitted for further review in the near future.

0421 – Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

NQF Endorsed – Steward: Centers for Medicare & Medicaid

QPS Link: http://www.qualityforum.org/QPS/0421

Description:	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25
Exclusions:	Patient is receiving palliative care, Patient is pregnant, Patient refuses BMI measurement (refuses height and/or weight), Any other reason documented in the medical record by the provider why BMI calculation or follow-up plan was not appropriate, Patient is in an urgent or emergent medical situation
Data Source:	Administrative claims, Electronic Clinical Data: Electronic Health Record, Registry, Paper Medical Records
Type:	Process
Level of Analysis:	Group/Practice, Individual, Population: County or City, National, Regional, State
Care Setting:	Clinician Office/Clinic
Alignment:	HEDIS

Measure by Measure Review: Measures with moderate levels of reporting

Consumer Assessment of Healthcare Providers Survey (CAHPS) Measures

- 0006 – CAHPS Health Plan Survey v 4.0 – Adult Questionnaire
- 0027 – Medical Assistance with Smoking and Tobacco Use Cessation
- N/A - Flu Shots for Adults Ages 50-64

0006 – CAHPS Health Plan Survey v 4.0 – Adult Questionnaire

NQF Endorsed – Steward: Agency for Healthcare Research and Quality

QPS Link: http://www.qualityforum.org/qps/0006

Description:	30-question core survey of adult health plan members that assesses the quality of care and services they receive.
Exclusions:	None
Data Source:	Patient Reported Data/Survey
Type:	Patient Engagement/Experience
Level of Analysis:	Health Plan
Care Setting:	Clinician Office/Clinic
Alignment:	Medicare Shared Savings Program, Health Insurance Marketplace Quality Rating System
Notes:	Four global rating questions reflect overall satisfaction Five composite scores summarize response in key areas: Customer service, getting care quickly, getting needed care, how well doctors communicate, shared decision making Summary results reported for the rating questions and composite scores, including two additional concepts: health promotion and education, and care coordination

0006 – CAHPS Health Plan Survey v 4.0 – Adult Questionnaire

NQF Endorsed – Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - Rates reported in two age groups: Ages 18-64, and 65 and older
- 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
- Challenges: Data source and vendor
  - States encouraged to collect CAHPS 5.0Husing NCQA-certified CAHPS survey vendor
- Reasons states did not report (n=14):
  - Information was not collected because the measure was not identified as a key priority (6)
  - CAHPS survey not collected (5)
  - Other reasons: Budget constraints, data inconsistencies/accuracy, other

0039 - Flu Vaccinations for Adults Ages 18 and Older

NQF Endorsed
Steward: National Committee for Quality Assurance

QPS Link: www.qualityforum.org/qps/0039

Description:	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.
Exclusions:	None
Data Source:	Patient Reported Data/Survey
Type:	Process
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic, Hospital/Acute Care Facility, Pharmacy, Inpatient Rehabilitation Facility, Nursing Home/Skilled Nursing Facility
Alignment:	HEDIS, Health Insurance Marketplace Quality Rating System

0039 - Flu Vaccinations for Adults Ages 18 and Older

NQF Endorsed

Steward: National Committee for Quality Assurance

Implementation:

- Adaptation: None
- 12 states reported FFY 2013
  - 11 states reported Medicaid Adult Core Set specifications
- Challenges: Methodology
  - States should capture flu vaccinations for all adult Medicaid enrollees
  - HEDIS no longer requires 2 year rolling average
- Reasons states did not report (n=18):
  - Information was not collected because the measure was not identified as a key priority (11)
  - Other reasons: Budget constraints, medical record review, data not collected by provider, other

Prior MAP Recommendation:

- 2014 specifications reflect uptake of MAP recommendation
- Flu Shots for Adults Ages 50-64 excludes Medicaid enrollees 18-49, a large portion of the Medicaid population. Expand the measure to include all adults.
  - NCQA completed an update to the measure and the currently NQF Endorsed version is 0039 Flu Vaccination for Adults Ages 18 and older
  - Incorporates all adults and includes two age ranges: 18-64, and 65 and older
  - Included in HEDIS and collected through CAHPS specifications

0027 – Medical Assistance with Smoking and Tobacco Use Cessation

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0027

Description:	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 patients 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year. **Discussing Cessation Medications:** A rolling average represents the percentage of patients 18 years of age and older who are 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 patients 18 years of age and older who are current smokers or tobacco users who discussed or were provided smoking cessation methods or strategies during the measurement year.
Data Source:	Patient Reported Data/Survey
Type:	Process
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Clinician Office/Clinic, Other
Alignment:	PQRS, HEDIS, Health Insurance Marketplace Quality Rating System

0027 – Medical Assistance with Smoking and Tobacco Use Cessation

NQF Endorsed – Steward: National Committee for Quality Assurance

Implementation:

- Adaptation:
  - Rates reported by two age groups: Ages 18-64, and 65 and older
- 15 states reported FFY 2013
  - 14 states reported Medicaid Adult Core Set Specifications
  - 1 state reported using CAHPS-like survey
- Challenges: Data Source
  - Clarification for reporting measure based on CAHPS 4.0H and 5.0H survey
- Reasons states did not report (n=15):
  - Information was not collected because the measure was not identified as a key priority (5)
  - Other reasons: Entire population not covered, budget constraints, data source not easily accessible, other, small sample size

0028 – Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

NQF Endorsed – Steward: American Medical Association - Physician Consortium for Performance Improvement

QPS Link: http://www.qualityforum.org/qps/0028

Description:	Percentage of patients aged 18 years and older who werescreened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user
Data Source:	Administrative claims, Paper Medical Records, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Registry
Type:	Process
Level of Analysis:	Clinician: Group/Practice, Individual, Team
Care Setting:	Clinician Office/Clinic, Behavioral Health/Psychiatric: Inpatient and Outpatient, Other
Alignment:	Meaningful Use Stage 2 – Eligible Professionals, Medicare Shared Savings Program, PQRS

Measure by Measure Review: Measures with Moderate Levels of Reporting

Measures of Women's Health and Related Topics

- 0469 – PC-01 Elective Delivery

- Related measures to be discussed in another section:
  - 1517 – Prenatal and Postpartum Care: Postpartum Care Rate
  - 0032 – Cervical Cancer Screening
  - 0031 – Breast Cancer Screening
  - 0033 – Chlamydia Screening in Women Ages 21-24
  - 0476 – PC-03 Antenatal Steroids

0469 – PC-01 Elective Delivery

NQF Endorsed
Steward: The Joint Commission

QPS Link: http://www.qualityforum.org/qps/0469

Description:	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed.
Exclusions:	• ICD-9-CM Principal Diagnosis Code or Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Enrolled in clinical trials • Gestational Age < 37 or >= 39 weeks
Data Source:	Administrative claims, Electronic Clinical Data, Paper Medical Records
Type:	Process
Level of Analysis:	Facility, National
Care Setting:	Hospital/Acute Care Facility
Alignment:	Hospital Inpatient Quality Reporting, Meaningful Use Stage 2-Hospitals, CAHs

0469 – PC-01 Elective Delivery

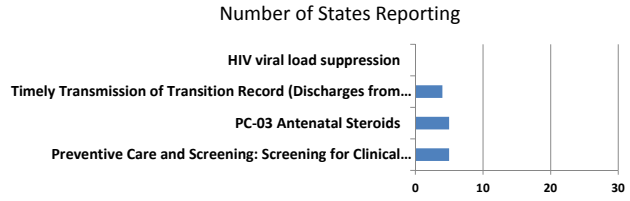
NQF Endorsed
Steward: The Joint Commission

Implementation:

- Note: Includes Medicaid and CHIP enrolled females at risk of preterm delivery
  - Related: NQF #0471 PC-02 Cesarean Section reported in the Child Core Set and NQF #0476 PC-03 Antenatal Steroids reported in the Medicaid Adult Core Set
- 13 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: Data source and calculation
  - Medical record review required to determine numerator and denominator
  - Sampling of medical records and use of vital records data to determine gestational age.
  - CMS and CDC assisting states in collecting and using vital records data through training series on data linkage
- Reasons states did not report (n=17):
  - Information was not collected, the measure was not identified as a key priority (7)
  - Requires medical record review (7)
  - Requires data linkage which does not currently exist (4)
  - Other reasons: Service not covered, staff constraints, other

Measure by Measure Review: Measures with few States reporting and/or significant reporting challenges

- Three measures with data collection challenges due to burden of medical record review
- Should these measures be maintained in the Core Set? Are there suggested changes to the application of the measures?
- Should state technological capacity be supported to increase reporting and reduce burden of hybrid data collection?
- (HIV Viral Load Suppression will be collected for the first time in FFY 2014)



Measure by Measure Review: Measures with few States reporting and/or significant reporting challenges

Measures of Women's Health and Related Topics

- 0476 – PC-03 Antenatal Steroids

- Related measures to be discussed in another section:
  - 1517 – Prenatal and Postpartum Care: Postpartum Care Rate
  - 0032 – Cervical Cancer Screening
  - 0031 – Breast Cancer Screening
  - 0033 – Chlamydia Screening in Women Ages 21-24
  - 0469 – PC-01 Elective Delivery

0476 – PC-03 Antenatal Steroids

NQF Endorsed
Steward: The Joint Commission

QPS Link: http://www.qualityforum.org/qps/0476

Description:	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns.
Exclusions:	• Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Enrolled in clinical trials • Documented Reason for Not Initiating Antenatal Steroid Therapy • ICD-9-CM Principal Diagnosis Code or Other Diagnosis Codes for fetal demise • Gestational Age < 24 or >= 32 weeks
Data Source:	Administrative claims, Electronic Clinical Data: Registry, Paper Medical Records
Type:	Process
Level of Analysis:	Facility, Population: National
Care Setting:	Hospital/Acute Care Facility
Alignment:	

0476 – PC-03 Antenatal Steroids

NQF Endorsed
Steward: The Joint Commission

Implementation:

- Notes: Includes Medicaid and CHIP enrolled females at risk of preterm delivery
  - Related: NQF #0471 PC-02 Cesarean Section reported in the Child Core Set and NQF #0469 PC-01 Elective Delivery reported in the Medicaid Adult Core Set
- 5 states reported FFY 2013
  - All used Medicaid Adult Core Set specifications
- Challenges: Data source and calculation
  - Medical record review to determine numerator and denominator
  - Sampling of medical records and use of vital records data to determine gestational age
  - CMS and CDC assisting states in collecting and using vital records data through training series on data linkage
- Reasons states did not report (n=25):
  - Requires medical record review (13)
  - Information was not collected because the measure was not identified as a key priority (12)
  - Requires data linkage which does not currently exist (6)
  - Other reasons: Budget constraints, staff constraints, data inconsistencies/accuracy, other

Measure by Measure Review: Measures with few States reporting and/or significant reporting challenges

Measures of Mental and Behavioral Health Topics

- 0418 – Screening for Clinical Depression and Follow-Up Plan

- Related measures discussed in previous sections:
  - 0576 – Follow-Up After hospitalization for Mental Illness
  - 0105 – Antidepressant Medication Management
  - 0004 – Initiation and Engagement of Alcohol and Other Drug Related Dependence Treatment
  - 1879 -Adherence to Antipsychotics for Individuals with Schizophrenia

0418 – Screening for Clinical Depression and Follow-Up Plan

NQF Endorsed – Steward: Centers for Medicare & Medicaid Services

QPS Link: http://www.qualityforum.org/qps/0418

Description:	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented
Exclusions:	Several exclusions, including referral with diagnosis with depression, participation in on-going treatment with screening of clinical depression, individuals with motivation to improve may impact the results such as in certain court appointed cases, severe mental or physical incapacity
Data Source:	Administrative claims, Electronic Health Record, Paper Medical Records
Type:	Process
Level of Analysis:	Clinician: Group, Individual, Team, Community, County/City, National, Regional, State
Care Setting:	Clinician Office/Clinic, Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Long Term Acute Care Hospital, Nursing Home/Skilled Nursing Facility
Alignment:	MU Stage 2 - Eligible Professionals, Medicare Shared Savings Program, PQRS

0418 – Screening for Clinical Depression and Follow-Up Plan

NQF Endorsed – Steward: Centers for Medicare & Medicaid Services

Implementation:

- Adaptations:
  - Rates reported by two age groups: 18-64, and 65 and older; Original included 12 and older
  - 2 G-codes compared to the original 6 were included in numerator to identify screening, and, if positive, follow-up plan documentation on the same day
- 5 states reported FFY 2013
  - 4 states reported Medicaid Adult Core Set specifications
  - 1 state reported PCMH measure (includes screening for 24 mo. but not follow-up plan)
- Challenges: Coding and calculating numerator and denominator
  - Clarification for reporting based on ICD-9 codes instead of CPT or G-codes
  - Numerator: screening and encounter should occur on the same day
  - Denominator: medical record review required to determine exclusions
  - CMS is currently developing hybrid specifications for the future
- Reasons states did not report (n=25):
  - Requires medical record review (10)
  - Information was not collected because the measure was not identified as a key priority (8)
  - Other reasons: Service not covered, budget constraints, data inconsistencies/accuracy, not collected by provider, other

Measure by Measure Review: Measures with few States reporting and/or significant reporting challenges

Measures of Chronic Disease and Care Coordination

- 0648 – Care Transition – Transition Record Transmitted to Health Care Professional

- Related measures discussed in other sections:
  - 1768 – Plan All-Cause Readmission
  - 0063 – Comprehensive Diabetes Care: LDL-C Screening
  - 0057 – Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
  - 2371– Annual Monitoring for Patients on Persistent Medications
  - PQI Measures
    - 0272 – Diabetes Short-Term Complications Admission Rate (PQI 01)
    - 0277 – Congestive Heart Failure (CHF) Admission Rate (PQI 08)
    - 0275 – Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (PQI 05)
    - 0283 – Adult Asthma Admission Rate (PQI 15)
  - 0018 – Controlling High Blood Pressure
  - N/A – Adult BMI Assessment

0648 – Care Transition – Transition Record Transmitted to Health Care Professional

NQF Endorsed – Steward: AMA-PCPI

QPS Link: http://www.qualityforum.org/qps/0648

Description:	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, 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
Exclusions:	Patients who died Patients who left against medical advice (AMA) or discontinued care
Data Source:	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records
Type:	Process
Level of Analysis:	Facility, Integrated Delivery System
Care Setting:	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Nursing Home/Skilled Nursing Facility
Alignment:	

0648 – Care Transition – Transition Record Transmitted to Health Care Professional

NQF Endorsed – Steward: AMA-PCPI

Implementation:

- Adaptation:
  - Rates reported in two age groups: Ages 18-64, and 65 and older
- 4 states reported FFY 2013
  - All states reported the Medicaid Adult Core Set specifications
- Challenges: Data collection
  - Numerator elements require medical record review
- Reasons states did not report (n=26):
  - Requires medical record review (14)
  - Information was not collected because the measure was not identified as a key priority (11)
  - Requires data linkage which does not currently exist (10)
  - Other reasons: Budget constraints, staff constraints, not collected by provider, other

MAP Prior Recommendation

- Measures #0647 and 0648 are *paired measures* designed to be used together but only #0648 is included in the Core Set.
  - 2036 Transition record received by discharged patients and transmitted to facility (Paired Measure)
- CMS should consider adding #0647 "Transition Record with Specified Elements Received by Discharged Patients" to the measure set; doing so enhances person-centeredness and may also improve the feasibility of data collection for #0648.

0647 – Transition Record with Specified Elements Received by Discharged Patients

NQF Endorsed – Steward: AMA-PCPI

QPS Link: http://www.qualityforum.org/qps/0647

Description:	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements
Exclusions:	Patients who died Patients who left against medical advice (AMA) or discontinued care
Data Source:	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records
Type:	Process
Level of Analysis:	Facility, Integrated Delivery System
Care Setting:	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Nursing Home/Skilled Nursing Facility
Alignment:	

2082 – HIV Viral Load Suppression

NQF Endorsed

Steward: Health Resources and Services Administration - HIV/AIDS Bureau

QPS Link: http://www.qualityforum.org/qps/2082

Description:	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.
Exclusions:	There are no patient exclusions.
Data Source:	Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Laboratory, Paper Medical Records
Type:	Outcome
Level of Analysis:	Clinician: Group/Practice, Facility
Care Setting:	Clinician Office/Clinic
Alignment:	

2082 – HIV Viral Load Suppression

NQF Endorsed

Steward: Health Resources and Services Administration - HIV/AIDS Bureau

Implementation: Will be reported for the first time FFY 2014

- Prior MAP Recommendation: In cases when a measure has lost endorsement but the steward has no intention to provide an update, use of the measure should stop and a suitable replacement on the same topic be identified.
  - Annual HIV/AIDS Medical Visit replaced with #2082 Viral Load Suppression
  - Uptake of recommendation provided in CMCS Informational Bulletin, December 19, 2013

Opportunity for Public Comment

Strategy for Filling High Priority Measure Gaps

Strategy for Filling High Priority Measure Gaps

- Are you aware of specific measures that address identified gaps for that CMS could implement within the next 2 years?
- Can the Task Force communicate just 2-3 highest-priority measure gaps for future development efforts?
  - Does enough evidence exist?
  - Is there a reasonable data source?

Previously Identified Gaps in the Medicaid Adult Core Set

- Mental/behavioral health
  - Substance use and abuse
  - Health screening for individuals with mental illness (potential to develop a composite)
- Disparities-sensitive measures
  - Access to services, particularly for reproductive health services and for individuals with disabilities
- Care coordination
- Person-centered care, patient activation and engagement
- Wrap-around services to mitigate social determinants of health (e.g., transportation)
- Individual goals for care (e.g., functional status, quality of life)

Filling Measure Gaps: Comorbid Conditions

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Agency for Healthcare Research and Quality and the
Office of the Assistant Secretary for Planning and Evaluation

Sarah Hudson Scholle
National Committee for Quality Assurance

Presentation to the MAP Medicaid Task Force, at the National Quality Forum, June 6, 2014

Project Background: Phase I

- Three year measure development project sponsored by ASPE and SAMHSA
- Conducted scan to identify measure gaps
- Held focus groups with stakeholders and TEP meeting in early 2012 to gather input on measure concepts
- Consensus for measures that examine comorbid conditions among populations with behavioral health conditions and for measures of follow up after ED use
- Reviewed strength of evidence for measure concepts

Project Background: Phase II

- Specified measures that assess screening and follow-up care for adults with:
  - Serious mental illness which includes schizophrenia, bipolar disorder, and major depression (SMI)
  - Alcohol and other drug dependence (AOD)
- Specified measure of follow-up after ED visit
- Held second TEP meeting in mid 2013 to gather input on measure specifications prior to testing
- Piloted measures in late 2013 to assess performance
  - Tested screening and follow-up measures in three diverse health plans
  - Tested follow-up after ED measure using Medicaid claims data

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Rationale for Screening & Follow-up Measures

- Higher prevalence of certain comorbid conditions (obesity, hypertension, etc) and negative health behaviors (tobacco use) among people with SMI and/or AOD
- Disparities in care for these conditions
- Contributes to premature mortality
- Effective interventions for these conditions
- Goal is to better monitor whether these subpopulations receive routine care; health plans well-positioned for this

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Rationale for Follow-up After ED Measure

- ED discharge an opportunity to ensure that individual is connected to care
- Health plans have access to information and care management processes to ensure that follow-up care happens

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Measures Under Development

Measure (NQF number of "parent" measure)	SMI	AOD
Tobacco screening & follow-up (# 0028)	✓	✓
BMI screening & follow-up (# 0421)	✓	
Blood pressure screening & follow-up (not endorsed, used in PQRS)	✓	✓
Alcohol use screening & brief counseling (# 2152)	✓	
Depression screening & follow-up (# 0418)		✓
Comprehensive diabetes care (# 0731)	✓	
Blood pressure control (# 0018)	✓	
Follow-up after ED visit for MH or AOD diagnosis (# 0575)	✓	✓

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Diabetes and Blood Pressure Monitoring: Adapted Existing Health Plan Measures for SMI population

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Preventive Care: Adapted Provider-Level Measures to Health Plan Reporting on SMI/AOD Populations

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Approach to Measure Testing

- Screening and Monitoring Measures
  - Piloted measures at three diverse health plans (two Medicaid only plans and one dual plan)
  - Health plans abstracted charts (both paper and electronic) and submitted data to us to calculate performance
- Follow-up After Emergency Department Use measures
  - Tested in Medicaid claims data

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Key Findings from Field Test

- Low rate of ambulatory use contributes to poor performance on quality measures
  - Across the 3 plans, 25 to 99% of SMI members had at least 1 ambulatory visit during measurement year.
- Performance on HEDIS diabetes and hypertension control measures were 14-18% points below the average rates for HEDIS Medicaid plans.
- Screening and follow-up also show room for improvement.

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Current Stage of Project: Phase III

- Recently conducted focus groups with stakeholders to gather feedback on measure performance
- Technical Expert Panel will provide input on measure performance, changes to specifications, and suitability of measures for NQF and reporting
- Refine measure specifications
- Will submit most promising measures for NQF endorsement, July 25, 2014

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Thank you for your time!

Contact:

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0059 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

NQF Endorsed - Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0059

Description:	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
Exclusions:	Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year.
Type:	Outcome
Data Source:	Administrative claims, Electronic Clinical Data: Pharmacy, Other
Level of Analysis:	Group/Practice, Individual Clinician, Health Plan, Integrated Delivery System, Population: National, Regional, State
Care Setting:	Clinician Office/Clinic
Alignment:	Meaningful Use Stage 2 (EHR Incentive Program) - Eligible Professionals, Medicare Shared Savings Program, Physician Quality Reporting System (PQRS)

0647 – Transition Record with Specified Elements Received by Discharged Patients

NQF Endorsed – Steward: AMA-PCPI

QPS Link: http://www.qualityforum.org/qps/0647

Description:	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements
Exclusions:	Patients who died Patients who left against medical advice (AMA) or discontinued care
Data Source:	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records
Type:	Process
Level of Analysis:	Facility, Integrated Delivery System
Care Setting:	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Nursing Home/Skilled Nursing Facility
Alignment:	

1799 – Medication Management for People with Asthma

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/1799

Description:	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates : 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.
Exclusions:	1) Exclude patients who had any diagnosis of Emphysema (Emphysema Value Set, Other Emphysema Value Set), COPD (COPD Value Set), Chronic Bronchitis (Obstructive Chronic Bronchitis Value Set, Chronic Respiratory Conditions Due To Fumes/Vapors Value Set), Cystic Fibrosis (Cystic Fibrosis Value Set) or Acute Respiratory Failure (Acute Respiratory Failure Value Set) any time during the patient's history through the end of the measurement year (e.g., December 31). 2) Exclude any patients who have no asthma controller medications (Table AMR-A) dispensed during the measurement year.
Data Source:	Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Pharmacy
Level of Analysis:	Health Plan, Integrated Delivery System
Care Setting:	Ambulatory Care: Clinician Office/Clinic, Pharmacy
Alignment:	HEDIS, Health Insurance Marketplace Quality Rating System

Top 10 Conditions for Readmission	Current Measures in the Medicaid Adult Core Set	Potential Additions
Septicemia (except in labor)	None	N/A
CHF (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 (PPC)	
Early or threatened labor	**0469** PC-01 Elective Delivery **0476** PC-03 Antenatal Steroids	

Top 10 Conditions for Readmission	Current Measures in the Medicaid Adult Core Set	Potential Additions
Schizophrenia and other Psychotic disorders	Adherence to Antipsychotics for individuals with schizophrenia **0576** Follow-Up After Hospitalization for Mental Illness (FUH)	**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
Mood disorders	**0576** Follow-Up After Hospitalization for Mental Illness **0105** Antidepressant medication management **0576** Follow-Up After Hospitalization for Mental Illness (FUH)	**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 (IET) **0576** Follow-Up After Hospitalization for Mental Illness (FUH)	
Substance related disorders	**0004** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) **0576** Follow-Up After Hospitalization for Mental Illness (FUH)	

Strategic Guidance for Strengthening the Medicaid Adult Core Set

Guidance for Future Medicaid Adult Core Set

- What changes to the reporting program for the Medicaid Adult Core Set would assist CMS in meeting its goals?
  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
- **Which of the gap areas should be the first area of focus?**

Round-Robin Discussion of Themes to Emphasize in Report and Coordinating Committee Review

Draft Report Outline

- Primary Sections:
  - Introduction and Purpose
  - Themes from state experience of collecting and reporting the core set
  - Measure-specific recommendations
  - Plan for addressing measure gaps
  - Strategic issues

Important Dates

- **July 9-30:** Public Comment on draft final report
- **July 18:** MAP Coordinating Committee review of draft final report via web meeting
- **August 30:** Final report due to CMS and made available to the public

Task Force Discussion

- What aspects of the Task Force discussion are most important to capture in MAP's recommendations to HHS?
  - Program features?
  - Individual measures in the Core Set?
  - Implementation?
  - Resulting quality improvement programs within states?

Opportunity for Public Comment

Adjourn

Strategy for Filling High Priority Measure Gaps: Identification of specific measures that address identified gaps for near-term implementation

Diabetes Care

- Existing measures:
  - 0272 - Diabetes Short-Term Complications Admission Rate (PQI 1)
  - 0063 - Comprehensive Diabetes Care: LDL-C Screening
  - 0057 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing
- Potential additions:
  - 0059 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
  - 0575 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)

0575 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)

NQF Endorsed - Steward: Centers for Medicare & Medicaid Services

QPS Link: http://www.qualityforum.org/qps/0575

Description:	The percentage of members 18 - 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year.
Exclusions:	Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year.
Type:	Process
Data Source:	Administrative claims, Electronic Clinical Data, Electronic Health Record, Imaging/Diagnostic Study, Laboratory
Level of Analysis:	Group/Practice, Individual, Health Plan, Integrated Delivery System, Population: National, Regional, State
Care Setting:	Clinician Office/Clinic
Alignment:	Physician Quality Reporting System (PQRS)

Strategy for Filling High Priority Measure Gaps: Identification of specific measures that address identified gaps for near-term implementation

- Mental/behavioral health
  - Substance use and abuse
  - Health screening (potential to develop a composite)
  - Schizophrenia and other Psychotic disorders
  - Mood Disorders
- Potential Gap Filling Measures:
  - 1880 - Adherence to Mood Stabilizers for Individuals with Bipolar Disorder
  - 0580 - Bipolar antimanic agent
  - 1927 – Cardiovascular Screening for people with Schizophrenia or Bipolar Disorders who are prescribe antipsychotic Medications
  - 1932– Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

1880 – Adherence to Mood Stabilizers for Individuals with Bipolar Disorder

NQF Endorsed - Steward: Centers for Medicare & Medicaid Services

QPS Link: http://www.qualityforum.org/qps/1880

Description:	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with bipolar I disorder who are prescribed a mood stabilizer medication, with adherence to the mood stabilizer medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).
Exclusions:	
Type:	Process
Data Source:	Administrative claims, Electronic Clinical Data: Pharmacy, Other
Level of Analysis:	Group/Practice, Health Plan, Integrated Delivery System, Population: State
Care Setting:	Clinician Office/Clinic, Behavioral Health/Psychiatric: Outpatient
Alignment:	

0580 – Bipolar antimanic agent

NQF Endorsed - Steward: Resolution Health Inc.

QPS Link: http://www.qualityforum.org/qps/0580

Description:	This measure identifies the percentage of patients with newly diagnosed bipolar disorder who have received at least 1 prescription for a mood-stabilizing agent during the measurement year.
Exclusions:	The following are excluded: home health stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window (60 days following the start of the home health stay) or until death; home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim; home health stays in which the patient receives service from multiple agencies during the first 60 days; and home health stays for patients who are not continuously enrolled in fee-for service Medicare for the 6 months prior the start of the home health stay.
Type:	Process
Data Source:	Administrative claims, Electronic Clinical Data: Pharmacy
Level of Analysis:	Group/Practice, Individual, Health Plan, Integrated Delivery System, Population: County or City
Care Setting:	Clinician Office/Clinic
Alignment:	

1927 – Cardiovascular Screening for people with Schizophrenia or Bipolar Disorders who are prescribe antipsychotic Medications

NQF Endorsed - Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/1927

Description:	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.
Exclusions:	Individuals are excluded from the denominator if they were discharged alive for a coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) (these events may occur in the measurement year or year prior to the measurement year), or diagnosed with ischemic vascular disease (IVD) (this diagnosis must appear in both the measurement year and the year prior to the measurement year), chronic heart failure, or had a prior myocardial infarction (identified in the measurement year or as far back as possible).
Type:	Process
Data Source:	Administrative claims, Electronic Clinical Data, Electronic Pharmacy Data
Level of Analysis:	Health Plan, Integrated Delivery System, Population: State
Care Setting:	Clinician Office/Clinic, Behavioral Health/Psychiatric: Outpatient, Other
Alignment:	

1932 – Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

NQF Endorsed - Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/1932

Description:	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Exclusions:	Patients are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify patients with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify patients with diabetes, but a patient only needs to be identified by one method to be excluded from the measure.
Type:	Process
Data Source:	Administrative claims, Electronic Clinical Data, Electronic Pharmacy Data
Level of Analysis:	Health Plan, Integrated Delivery System, Population: State
Care Setting:	Clinician Office/Clinic, Other
Alignment:	

Strategy for Filling High Priority Measure Gaps: Identification of specific measures that address identified gaps for near-term implementation

- Care coordination
- Person-centered care, patient activation and engagement
- Potential Gap Filling Measures:
  - *0526 – Timely Initiation of Care*
  - *0173 – Emergency Department Use without Hospitalization*
  - 0646 – Reconciled Medication List Received by Discharged Patients

0526 – Timely Initiation of Care

NQF Endorsed
Steward: Centers for Medicare & Medicaid Services

QPS Link: http://www.qualityforum.org/qps/0526

Description:	Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.
Exclusions:	No measure-specific exclusions.
Data Source:	Electronic Clinical Data
Level of Analysis:	Facility
Care Setting:	Home Health
Alignment:	Home Health Quality Reporting

0173 – Emergency Department Use without Hospitalization

NQF Endorsed - Steward: Centers for Medicare & Medicaid Services

QPS Link: http://www.qualityforum.org/qps/0173

Description:	Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.
Exclusions:	The following are excluded: home health stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator window (60 days following the start of the home health stay) or until death; home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim; home health stays in which the patient receives service from multiple agencies during the first 60 days; and home health stays for patients who are not continuously enrolled in fee-for service Medicare for the 6 months prior the start of the home health stay.
Type:	Outcome
Data Source:	Administrative claims
Level of Analysis:	Facility
Care Setting:	Home Health
Alignment:	

Strategy for Filling High Priority Measure Gaps: Identification of specific measures that address identified gaps for near-term implementation

- Disparities sensitive measures
  - Access to services, particularly for reproductive health services and for individuals with disabilities
- Potential Gap Filling Measures:
  - Suggestions?

0646 – Reconciled Medication List Received by Discharged Patients

NQF Endorsed – Steward: AMA – PCPI

QPS Link: http://www.qualityforum.org/qps/0646

Description:	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories
Exclusions:	Patients who died Patients who left against medical advice (AMA) or discontinued care
Data Source:	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records
Level of Analysis:	Facility, Integrated Delivery System
Care Setting:	Ambulatory Surgery Center (ASC), Hospital/Acute Care Facility, Inpatient Rehabilitation Facility, Nursing Home/Skilled Nursing Facility
Alignment:	

FVA: Flu Shots for Adults Ages 50 to 64

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

A rolling average represents the percentage of Medicaid enrollees ages 50 to 64 who received an influenza vaccination between September 1 of the measurement year and the date when the CAHPS 5.0H adult survey was completed.

Adaptation for the Medicaid Adult Core Set

- Not applicable

Overview of State Reporting

- Twelve states reported the Flu Shots for Adults Ages 50 to 64 measure for FFY 2013.[1]
- Of the 12 states reporting the measure for FFY 2013, 3 states reported the measure for their Medicaid and CHIP populations; 6 included their Medicaid population only; 1 included their Medicaid and Medicare-Medicaid dual-eligible populations; 1 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations; and 1 specified another population.[2]
- In FFY 2013, 11 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications, and 1 state reported the measure using another specification.[3] The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, two TA requests were submitted by two states. States sought clarification about using an alternate methodology and reporting two years of data as a rolling average.
- CMS's TA team developed guidance to assist states in reporting the measure for FFY 2014. This guidance noted that HEDIS 2014 no longer requires a two-year rolling average, but rather captures flu vaccinations for all adult Medicaid enrollees.

Reasons for Not Reporting the Measure

- Eighteen states provided reasons for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

[2] Texas specified "STAR and STAR+Plus managed care populations."

[3] Alabama indicated that a "national steward" was not used in reporting this measure.

Table 1. Reasons for not reporting the Flu Shots for Adults Ages 50 to 64 measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (1)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (1)
  • Requires medical record review (1)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (17)
  • Not identified as key priority area this year (11)
  • Not collected by provider (hospital/health plan) (2)
  • Other (5)
• Other (1)
	18

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-Not included in CAHPS survey.

-While CAHPS is conducted in the adult population, the data are not available to report at this time. Over the next year, state will investigate our capacity to report in FFY2014 as specified in the Adult Core Measures.

-State does not collect CAHPS measures for adults.

-CAHPS survey not administered

Additional Support Provided to States on the Measure

- Not applicable

ABA: Adult Body Mass Index Assessment

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

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.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 to 74.

Overview of State Reporting

- Sixteen states reported the Adult Body Mass Index Assessment measure for FFY 2013.[1]
- Of the 16 states reporting the measure for FFY 2013, 4 states reported the measure for their Medicaid and CHIP populations; 8 included their Medicaid population only; 3 included their Medicaid and Medicare-Medicaid dual-eligible populations; 1 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations; and 1 specified another population.[2]
- In FFY 2013, all 16 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, three TA requests were submitted by three states. The TA topics included:
    - Data sources used to calculate the measure (1 request)
        - Clarification on whether data elements need to be from the same data source
    - Calculation of the denominator (2 requests)
        - Clarification of continuous enrollment criteria
        - Clarification of the measure-eligible population
- Adult Medicaid Quality grantees expressed concern that the measure is underreported when calculated using only administrative data because BMI codes are not always reported on the claim. The measure includes a hybrid specification to address this issue, but grantees noted that the hybrid method is costly and can be burdensome to providers.

[1] The term "states" includes the 50 states and the District of Columbia.

[2] West Virginia specified "managed care population."

Reasons for Not Reporting the Measure

- Fourteen states provided reasons for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

Table 1. Reasons for not reporting the Adult Body Mass Index measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (1)
• Staff constraints (0)
• Data inconsistencies/accuracy (1)
• Data source not easily accessible (3)
  • Requires medical record review (3)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (8)
  • Not identified as key priority area this year (6)
  • Not collected by provider (hospital/health plan) (1)
  • Other (1)
• Other (0)
	11

Small sample size (less than 30)	0
Other	3

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-Not reported by plans for 2012. It is included in plan reporting for 2013. Due to requirements of chart data of measure, we are dependent on plans to report.

-Potential data insufficiency: data is insufficient to calculate. Requires V-codes (V85.0 - V85.5), which may be underutilized by providers.

-Data is insufficient. Accurate and complete calculation requires providers submit V-codes (i.e., V85.0-V85.5). These codes are under reported by providers.

-State is reviewing specifications to implement next year.

-Administrative-only results not representative.

Additional Support Provided to States on the Measure

- Not applicable

BCS: Breast Cancer Screening

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

The percentage of Medicaid-enrolled women ages 42 to 69 who received a mammogram in the measurement year or the year prior to the measurement year.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 42 to 64 and 65 to 69.

Overview of State Reporting

- Twenty-six states reported the Breast Cancer Screening measure for FFY 2013.[1]
- Of the 26 states reporting the measure for FFY 2013, 5 states reported the measure for their Medicaid and CHIP populations; 15 included their Medicaid population only; 4 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 2 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, all 26 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, two TA requests were submitted by two states. States sought clarification about calculating the age ranges and determining the eligible population for the measure.
- As a result of the TA requests, CMS's TA team updated the FFY 2014 technical specification to provide additional guidance on determining the measure-eligible population to account for the look-back period and changes in the HEDIS specifications. The denominator for FFY 2014 reporting should include women who are ages 52 to 74 at the end of the measurement year to account for the 2-year, 3-month look-back period.

Reasons for Not Reporting the Measure

- Four states provided reasons for not reporting the measure; the most common reason for not reporting was "data not available" (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

Table 1. Reasons for not reporting the Breast Cancer Screening measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (0)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (1)
  • Not identified as key priority area this year (1)
  • Not collected by provider (hospital/health plan)
  • Other (0)
• Other (1)
	2

Small sample size (less than 30)	0
Other	2

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-State is reviewing specifications to implement next year.

-Administrative-only data are not representative.

Additional Support Provided to States on the Measure

- Not applicable

CCS: Cervical Cancer Screening

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

The percentage of Medicaid-enrolled women ages 24 to 64 who received one or more Pap tests during the measurement year or the two years prior to the measurement year.

Adaptation for the Medicaid Adult Core Set

- Not applicable

Overview of State Reporting

- Twenty-seven states reported the Cervical Cancer Screening measure for FFY 2013.[1]
- Of the 27 states reporting the measure for FFY 2013, 5 states reported the measure for their Medicaid and CHIP populations; 17 included their Medicaid population only; 2 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 3 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, all 27 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, four TA requests were submitted by four states. States sought clarification about determining the eligible population for the measure.
- As a result of the TA requests, CMS's TA team developed guidance on determining the measure-eligible population to account for the look-back period. The denominator should include women who are ages 24 to 64 at the end of the measurement year to account for the three-year look-back period.

Reasons for Not Reporting the Measure

- Three states provided reasons for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

Table 1. Reasons for not reporting the Cervical Cancer Screening measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (0)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (2)
  • Not identified as key priority area this year (2)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	3

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.

Additional Support Provided to States on the Measure

- Not applicable

MCS: Medical Assistance with Smoking and Tobacco Use Cessation

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

A rolling average represents the percentage of Medicaid enrollees age 18 and older who were current smokers or tobacco users and who received advice to quit, discussed or were recommended cessation medications, and discussed or were provided cessation methods or strategies during the measurement year.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 and older.

Overview of State Reporting

- Fifteen states reported the Medical Assistance with Smoking and Tobacco Use Cessation measure for FFY 2013.[1]
- Of the 15 states reporting the measure for FFY 2013, 5 states reported the measure for their Medicaid and CHIP populations; 7 included their Medicaid population only; 2 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 1 included their Medicaid, CHIP, and dual-eligible populations.
- In FFY 2013, 14 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications, and 1 state reported the measure using another specification.[2] The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, four TA requests were submitted by four states. States sought clarification about reporting the measure, use of the CAHPS 4.0H versus 5.0H survey, and whether an alternate data source could be used.

Reasons for Not Reporting the Measure

- Fifteen states provided reasons for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

[2] Connecticut reported that it used an agency-designed CAHPS-like survey.

Table 1. Reasons for not reporting the Medical Assistance with Smoking and Tobacco Use Cessation measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (1) • Partial population not covered (0)	1

Data not available
• Budget constraints (1)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (2)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (2)
• Information not collected (9)
  • Not identified as key priority area this year (5)
  • Not collected by provider (hospital/health plan) (0)
  • Other (4)
• Other (2)
	14

Small sample size (less than 30)	1
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.
State-specific comments:
-CAHPS survey not administered.
-Not included in CAHPS survey.
-This measure requires two years of data in order to report the rolling average. We only have one year of data.
-While CAHPS is conducted in the adult population, the data are not available to report at this time. Over the next year, state will investigate our capacity to report the rolling average in FFY2014 as specified in the Adult Core Measures.
-State does not collect CAHPS measures for adults.

Additional Support Provided to States on the Measure

- Not applicable

CDF: Screening for Clinical Depression and Follow-Up Plan

Measure Steward: Centers for Medicare & Medicaid Services (CMS)

Measure Description

The percentage of Medicaid enrollees age 18 and older screened for clinical depression using a standardized tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 and older. (The original specification included enrollees ages 12 and older.)
- The numerator includes only two G-codes identifying that a clinical depression screening was done and, if the screen was positive, that a follow-up plan was documented on the same day.

Overview of State Reporting

- Five states reported the Screening for Clinical Depression and Follow-Up Plan measure for FFY 2013.[1]
- Of the five states reporting the measure for FFY 2013, two states reported the measure for their Medicaid and CHIP populations; two included their Medicaid population only; and one state included their Medicaid and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, four states reported the measure using the Medicaid Adult Core Set specifications, which were based on CMS specifications, and one state reported the measure using another specification.[2] The measure was originally specified for reporting at the provider level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, eight TA requests were submitted by four states. The TA topics included:
  - Coding issues (2 requests)
    - The use of ICD-9 codes in place of CPT codes and G-codes
    - Whether CPT codes for hearing tests should be included
  - Calculation of the denominator (3 requests)

[1] The term "states" includes the 50 states and the District of Columbia.

[2] Rhode Island reported that it used the patient-centered medical home (PCMH) measure definition, which includes all screens in the past 24 months, but does not include whether there is a follow-up plan.

    - Calculation of the numerator (2 requests)
- As a result of the TA requests, CMS's TA team developed guidance to assist states in reporting the measure for FFY 2014. This guidance focused on:
    - Adapting the numerator for the purpose of Medicaid Adult Core Set reporting to include only two G-codes that identify whether a patient was screened for clinical depression and if the screen was positive, whether a follow-up plan was documented. The original measure included six G-codes related only to documentation of the screen and follow-up plan in the medical record.
    - Clarifying that the date of the screening and encounter must occur on the same date of service and if a patient has more than one encounter during the measurement year, they should be counted in the numerator and denominator only once.
    - Clarifying that medical record review is required to determine denominator exclusions.

Reasons for Not Reporting the Measure

- Twenty-five states provided reasons for not reporting the measure; the most common reason for not reporting was "data source not easily accessible" because the measure requires medical record review (Table 1).

Table 1. Reasons for not reporting the Screening for Clinical Depression and Follow-Up Plan measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	1
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (2)
• Staff constraints (0)
• Data inconsistencies/accuracy (4)
• Data source not easily accessible (12)
  • Requires medical record review (10)
  • Requires data linkage which does not currently exist (2)
  • Other (0)
• Information not collected (12)
  • Not identified as key priority area this year (8)
  • Not collected by provider (hospital/health plan) (3)
  • Other (1)
• Other (1)
	23

Small sample size (less than 30)	0
Other	1

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:
-Providers just began coding for this measure within the past few months.
-Although we pay for the services, we do not pay with the codes in the measure and our codes do not indicate a negative or positive outcome of the depression screen.
-No specific form all providers use; screening not always documented as such.
-Indication of follow-up plan not submitted on claims data.
-Data source requires HCPCS codes (G8431, G8510). A query into the data suggested these codes are rarely submitted by providers which would limit accuracy of measure result.
-Not able to abstract using administrative data.

Additional Support Provided to States on the Measure

- CMS's TA team specified this measure in terms of outcomes, that is, to capture whether a clinical depression screening was done and if the screen was positive, whether a follow-up plan was documented. The original measure specification captured only whether providers documented a screening and follow-up plan.
- CMS is currently developing hybrid specifications for this measure that may be included in a future version of the resource manual.

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PCR: Plan All-Cause Readmission Rate

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

For Medicaid enrollees age 18 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.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 and older.

Overview of State Reporting

- Eighteen states reported the Plan All-Cause Readmission measure for FFY 2013.[1]
- Of the 18 states reporting the measure for FFY 2013, 6 states reported the measure for their Medicaid and CHIP populations; 9 included their Medicaid population only; 2 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 1 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible population.
- In FFY 2013, 14 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications, and 4 states reported the measure using another specification.[2] The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, six TA requests were submitted by six states. States sought clarification about risk-adjustment methodology and denominator exclusions.
- As a result of the TA requests, CMS's TA team updated the FFY 2014 technical specification to encourage states to report unadjusted readmission rates for FFY 2014. The guidance explains that CMS suggests this approach because there are no standardized risk adjustment tables for Medicaid.

Reasons for Not Reporting the Measure

- Twelve states provided reasons for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

[2] Colorado used the MMDLN specifications; Indiana used the Symmetry EMB Connect v. 8.2 tool; Oregon used the HEDIS 2011 specifications; and Pennsylvania reported results generated by MCOs.

Table 1. Reasons for not reporting the Plan All-Cause Readmission measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (1)
• Staff constraints (3)
• Data inconsistencies/accuracy (4)
• Data source not easily accessible (1)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (1)
• Information not collected (5)
  • Not identified as key priority area this year (5)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	11

Small sample size (less than 30)	0
Other	2

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-Lack of clarity on what to collect.

-Instructions for risk stratification not clear.

-No risk adjustment methodology.

-Analytical resources unavailable, uncertainty about measure specifications. Readmissions within 72 hours for the same condition is not covered, so facilities likely are not billing.

-No risk adjustment methodology.

-Difficulties in service area with carved out services.

Additional Support Provided to States on the Measure

- CMS held a call with the Medicaid Adult Quality grantees to discuss the measure and how/whether states used a risk adjustment methodology
- After meeting with NQF to discuss adaptations to the Medicaid Adult Core Set measures, CMS decided to encourage states to report unadjusted readmission rates until a Medicaid risk adjustment methodology is developed.

PQI-01: Diabetes Short-Term Complications Admission Rate

Measure Steward: Agency for Healthcare Research and Quality (AHRQ)

Measure Description

Number of discharges for diabetes short-term complications per 100,000 member months for Medicaid enrollees age 18 and older.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 and older.
- Updated measure description, denominator, and eligible population criteria to reflect reporting per 100,000 member months versus 100,000 Medicaid enrollees to account for part-year Medicaid enrollment.

Overview of State Reporting

- Twenty-three states reported the PQI-01: Diabetes Short-Term Complications Admission Rate measure for FFY 2013.[1]
- Of the 23 states reporting the measure for FFY 2013, 6 states reported the measure for their Medicaid and CHIP populations; 12 included their Medicaid population only; 4 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 1 included their Medicaid, CHIP and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, all 23 states reported the measure using the Medicaid Adult Core Set specifications, which were based on AHRQ specifications. The measure was originally specified for reporting at the population level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, 12 TA requests were submitted by 8 states. The TA topics included:
  - Calculation of the denominator (8 requests)
  - Calculation of the numerator (4 requests)
- As a result of the TA requests, CMS released a resource manual addendum in November 2013 that provided an updated measure description and denominator criteria using the number of member months rather than number of enrollees. Updating the specification late in the reporting year likely led to confusion for states regarding which denominator to report.
- CMS's TA team developed guidance to assist states in reporting the measure for FFY 2014. This guidance focused on:

[1] The term "states" includes the 50 states and the District of Columbia.

- Clarification that age can be calculated as of the 15th or the 30th of the month to determine measure eligibility
- Information about the AHRQ software that can be used to calculate the measure
- Clarification on identifying transfers for the denominator exclusions

Reasons for Not Reporting the Measure

- Seven states provided a reason for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

Table 1. Reasons for not reporting the Diabetes Short-Term Complications Admission Rate measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (0)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (6)
  • Not identified as key priority area this year (6)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	7

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.

Additional Support Provided to States on the Measure

- CMS's TA team provided one-on-one TA to one state about calculating the measure.
- CMS's TA team worked with AHRQ to decide whether to adapt the Medicaid Adult Core Set to report the measure per 100,000 member months due to part-year enrollment in Medicaid.

PQI-05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate

Measure Steward: Agency for Healthcare Research and Quality (AHRQ)

Measure Description

Number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid enrollees ages 40 and older.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 40 to 64 and 65 and older.
- Updated measure description, denominator, and eligible population criteria to reflect reporting per 100,000 member months versus 100,000 Medicaid enrollees to account for part-year Medicaid enrollment.

Overview of State Reporting

- Twenty-three states reported the PQI-05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate measure for FFY 2013.[1]
- Of the 23 states reporting the measure for FFY 2013, 4 states reported the measure for their Medicaid and CHIP populations; 15 included their Medicaid population only; 3 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 1 included their Medicaid, CHIP and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, all 23 states reported the measure using the Medicaid Adult Core Set specifications, which were based on AHRQ specifications. The measure was originally specified for reporting at the population level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, 14 TA requests were submitted by 8 states. The TA topics included:
    - Calculation of the denominator (6 requests)
    - Calculation of the numerator (3 requests)
    - Measure exclusions (1 request)
- As a result of the TA requests, CMS released a resource manual addendum in November 2013 that provided an updated measure description and denominator criteria using the number of member months rather than number of enrollees. Updating the specification late in the reporting year likely led to confusion for states regarding which denominator to report.

[1] The term "states" includes the 50 states and the District of Columbia.

- CMS's TA team developed guidance to assist states in reporting the measure for FFY 2014. This guidance focused on:
  - Clarification that age can be calculated as of the 15th or the 30th of the month to determine measure eligibility
  - Information about the AHRQ software that can be used to calculate the measure
  - Clarification on identifying transfers for the denominator exclusions

Reasons for Not Reporting the Measure

- Seven states provided a reason for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

Table 1. Reasons for not reporting the COPD or Asthma in Older Adults Admission Rate measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (0)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (6)
  • Not identified as key priority area this year (6)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	7

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.

Additional Support Provided to States on the Measure

- CMS's TA team provided one-on-one TA to one state about calculating the measure.
- CMS's TA team worked with AHRQ to decide whether to adapt the Medicaid Adult Core Set to report the measure per 100,000 member months due part-year enrollment in Medicaid.

PQI-08: Congestive Heart Failure Admission Rate

Measure Steward: Agency for Healthcare Research and Quality (AHRQ)

Measure Description

Number of discharges for congestive heart failure (CHF) per 100,000 member months for Medicaid enrollees age 18 and older.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 and older.
- Updated measure description, denominator, and eligible population criteria to reflect reporting per 100,000 member months versus 100,000 Medicaid enrollees to account for part-year Medicaid enrollment.

Overview of State Reporting

- Twenty-three states reported the PQI-08: Congestive Heart Failure Admission Rate measure for FFY 2013.[1]
- Of the 23 states reporting the measure for FFY 2013, 7 states reported the measure for their Medicaid and CHIP populations; 13 included their Medicaid population only; and 3 included their Medicaid and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, all 23 states reported the measure using the Medicaid Adult Core Set specifications, which were based on AHRQ specifications. The measure was originally specified for reporting at the population level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, 11 TA requests were submitted by 8 states. The TA topics included:
  - Calculation of the denominator (5 requests)
  - Calculation of the numerator (2 requests)
- As a result of the TA requests, CMS's TA team released a resource manual addendum in November 2013 that provided an updated measure description and denominator criteria using the number of member months rather than number of enrollees. Updating the specification late in the reporting year likely led to confusion for states regarding which denominator to report.
- CMS's TA team also developed guidance to assist states in reporting the measure for FFY 2014. This guidance focused on:

[1] The term "states" includes the 50 states and the District of Columbia.

- Clarification that age can be calculated as of the 15th or the 30th of the month to determine measure eligibility
- Information about the AHRQ software that can be used to calculate the measure
- Clarification on identifying transfers for the denominator exclusions

Reasons for Not Reporting the Measure

- Seven states provided a reason for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

Table 1. Reasons for not reporting the Congestive Heart Failure Admission Rate measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (0)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (6)
  • Not identified as key priority area this year (6)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	7

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.

Additional Support Provided to States on the Measure

- CMS's TA team provided one-on-one TA to one state about calculating the measure.
- CMS's TA team worked with AHRQ to decide whether to adapt the Medicaid Adult Core Set to report the measure per 100,000 member months due part-year enrollment in Medicaid.

PQI-15: Asthma in Younger Adults Admission Rate

Measure Steward: Agency for Healthcare Research and Quality (AHRQ)

Measure Description

Number of discharges for asthma per 100,000 member months for Medicaid enrollees ages 18 to 39.

Adaptation for the Medicaid Adult Core Set

- Updated measure description, denominator, and eligible population criteria to reflect reporting per 100,000 member months versus 100,000 Medicaid enrollees to account for part-year Medicaid enrollment.

Overview of State Reporting

- Twenty-three states reported the PQI-15: Asthma in Younger Adults Admission Rate measure for FFY 2013.[1]
- Of the 23 states reporting the measure for FFY 2013, 5 states reported the measure for their Medicaid and CHIP populations; 14 included their Medicaid population only; 2 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 2 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, all 23 states reported the measure using the Medicaid Adult Core Set specifications, which were based on AHRQ specifications. The measure was originally specified for reporting at the population level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, 15 TA requests were submitted by 9 states. The TA topics included:
  - Calculation of the denominator (8 requests)
  - Calculation of the numerator (2 requests)
  - Measure exclusions (2 requests)
- As a result of the TA requests, CMS's TA team released a resource manual addendum in November 2013 that provided an updated measure description and denominator criteria using the number of member months rather than number of enrollees. Updating the specification late in the reporting year likely led to confusion for states regarding which denominator to report.
- CMS's TA team also developed guidance to assist states in reporting the measure for FFY 2014. This guidance focused on:

[1] The term "states" includes the 50 states and the District of Columbia.

- Clarification that age can be calculated as of the 15th or the 30th of the month to determine measure eligibility
- Information about the AHRQ software that can be used to calculate the measure
- Clarification on identifying transfers for the denominator exclusions

Reasons for Not Reporting the Measure

- Seven states provided a reason for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

Table 1. Reasons for not reporting the Asthma in Younger Adults Admission Rate measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (0)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (6)
  • Not identified as key priority area this year (6)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	7

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.

Additional Support Provided to States on the Measure

- CMS's TA team provided one-on-one TA to one state about calculating the measure.
- CMS's TA team worked with AHRQ to decide whether to adapt the Medicaid Adult Core Set to report the measure per 100,000 member months due part-year enrollment in Medicaid.

CHL: Chlamydia Screening in Women Ages 21-24

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

The percentage of Medicaid-enrolled women ages 21 to 24 who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.

Adaptation for the Medicaid Adult Core Set

- The HEDIS 2013 specification includes three rates: ages 16 to 20, 21 to 24, and 16 to 24 (total rate). The Medicaid Adult Core Set includes the rate for women ages 21 to 24. The Child Core Set includes the rate for women ages 16 to 20.

Overview of State Reporting

- Twenty-five states reported the Chlamydia Screening in Women Ages 21 to 24 measure for FFY 2013.[1]
- Of the 25 states reporting the measure for FFY 2013, 7 states reported the measure for their Medicaid and CHIP populations; 13 included their Medicaid population only; 2 included their Medicaid and Medicare-Medicaid dual-eligible populations; 2 included their Medicaid, CHIP; and Medicare-Medicaid dual-eligible populations and 1 specified another population.[2]
- In FFY 2013, all 25 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, one TA request was submitted by one state. The state sought clarification about coding of medications.
- CMS's TA team developed guidance to assist states in reporting the measure for FFY 2014. This guidance included a link to NCQA's list of National Drug Codes (NDCs) for contraceptive medications.

Reasons for Not Reporting the Measure

- Five states provided reasons for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

[2] West Virginia specified "managed care population."

Table 1. Reasons for not reporting the Chlamydia Screening in Women Ages 21 to 24 measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (2)
• Staff constraints (1)
• Data inconsistencies/accuracy (1)
• Data source not easily accessible (0)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (3)
  • Not identified as key priority area this year (3)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (0)
	5

Small sample size (less than 30)	0
Other	1

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-Claims may be unavailable if test sought in free clinic settings. Analytical resources unavailable; uncertainty about validity of eligible population specs.

Additional Support Provided to States on the Measure

- Not applicable

FUH: Follow-Up After Hospitalization for Mental Illness

Measure Steward: National Committee for Quality Assurance

Measure Description

The percentage of discharges for Medicaid enrollees age 21 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 within 7 days of discharge and within 30 days of discharge.

Adaptation for the Medicaid Adult Core Set

- The HEDIS 2013 specification includes ages 6 and older. The Child Core Set includes rates for ages 6 to 20. The Medicaid Adult Core Set includes rates that are reported by two age groups: 21 to 64 and 65 and older.

Overview of State Reporting

- Twenty-seven states reported the Follow-Up After Hospitalization for Mental Illness measure for FFY 2013.[1]
- Of the 27 states reporting the measure for FFY 2013, 8 states reported the measure for their Medicaid and CHIP populations; 14 included their Medicaid population only; 3 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 2 included their Medicaid, CHIP, and dual-eligible populations.
- In FFY 2013, all 27 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Between March 2013 and March 2014, no TA requests were submitted on this measure and no additional guidance for reporting was provided.

Reasons for Not Reporting the Measure

- Three states provided reasons for not reporting the measure; the most common reasons for not reporting were (1) "data source not easily accessible" because the measure requires data linkage which does not currently exist and (2) "information not collected" because the measure was not identified as a key priority area for FFY 2013 (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

Table 1. Reasons for not reporting the Follow-Up After Hospitalization for Mental Illness measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (1)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (1)
  • Other (0)
• Information not collected (1)
  • Not identified as key priority area this year (1)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	3

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.

Additional Support Provided to States on the Measure

- Not applicable

PC-01: Elective Delivery

Measure Steward: The Joint Commission

Measure Description

The percentage of Medicaid and CHIP enrolled females with elective vaginal deliveries or elective cesarean sections delivering newborns with ≥ 37 and < 39 weeks of gestation completed.

Adaptation for the Medicaid Adult Core Set

- Not applicable

Overview of State Reporting

- Thirteen states reported the PC-01: Elective Delivery measure for FFY 2013.[1]
- Of the 13 states reporting the measure for FFY 2013, 8 states reported the measure for their Medicaid and CHIP populations; 4 included their Medicaid population only; and 1 included their Medicaid and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, all 13 states reported the measure using the Medicaid Adult Core Set specifications, which were based on The Joint Commission specifications. The measure was originally specified for reporting at the hospital level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, six TA requests were submitted by six states. The TA topics included:
    - Data sources used to calculate the measure (4 requests)
        - Clarification regarding the medical record review requirement to determine the numerator and denominator for the measure
        - Requests for guidance on sampling
        - Use of vital records to determine gestational age
    - Calculation of the denominator (1 request)
    - Calculation of the numerator (2 requests)
- As a result of the TA requests, CMS's TA team clarified data sources and calculation methods with the measure steward and updated the FFY 2014 technical specification to provide additional guidance:
    - Clarified measurement eligibility criteria.

[1] The term "states" includes the 50 states and the District of Columbia.

- Clarified numerator and denominator data collection criteria, including additional guidance on sampling of medical records and the use of vital records data to determine gestational age.

Reasons for Not Reporting the Measure

- Seventeen states provided reasons for not reporting the measure; the most common reason for not reporting were "data source not easily accessible" because the measure requires medical record review and "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

Table 1. Reasons for not reporting the Elective Delivery measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	2
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (1)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (8)
  • Requires medical record review (7)
  • Requires data linkage which does not currently exist (4)
  • Other (0)
• Information not collected (7)
  • Not identified as key priority area this year (7)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	15

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-State does not require the codes which indicate the gestational age.

Additional Support Provided to States on the Measure

- CMS supported a Medicaid Medical Directors (MMD) project related to measurement of early elective delivery.
- CMS worked with MMDs to understand the differences between PC-01: Elective Delivery and the MMD early elective delivery measure. CMS's TA team prepared a chart comparing the measures.
- CMS/CDC are leading a data linkage training series to assist states in collecting and using vital records data for Medicaid Adult Core Set reporting. These data can be used to identify the eligible population for PC-01: Elective Delivery.

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PC-03: Antenatal Steroids

Measure Steward: The Joint Commission

Measure Description

The percentage of Medicaid and CHIP enrolled females at risk of preterm delivery who received a full course of antenatal steroids completed prior to delivery of a preterm infant.

Adaptation for the Medicaid Adult Core Set

- Not applicable

Overview of State Reporting

- Five states reported the PC-03: Antenatal Steroids measure for FFY 2013.[1]
- Of the five states reporting the measure for FFY 2013, two states reported the measure for their Medicaid and CHIP populations and three included their Medicaid population only.
- In FFY 2013, all five states reported the measure using the Medicaid Adult Core Set specifications, which were based on The Joint Commission specifications. The measure was originally specified for reporting at the hospital level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, five TA requests were submitted by four states. The TA topics included:
    - Data sources used to calculate the measure (3 requests)
        - Clarification regarding the medical record review requirement to determine the numerator and denominator for the measure
        - Requests for guidance on sampling
        - Use of vital records to determine gestational age
    - Calculation of the denominator (1 request)
    - Allowable codes to identify live births (1 request)
- As a result of the TA requests, CMS's TA team clarified data sources and calculation methods with the measure steward and updated the FFY 2014 technical specification to provide additional guidance:
    - Clarified measurement eligibility criteria.
    - Clarified numerator and denominator data collection criteria, including additional guidance on sampling of medical records and the use of vital records data to determine gestational age.

[1] The term "states" includes the 50 states and the District of Columbia.

- Clarified that The Joint Commission does not provide National Drug Codes (NDCs) to identify antenatal steroid medications.

Reasons for Not Reporting the Measure

- Twenty-five states provided reasons for not reporting the measure; the most common reasons for not reporting were "information not collected" because the measure was not identified as a key priority for FFY 2013 and "data source not easily accessible" because the measure requires medical record review (Table 1).

Table 1. Reasons for not reporting the Antenatal Steroids measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (1)
• Staff constraints (1)
• Data inconsistencies/accuracy (1)
• Data source not easily accessible (13)
  • Requires medical record review (10)
  • Requires data linkage which does not currently exist (6)
  • Other (1)
• Information not collected (12)
  • Not identified as key priority area this year (12)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (0)
	23

Small sample size (less than 30)	0
Other	2

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-State cannot get pharmacy data from hospitals.

-Analytical resources unavailable.

Additional Support Provided to States on the Measure

- CMS/CDC are leading a data linkage training series to assist states in collecting and using vital records data for Medicaid Adult Core Set reporting. These data can be used to identify the eligible population for PC-03: Antenatal Steroids.

CBP: Controlling High Blood Pressure

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

The percentage of Medicaid enrollees ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 and older.

Overview of State Reporting

- Fifteen states reported the Controlling High Blood Pressure measure for FFY 2013.[1]
- Of the 15 states reporting the measure for FFY 2013, 4 states reported the measure for their Medicaid and CHIP populations; 8 included their Medicaid population only; 2 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 1 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, all 15 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Between March 2013 and March 2014, no TA requests were submitted regarding this measure.

Reasons for Not Reporting the Measure

- Fifteen states provided reasons for not reporting the measure; the most common reason for not reporting was "data source not easily accessible" because the measure requires medical record review (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

Table 1. Reasons for not reporting CBP: Controlling High Blood Pressure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (1)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (11)
  • Requires medical record review (11)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (5)
  • Not identified as key priority area this year (4)
  • Not collected by provider (hospital/health plan) (1)
  • Other (0)
• Other (0)
	15

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.

Additional Support Provided to States on the Measure

- Not applicable

LDL: Comprehensive Diabetes Care: LDL-C Screening

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

The percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) who had a LDL-C screening test.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 to 75.

Overview of State Reporting

- Twenty-nine states reported the Comprehensive Diabetes Care: LDL-C Screening measure for FFY 2013.[1]
- Of the 29 states reporting the measure for FFY 2013, 9 states reported the measure for their Medicaid and CHIP populations; 14 included their Medicaid population only; 3 included their Medicaid and Medicare-Medicaid dual-eligible populations; 2 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations; and 1 specified another population.[2]
- In FFY 2013, all 29 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, one TA request was submitted by one state. The state sought clarification about coding of medications.
- CMS's TA team developed guidance to assist states in reporting the measure for FFY 2014. This guidance included a link to NCQA's list of National Drug Codes (NDCs) for insulin or oral hypoglycemic/antihyperglycemic medications.

Reasons for Not Reporting the Measure

- One state provided a reason for not reporting the measure; the reason for not reporting was "data not available" (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

[2] West Virginia specified "managed care population."

Table 1. Reasons for not reporting the Comprehensive Diabetes Care: LDL-C Screening measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (0)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (0)
  • Not identified as key priority area this year (0)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	1

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.

Additional Support Provided to States on the Measure

- Not applicable

HA1C: Comprehensive Diabetes Care: Hemoglobin A1c Testing

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

The percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c test.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 to 75.

Overview of State Reporting

- Twenty-nine states reported the Comprehensive Diabetes Care: Hemoglobin A1c testing measure for FFY 2013.[1]
- Of the 29 states reporting the measure for FFY 2013, 9 states reported the measure for their Medicaid and CHIP populations; 14 included their Medicaid population only; 4 included their Medicaid and Medicare-Medicaid dual-eligible populations; 1 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations; and 1 specified another population.[2]
- In FFY 2013, all 29 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, one TA request was submitted by one state. The state sought clarification about calculation of the denominator.
- CMS's TA team developed guidance to assist states in reporting the measure for FFY 2014. This guidance included a link to NCQA's list of National Drug Codes (NDCs) for medications to treat diabetes.

Reasons for Not Reporting the Measure

- One state provided a reason for not reporting the measure; the reason for not reporting was "data not available" (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

[2] West Virginia specified "managed care population."

Table 1. Reasons for not reporting the Comprehensive Diabetes Care: Hemoglobin A1c Testing measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (0)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (0)
  • Not identified as key priority area this year (0)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	1

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.

Additional Support Provided to States on the Measure

- Not applicable

AMM: Antidepressant Medication Management

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

The percentage of Medicaid enrollees age 18 and older with a diagnosis of major depression, who were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks) and for at least 180 days (6 months).

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 to 74.

Overview of State Reporting

- Twenty-four states reported the Antidepressant Medication Management measure for FFY 2013.[1]
- Of the 24 states reporting the measure for FFY 2013, 6 states reported the measure for their Medicaid and CHIP populations; 14 included their Medicaid population only; 3 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 1 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, all 24 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, one TA request was submitted by one state.
- CMS's TA team developed guidance to assist states in reporting the measure for FFY 2014. This guidance included a link to NCQA's list of National Drug Codes (NDCs) for antidepressant medications.

Reasons for Not Reporting the Measure

- Six states provided reasons for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority area for FFY 2013 (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

Table 1. Reasons for not reporting the Antidepressant Medication Management measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (0)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (3)
  • Not identified as key priority area this year (3)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	4

Small sample size (less than 30)	0
Other	1

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-Scheduled for production this coming year.

-"Newly treated" is not considered reliable.

Additional Support Provided to States on the Measure

- Not applicable

SAA: Adherence to Antipsychotics for Individuals with Schizophrenia

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

The percentage of Medicaid enrollees ages 19 to 64 with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Adaptation for the Medicaid Adult Core Set

- Not applicable.

Overview of State Reporting

- Fifteen states reported the Adherence to Antipsychotics for Individuals with Schizophrenia measure for FFY 2013.[1]
- Of the 15 states reporting the measure for FFY 2013, 3 states reported the measure for their Medicaid and CHIP populations; 10 included their Medicaid population only; and 2 included their Medicaid and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, all 15 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, one TA request was submitted by one state. The state sought clarification about calculation of the denominator.
- Adult Medicaid Quality grantees noted challenges related to identifying medications by name without National Drug Codes (NDCs).
- CMS's TA team developed guidance to assist states in reporting the measure for FFY 2014. This guidance included a link to NCQA's list of National Drug Codes (NDCs) for antipsychotic medications

Reasons for Not Reporting the Measure

- Fourteen states provided reasons for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

Table 1. Reasons for not reporting the Adherence to Antipsychotics for Individuals with Schizophrenia measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (1)
  • Requires medical record review (1)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (11)
  • Not identified as key priority area this year (11)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (0)
	12

Small sample size (less than 30)	0
Other	2

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.
State-specific comments:
-Analytical resources unavailable.
-Scheduled for production later this year.

Additional Support Provided to States on the Measure

- Not applicable

MPM: Annual Monitoring for Patients on Persistent Medications

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

The percentage of Medicaid enrollees age 18 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and who received annual monitoring for the therapeutic agent during the measurement year.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 65 and 65 and older.

Overview of State Reporting

- Twenty-two states reported the Annual Monitoring for Patients on Persistent Medications measure for FFY 2013.[1]
- Of the 22 states reporting the measure for FFY 2013, 5 states reported the measure for their Medicaid and CHIP populations; 14 included their Medicaid population only; 2 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 1 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, all 22 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, one TA request was submitted by one state. The state sought clarification about coding medications.
- CMS's TA team developed guidance to assist states in reporting the measure for FFY 2014. This guidance included a link to NCQA's list of National Drug Codes (NDCs) for ACE inhibitors/ARB medications.

Reasons for Not Reporting the Measure

- Eight states provided reasons for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

Table 1. Reasons for not reporting the Annual Monitoring for Patients on Persistent Medications measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (1)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (1)
  • Other (0)
• Information not collected (5)
  • Not identified as key priority area this year (5)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	7

Small sample size (less than 30)	0
Other	1

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-Scheduled for production this coming year

Additional Support Provided to States on the Measure

- Not applicable

CPA: CAHPS Health Plan Survey 5.0H – Adult Questionnaire

Measure Steward: Agency for Healthcare Research and Quality (AHRQ), National Committee for Quality Assurance (NCQA)

Measure Description

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey provides information on Medicaid enrollees' age 18 and older experiences with their health care and gives a general indication of how well the health care meets their expectations. Results summarize Medicaid enrollees' experiences through ratings, composites, and question summary rates.

- Four global rating questions reflect overall satisfaction: Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of Health Plan
- Five composite scores summarize responses in key areas: Customer Service, Getting Care Quickly, Getting Needed Care, How Well Doctors Communicate, Shared Decision Making
- Summary results are reported for the rating questions and each composite score. Question summary rates are also reported individually for two items summarizing the following concepts: Health Promotion and Education, Coordination of Care

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 and older.

Overview of State Reporting

- Sixteen states reported the CAHPS Health Plan Survey 5.0H – Adult Questionnaire measure for FFY 2013.[1]
- Of the 16 states reporting the measure for FFY 2013, 4 states reported the measure for their Medicaid and CHIP populations; 9 included their Medicaid population only; 2 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 1 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations.
- In FFY 2013, 11 states reported the measure using CAHPS 5.0H, 4 states reported the measure using CAHPS 4.0, and 1 state reported the measure using another specification.[2] The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, four TA requests were submitted by four states. States sought clarification about the data sources used to calculate the measure (2 requests) and vendor issues (2 requests).

[1] The term "states" includes the 50 states and the District of Columbia.

[2] Connecticut reported that it used an agency-designed CAHPS-like survey.

- As a result of the TA requests, CMS's TA team provided clarification that States are encouraged to collect the CAHPS 5.0H using a NCQA-certified CAHPS survey vendor and provided an updated link to NCQA-certified HEDIS 5.0H survey vendors.

Reasons for Not Reporting the Measure

- Fourteen states provided reasons for not reporting the measure; the most common reason for not reporting was "information not collected" (Table 1).

Table 1. Reasons for not reporting the CAHPS Health Plan Survey 5.0H – Adult Questionnaire measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (2)
• Staff constraints (0)
• Data inconsistencies/accuracy (1)
• Data source not easily accessible (1)
  • Requires medical record review (0)
  • Requires data linkage which does not currently exist (0)
  • Other (1)
• Information not collected (11)
  • Not identified as key priority area this year (6)
  • Not collected by provider (hospital/health plan) (0)
  • Other: CAHPS survey not collected (5)
• Other (1)
	14

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.
Note: States can specify multiple reasons for not reporting a measure.
State-specific comments:
-CAHPS survey results for state produced invalid data due to the small response rate from the sample population.
-While CAHPS is conducted within plans serving the adult population, the aggregate data are not available to report at this time. Over the next year, state will investigate our capacity to report summary rates in FFY2014 as specified in the Adult Core Measures.

Additional Support Provided to States on the Measure

- An updated link to NCQA-certified HEDIS 5.0H survey vendors was provided to states.

CTR: Care Transition – Timely Transmission of Transition Record

Measure Steward: American Medical Association/Physician Consortium for Performance Improvement (AMA/PCPI)

Measure Description

The percentage of Medicaid enrollees age 18 and older discharged from an inpatient 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.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 and older.

Overview of State Reporting

- Four states reported the Care Transition – Timely Transmission of Transition Record measure for FFY 2013.[1]
- Of the 4 states reporting the measure for FFY 2013, 2 states reported the measure for their Medicaid and CHIP populations and 2 included their Medicaid population only.
- In FFY 2013, all 4 states reported the measure using the Medicaid Adult Core Set specifications, which were based on AMA/PCPI specifications. The measure was originally specified for reporting at the facility level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, five TA requests were submitted by three states. States sought clarification about calculation of the numerator and denominator.
- Adult Medicaid Quality grantees provided feedback regarding the challenge of conducting medical record review to determine numerator data elements. They also noted that this measure was originally specified for facility level reporting and lacks state level specifications for data collection and documentation of transition record transmission.
- As a result of the TA requests, CMS's TA team updated the FFY 2014 technical specification to provide (1) additional guidance on numerator elements that require medical record review and (2) a data collection flowsheet to assist states in medical record review.

[1] The term "states" includes the 50 states and the District of Columbia.

Reasons for Not Reporting the Measure

- Twenty-six states provided reasons for not reporting the measure; the most common reason for not reporting was "data source not easily accessible" because the measure requires medical record review (Table 1).

Table 1. Reasons for not reporting the Care Transition: Timely Transmission of Transition Record measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (3)
• Staff constraints (1)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (16)
  • Requires medical record review (14)
  • Requires data linkage which does not currently exist (10)
  • Other (1)
• Information not collected (12)
  • Not identified as key priority area this year (11)
  • Not collected by provider (hospital/health plan) (1)
  • Other (1)
• Other (1)
	26

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-Although this is an interest, it is currently resource prohibited to pursue.

-Currently, state does not gather the necessary data to identify the numerator population.

-Have not determined how to collect the information yet.

Additional Support Provided to States on the Measure

- CMS's TA team worked with measure steward to develop updated specifications that clarified required numerator data elements and provided states with a data collection flowsheet to assist them in collecting medical record review data.

IET: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

The percentage of Medicaid enrollees age 18 and older with a new episode of alcohol or other drug (AOD) dependence who:

- Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.
- Initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Adaptation for the Medicaid Adult Core Set

- Rates are reported by two age groups: 18 to 64 and 65 and older.

Overview of State Reporting

- Eighteen states reported the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure for FFY 2013.[1]
- Of the 18 states reporting the measure for FFY 2013, 6 states reported the measure for their Medicaid and CHIP populations; 9 included their Medicaid population only; 2 included their Medicaid and Medicare-Medicaid dual-eligible populations; and 1 included their Medicaid, CHIP, and dual-eligible populations.
- In FFY 2013, all 18 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, one TA request was submitted by one state. The state sought clarification about exclusions in the calculation of the denominators.
- CMS's TA team updated the FFY 2014 technical specification to clarify that any enrollee excluded from the initiation rate must also be excluded from the engagement rate.

Reasons for Not Reporting the Measure

- Twelve states provided reasons for not reporting the measure; the most common reason for not reporting was "information not collected" because the measure was not identified as a key priority for FFY 2013 (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

Table 1. Reasons for not reporting the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (1) • Partial population not covered (0)	1

Data not available
• Budget constraints (0)
• Staff constraints (0)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (2)
  • Requires medical record review (2)
  • Requires data linkage which does not currently exist (1)
  • Other (1)
• Information not collected (8)
  • Not identified as key priority area this year (8)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (1)
	10

Small sample size (less than 30)	0
Other	2

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-Benefits are limited and under reassessment by the ACA.

-Analytical resources unavailable.

-Federal and state regulations regarding confidentiality create barriers to data collection and exchange.

-Behavioral health services are carved out from physical health services in state.

Additional Support Provided to States on the Measure

- Not applicable

PPC: Postpartum Care Rate

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Description

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 who had a postpartum visit on or between 21 and 56 days after delivery.

Adaptation for the Medicaid Adult Core Set

- Not applicable

Overview of State Reporting

- Twenty-eight states reported the Postpartum Care Rate measure for FFY 2013.[1]
- Of the 28 states reporting the measure for FFY 2013, 11 states reported the measure for their Medicaid and CHIP populations; 13 included their Medicaid population only; 2 included their Medicaid and Medicare-Medicaid dual-eligible populations; 1 included their Medicaid, CHIP, and Medicare-Medicaid dual-eligible populations; and 1 specified another population.[2]
- In FFY 2013, all 28 states reported the measure using the Medicaid Adult Core Set specifications, which were based on HEDIS 2013 specifications. The measure was originally specified for reporting at the health plan level.

State Challenges to Reporting the Measure

- Reporting challenges were reflected in the technical assistance (TA) requests submitted to the TA Mailbox. Between March 2013 and March 2014, two TA requests were submitted by two states. States sought clarification about how to define the delivery date and coding issues.
- Adult Medicaid Quality grantees expressed concern that the measure is underreported when calculated using only administrative data because postpartum visits are included in global payments. The measure includes a hybrid specification to address this issue, but grantees note that the hybrid method is costly and can be burdensome to providers.

Reasons for Not Reporting the Measure

- Two states provided reasons for not reporting the measure; the most common reason for not reporting was "data not available" (Table 1).

[1] The term "states" includes the 50 states and the District of Columbia.

[2] West Virginia specified "Managed Care Population."

Table 1. Reasons for not reporting the Postpartum Care Rate measure, FFY 2013

Reason for not reporting	Number of states
Service not covered	0
Population not covered • Entire population not covered (0) • Partial population not covered (0)	0

Data not available
• Budget constraints (1)
• Staff constraints (1)
• Data inconsistencies/accuracy (0)
• Data source not easily accessible (1)
  • Requires medical record review (1)
  • Requires data linkage which does not currently exist (0)
  • Other (0)
• Information not collected (0)
  • Not identified as key priority area this year (0)
  • Not collected by provider (hospital/health plan) (0)
  • Other (0)
• Other (2)
	2

Small sample size (less than 30)	0
Other	0

Source: Mathematica analysis of FFY 2013 Medicaid Adult CARTS reports.

Note: States can specify multiple reasons for not reporting a measure.

State-specific comments:

-State uses a bundled code for post partum services (59430) which covers all visits, therefore all dates of service are not billed. State would have to request all records from the delivery data on from every possible provider.

Additional Support Provided to States on the Measure

- Not applicable

Measure Applications Partnership: Expedited Review of the Initial Core Set of Measures for Medicaid-Eligible Adults

REPORT TO HHS

October 15, 2013

NATIONAL QUALITY FORUM

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I, task order 11.

I. Introduction

The Measure Applications Partnership (MAP) is a multi-stakeholder group of public- and private-sector organizations and experts convened by the National Quality Forum (NQF). The Department of Health and Human Services (HHS) recently engaged MAP to provide input on the Initial Core Set of Measures for Medicaid-Eligible Adults (Medicaid Adult Core Set or Core Set, see Appendix A). The MAP Dual Eligible Beneficiaries Workgroup reviewed the Core Set and provided its input to the MAP Coordinating Committee, which is issuing this final input to HHS (see Appendices B and C for workgroup and committee rosters). NQF solicited public comment on draft findings and incorporated additional points into this report (see Appendix D).

In its review of the measures, MAP identified opportunities to revise and strengthen the Medicaid Adult Core Set. MAP offers a mix of general and measure-specific recommendations to improve the accuracy, breadth, and feasibility of reporting the Medicaid Adult Core Set. This report also includes information that was provided to MAP as background to inform its review of the Core Set, specifically an overview of the population of adults enrolled in Medicaid and the purpose and history of the Adult Medicaid Quality Reporting Program (see Appendices E and F).

HHS will use MAP's findings to inform an update of the Medicaid Adult Core Set required by statute to occur in 2014. A MAP Medicaid Task Force will convene in 2014 to provide additional input on future revisions.

II. MAP Review of the Medicaid Adult Core Set

MAP used the MAP Measure Selection Criteria (MSC) (see Appendix G) to evaluate the strength of the Medicaid Adult Core Set. 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 National Quality Strategy, fill critical measurement gaps, and increase alignment across programs.

MAP used the MSC to guide the evaluation of the program measure set and its ability to meet the program goals outlined by CMS. CMS identified a three-part goal: increasing the number of states reporting Medicaid Adult Core Set measures, increasing the number of measures reported by each state, and increasing the number of states using Core Set measures to drive quality improvement. Thus, MAP's review concentrated on issues that affect the feasibility of state participation in the program.

Table 1 describes the properties of the 26 measures included in the Medicaid Adult Core Set. Some characteristics such as care setting and level of analysis are not mutually exclusive. Measures may also be in one or more Federal program(s) or State Dual Eligible Beneficiaries Integration Demonstrations. The majority of measures in the Medicaid Adult Core Set are NQF-endorsed process measures; are most commonly applied to the ambulatory care setting; can be analyzed for health plans and populations; and align with other public and private programs.

Table 1: Medicaid Adult Core Set Measure Properties

Measure Properties	Measure Sub-Properties	Measure Count (Total n=26)
NQF Endorsement	Endorsed	21
	Not Currently Endorsed	5
Measure Type	Outcome	7
	Process	19
Care Setting	Ambulatory Care	21
	Behavioral Health	4
	Hospital/Acute Care	9
	Post-Acute/Long-Term Care	3
	Other (e.g., Pharmacy)	3
Level of Analysis	Clinician	12
	Facility	3
	Health Plan	17
	Integrated Delivery System	9
	Population	15
Alignment	In one or more Federal Programs reviewed by MAP	19
	In one or more State Demonstrations for Dual Eligible Beneficiaries	15
	In one or more of MAP's Families of Measures	12
	In NCQA's HEDIS Program	17

General Recommendations

MAP's recommendations are based on the deliberations of the MAP Dual Eligible Beneficiaries Workgroup, the MAP Coordinating Committee, and additional feedback from public comments. In assessing the Medicaid Adult Core Set with the MAP MSC, MAP found that it is adequate to advance CMS' stated goals for the program. MAP judged the Core Set to have a satisfactory share of outcome measures, to give sufficient attention to the three aims and six priorities of the National Quality Strategy, and to adequately respond to the program's goals and requirements. The Medicaid Adult Core Set is particularly strong in its alignment with other program sets and its parsimonious number of measures.

In selecting measures for the first iteration of the Medicaid Adult Core Set, CMS was limited to those that were available for immediate use at the time. MAP recognizes the investments that have been

made in the current measures and the need for states and CMS to gain experience with their use. Large changes to the measure set in the first two years of the program would be premature and 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 are to address the known challenges in data collection and reporting, monitor the program's continuing development, and consider the measure-specific recommendations later in this report to bolster program feasibility. Public comments also urged further attention to reducing the resources required for data collection, noting that measures collected via administrative methodologies should be prioritized over measures that require hybrid data sources.

While acknowledging the need for continuity, MAP members were vocal in calling for the addition of new measures to strengthen the set over time. MAP recommends that the measure set continue to evolve in parallel with advances in the field of health care quality measurement. One example, noted by a comment, is that the current version of the CAHPS® survey is 5.0, while the Medicaid Adult Core Set still references version 4.0. As revisions are published and additions are considered, MAP encourages CMS to consult MAP's families of measures, including the Family of Measures for Dual Eligible Beneficiaries, for promising measures and measure concepts. In addition, MAP strongly encourages development of new measures in key areas so that they might be added to the program in the future.

Though several measures in the Medicaid Adult Core Set relate to mental health, they are fairly narrow in scope. Behavioral health conditions are highly prevalent in the Medicaid population, yet they go undiagnosed and untreated far too often, warranting more comprehensive screening. They present serious health conditions in and of themselves, while also acting as major and costly barriers to adequate health care access and delivery. MAP suggests that development of a composite measure of mental health screening would be a first step in helping to address this disparity issue—the next step being to link individuals who screen positively to an adequate system of care. The suggested state-level composite measure should include a wide variety of conditions, including depression, schizophrenia, and anxiety disorders. Comments also suggested that CMS consult the Substance Abuse and Mental Health Services Administration's most recent draft of the National Behavioral Health Quality Framework as a source for aligned measures.

MAP noted an additional gap area related to structural measures of access to care. As large numbers of vulnerable individuals gain Medicaid coverage or transition to new delivery models, access will remain a fundamentally important policy issue. In addition, measures of access also touch on key issues related to healthcare disparities and cultural competency. The CAHPS survey in the Core Set contains items related to individuals' experiences accessing care; this data could prove very useful to states seeking to establish a baseline level of performance and evaluate improvement over time.

MAP members and public commenters also discussed social determinants of health and their strong effects on Medicaid enrollees and other types of vulnerable beneficiaries. MAP shares the general view that the health system is not doing enough to address modifiable risk factors upstream and support overall wellness. Stronger partnerships are needed to improve public health outcomes. Short of that, measuring variability in states' provision of wrap-around support services may illustrate marked differences in beneficiaries' ability to access needed supports. These include enrollment assistance and benefit navigation, specialized services for individuals with disabilities, transportation, and translation services.

Finally, and perhaps most importantly, the field lacks performance measures that evaluate goal-directed, person-centered care and outcomes that matter to individuals enrolled in Medicaid. MAP members remarked on the clinical orientation of the measure set and its inability to gauge fundamental concepts such as functional status and quality of life. MAP perceived use of CAHPS survey tools as the bare minimum standard for monitoring and understanding beneficiaries' experience. Comments further noted the importance of developing measures that assess whether individuals feel like they have a say in their own care, whether their rights are respected and promoted, and whether they are well integrated into the larger community. MAP strongly encourages CMS to pursue development activities in these topic areas.

Measure-Specific Recommendations

Application of the MAP MSC also generated a series of measure-specific recommendations to immediately strengthen the Medicaid Adult Core Set. Several relate to MSC #1 and the general principle that the best available NQF-endorsed measures are strongly preferred for use in program measure sets. For measures that have not been endorsed or have had endorsement removed, CMS should consider updates or possible substitutions as detailed below. MAP recommends that Core Set measures not specifically discussed below remain unchanged.

NQF #0031: Breast Cancer Screening

Discussion: Breast Cancer Screening has lost NQF endorsement since the Medicaid Adult Core Set was published. Since that time, the measure steward, the National Committee on Quality Assurance (NCQA), has completed an update of the measure that incorporates new clinical practice guidelines and has included new specifications in the 2014 HEDIS manual. NCQA plans to submit the revised measure at the next endorsement review opportunity offered by NQF.

Recommendation: MAP requires the use of NQF-endorsed measures in program sets, if available, because of their recognized rigor. While this measure is not currently endorsed, MAP supports continued focus on breast cancer screening. MAP recommends that CMS use the most current version of the measure in the Medicaid Adult Core Set and encourages NCQA to submit the updated measure for NQF endorsement. One comment further supported this recommendation.

NQF #0403: Annual HIV/AIDS Medical Visit

Discussion: Annual HIV/AIDS Medical Visit has lost NQF endorsement since the Medicaid Adult Core Set was published. Endorsement was removed during the measure's most recent maintenance review. The measure steward, NCQA, has no intention to edit and resubmit the measure.

Recommendation: In cases when a measure has lost endorsement and it is not updated or replaced, use of the measure should stop. Such a measure should be replaced in the program set by a superior measure on the same topic. HIV/AIDS is a high-impact condition in the Medicaid population and MAP recommends that CMS consider another NQF-endorsed HIV/AIDS measure as a replacement. MAP strongly supports use of measure #2082: Viral Load Suppression because it is a highly meaningful and regularly collected clinical indicator that is predictive of overall outcomes. This measure is also perceived as relatively less burdensome for data collection because it can be drawn from administrative data. The workgroup also supported #2083: Prescription of HIV Antiretroviral Therapy Regardless of Age as a possible alternative.

One comment noted that it is challenging to identify individuals with HIV and ensure that they receive treatment, suggesting a measure of early diagnosis as an alternative to the outcome-oriented measures. Another comment voiced support for use of #2083: Prescription of HIV Antiretroviral Therapy Regardless of Age.

NQF #0021: Annual Monitoring for Patients on Persistent Medications

Discussion: Annual Monitoring for Patients on Persistent Medications has lost NQF endorsement since the Medicaid Adult Core Set was published. The steward, NCQA, withdrew this measure from consideration during its most recent maintenance review. NCQA has not yet determined whether they will revise and resubmit the measure.

Recommendation: The measure should be updated or replaced with an endorsed measure on the same topic. Medication management is critical to achieving high quality care and good health outcomes; measures of this process are therefore very important quality indicators. Measurement should reflect frequent beneficiary-provider interactions and a shared decision-making process about medication choices. Measures that assess a single point in time, one condition, or only one prescription will fail to reflect the quality of attention being paid to medication management in states' Medicaid programs. Unfortunately, currently endorsed measures on this topic tend to focus on single medications (e.g., warfarin) or an older population (65+) and are not as appropriate as the original measure for a broad-based program like the Medicaid Adult Core Set. MAP recommends that CMS retain the measure in the set for the time being, monitor measure development in this topic area, and update or replace the measures as soon as a suitable alternative is available.

A comment from the Pharmacy Quality Alliance suggested several specific measures as possible substitutes. The suggested measures are NQF-endorsed, in use by the Medicare Part D Star Ratings program, and are derived from claims. However, each one is focused on a single condition (e.g., diabetes, asthma, cardiovascular disease).

NQF #0039: Flu Shots for Adults Ages 50-64

Discussion: Flu Shots for Adults Ages 50-64 excludes Medicaid enrollees 18-49, a large portion of the Medicaid population. The Centers for Disease Control and Prevention (CDC) recommends that all adults receive annual vaccination against the flu. Moreover, pregnant women, older adults, and people with certain chronic conditions or disabilities are at higher risk of poor outcomes if they become infected with influenza.

Recommendation: MAP recommends that the measure be expanded to include all adults. The measure steward, NCQA, has completed an update of the measure that broadens the denominator age group to include all individuals age 18 and older and has included new specifications in the 2014 HEDIS manual. MAP strongly encourages NCQA to submit the new specifications to NQF during the measure's annual update process. MAP further recommends that CMS use the most current, expanded version of the measure in the Medicaid Adult Core Set.

Comments also supported expansion of the measure's age range as a way to bolster influenza immunization rates in the Medicaid population. Comments also noted concern that references in the measure to flu "shots" were too limiting given the availability of other modes of vaccination such as

nasal spray. Adoption of the measure specifications in the 2014 HEDIS set would address this concern as the measure is now titled "Flu Vaccinations for Adults Ages 18-64."

Other comments stated that 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. NQF notes that the final notice announcing the Core Set described this measure as being collected as part of the HEDIS CAPHS Supplemental Survey. If that is still the case, potential weakness in the measure is more likely to stem from respondents recall ability than it is from health plans' incomplete data. MAP encourages CMS to devote further attention to this feasibility issue once the first round of data from states is available.

NQF# 1690: Adult Body Mass Index (BMI) Assessment

Discussion: Adult Body Mass Index (BMI) Assessment has not been NQF-endorsed. The steward, NCQA, withdrew this measure from consideration during the endorsement process and intends to revise and re-submit the measure for future NQF review.

Recommendation: The measure should be updated or replaced with an endorsed measure on the same topic. Obesity is common in the Medicaid population, and MAP recommends that CMS consider an NQF-endorsed measure as a replacement if NCQA's update is not forthcoming. MAP specifically supports use of measure #0421: Preventive Care and Screening: BMI Screening and Follow-Up, as an alternative. This NQF-endorsed measure complies with the current USPSTF recommendations. Moreover, it is possible to collect measure #0421 from administrative claims data or electronic medical records, an important consideration for the feasibility of implementing this measure in the Medicaid Adult Core Set.

Comments cautioned that Adult BMI Assessment is burdensome to health plans as it requires electronic health record data extraction or medical chart review. CPT-II codes are available for use; however, industry experience shows that codes are not always submitted. Comments also supported MAP's suggestion of an alternative measure.

NQF #1768: Plan All-Cause Readmissions

Discussion: There is not a risk adjustment methodology for the Medicaid population in Plan All-Cause Readmissions. Risk adjustment is necessary to fairly interpret measure results. Without it, 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 be significantly different than the general population and justifies use of an appropriate risk adjustment methodology.

Recommendation: MAP stressed the importance of risk adjustment for the Medicaid population and strongly supports CMS' planned effort to work with the measure steward to develop a Medicaid-specific methodology. Comments underscored MAP's recommendation. MAP also encourages CMS to consider other potential applications of this work to other measurement programs for the Medicaid population.

NQF #0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Discussion: NQF #0647: Transition Record with Specified Elements Received by Discharged Patients and NQF #0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) are paired measures; however, only #0648 is included in the Medicaid Adult Core Set. Safe and effective care transitions after discharge from a hospital environment are highly dependent upon many levels of communication. Transition records need to be effectively shared with providers receiving the hand-off as well as individuals being discharged and their families and caregivers. Participants in the review noted that these measures are specified for the facility level of analysis and therefore are more challenging to collect than those designed for populations or health plans. CMS noted that they are aware of the difficulties and view Timely Transmission of Transition Record as a "stretch" or "aspirational" measure but want to encourage states to build the relationships with providers that are necessary to collect and report this measure.

Recommendation: CMS should consider adding Transition Record with Specified Elements Received by Discharged Patients to the measure set. Doing so would enhance person-centeredness and may also improve the feasibility of data collection for Timely Transmission of Transition Record. MAP noted that these paired measures do not fully address the important issues of care coordination or care management, however Timely Transmission of Transition Record is the only measure in the Medicaid Adult Core Set that directly assesses care coordination, and so it should be preserved.

Because the current care coordination measure is known to be very challenging to implement, MAP discussed the possibility that adding a second similar measure may have limited utility. Comments also remarked upon the burden associated with collecting this measure. However, MAP would prefer that states be encouraged to collect the paired measures and that CMS support their efforts to do so. In the event that more meaningful and/or more feasible measures of care coordination are identified, MAP would support their substitution for the paired measures related to communication upon discharge.

III. Future Activities

In the coming months, CMS and its technical assistance team will work with participating states to complete the first submission of performance measure data to CMS. This data is scheduled to be made publicly available by September 30, 2014. CMS is also planning to begin measure development activities in 2014, moving one step closer to making new measures available to fill key gaps in the Core Set.

MAP will have the opportunity to conduct a second review of the Medicaid Adult Core Set in mid-2014. NQF and MAP will continue to work closely with CMS and its technical assistance providers to monitor implementation challenges and further opportunities for strengthening the Core Set. At the request of MAP members, NQF will support future deliberations by gathering information on data collection methodologies and their relative feasibility at the state level, the testing of scientific properties of any measures altered after endorsement, how states are acting on the performance data they collect to improve quality, and plans for public reporting.

Alignment across programs will continue to be an important theme for MAP's second review of the Medicaid Adult Core Set. Specifically, MAP will examine the Core Set's relationship to the to the Children's Health Insurance Program Reauthorization Act (CHIPRA) Core Set of Children's Health Care

Quality Measures to assess comprehensiveness and alignment between the two programs. MAP will seek lessons learned from the development and implementation of the CHIPRA Core Set and identify best practices that can be generalized to the Medicaid Adult Core Set. In addition, a close comparison of the two program measure sets will provide a more complete picture of the measures available to assess the critical areas of maternity care and birth outcomes.

Appendix A: Initial Core Set of Measures for Medicaid-Eligible Adults

On January 4, 2012, HHS published a final notice in the *Federal Register* to announce the initial core set of health care quality measures for Medicaid-Eligible adults. The table below lists the measures included in the Core Set along with their current NQF endorsement number and status. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's Quality Positioning System.

Measure # and NQF Endorsement Status	Measure Title	Measure Steward
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA
0006 Endorsed	CAHPS Health Plan Survey v 4.0 - Adult questionnaire	AHRQ
0007 Endorsed	NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)	NCQA
0018 Endorsed	Controlling High Blood Pressure	NCQA
0021 Endorsement Removed	Annual monitoring for patients on persistent medications	NCQA
0027 Endorsed	Medical Assistance With Smoking and Tobacco Use Cessation	NCQA
0031 Endorsement Removed	Breast Cancer Screening	NCQA
0032 Endorsed	Cervical Cancer Screening	NCQA
0033 Endorsed	Chlamydia screening in women [ages 21-24 only]	NCQA
0039 Endorsed	Flu shots for Adults Ages 50 and Over	NCQA
0057 Endorsed	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	NCQA
0063 Endorsed	Comprehensive Diabetes Care: LDL-C Screening	NCQA
0105 Endorsed	Antidepressant Medication Management	NCQA
0272 Endorsed	Diabetes Short-Term Complications Admissions Rate (PQI 1)	AHRQ
0275 Endorsed	Chronic obstructive pulmonary disease (PQI 5)	AHRQ
0277 Endorsed	Heart Failure Admission Rate (PQI 8)	AHRQ
0283 Endorsed	Asthma in Younger Adults Admission Rate (PQI 15)	AHRQ
0403 Endorsement Removed	HIV/AIDS: Medical Visit	NCQA
0418 Endorsed	Screening for Clinical Depression	CMS
0469 Endorsed	PC-01 Elective Delivery	The Joint Commission
0476 Endorsed	PC-03 Antenatal Steroids	The Joint Commission
0576 Endorsed	Follow-Up After Hospitalization for Mental Illness	NCQA
0648 Endorsed	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	AMA-PCPI
1517 Endorsed	Prenatal & Postpartum Care [postpartum care rate only]	NCQA
1690 Not Endorsed	Adult BMI Assessment	NCQA
1768 Endorsed	Plan All-Cause Readmissions	NCQA
1879 Endorsed	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	CMS

Appendix B: Roster for the MAP Dual Eligible Beneficiaries Workgroup

CHAIR (VOTING)
Alice Lind, MPH, BSN

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	Gwendolen Buhr, MD, MHS, MEd, CMD
America's Essential Hospitals	Steven Counsell, MD
Center for Medicare Advocacy	Alfred J. Chiplin, JD, MDiv
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE
L.A. Care Health Plan	Jennifer Sayles, MD, MPH
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Substance Abuse	Mady Chalk, MSW, PhD
Disability	Anne Cohen, MPH
Emergency Medical Services	James Dunford, MD
Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Medicaid ACO	Ruth Perry, MD
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Jamie Kendall, MPP

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Substance Abuse and Mental Health Services Administration	Lisa Patton, PhD
Veterans Health Administration	Daniel Kivlahan, PhD

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

Appendix C: Roster for the MAP Coordinating Committee

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

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Gerry Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip Kahn
LeadingAge	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Shari Davidson
National Partnership for Women and Families	Representative to be determined
Pacific Business Group on Health	William Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher Dezii, RN, MBA,CPHQ

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Gail Janes, PhD, MS
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Health Resources and Services Administration (HRSA)	John E. Snyder, MD, MS, MPH (FACP)
Office of Personnel Management/FEHBP (OPM)	Edward Lennard, PharmD, MBA
Office of the National Coordinator for HIT (ONC)	Representative to be determined

ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
American Board of Medical Specialties	Lois Margaret Nora, MD, JD, MBA
National Committee for Quality Assurance	Peggy O'Kane, MHS
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

Appendix D: Public Comments Received on Draft Report

Comment Category	Commenter Name and Organization	Comment
Comments on Population, Program, or MAP's Approach	Carmella Bocchino America's Health Insurance Plans	While we recognize that the current measure set represents a starter set, we would like to encourage CMS to adopt measures that take into account social determinants of health (e.g. education and income) as these factors are important for the Medicaid population.
Comments on Population, Program, or MAP's Approach	Thomas James AmeriHealth Caritas	AmeriHealth Caritas appreciates the opportunity to comment. We agree that the Medicaid population is a special, vulnerable population for which specific measures recognizing the complex social, behavioral, and physical issues are important. The MAP approach to this population was appropriate however due to truncated timelines, AmeriHealth Caritas is concerned that the Work Group was unable to devote the effort toward more in-depth consideration of the impact of social and behavioral forces; nor separate out the different health pattern needs of the non-elderly disabled, CHIP, and the new populations joining via the Marketplace. We encourage a greater exploration of measures to adequately describe the health conditions of the various populations within Medicaid in order to strengthen the Medicaid adult core measure set. Additional comments on areas not addressed in the report but have operational impacts on measure capture: IT: One issue not address in the MAP's recommendations includes IT platform variation. The various states have different IT platforms, different fields in reporting, and gather much of their quality data in different fashions making comparisons across states not valid. Behavioral health: Many states carve out pharmacy, mental health and dental from medical so that measures of medication persistence or follow-up from mental health may not be valid.

Comment Category	Commenter Name and Organization	Comment
Comments on MAP's General Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Phyllis Arthur Biotechnology Industry Organization	The Biotechnology Industry Organization (BIO) appreciates the opportunity to comment on the report entitled: Measure Applications Partnership: Expedited Review of the Core Set of measures for Medicaid-Eligible Adults. BIO represents more than 1,100 biotechnology companies, academic institutions, state biotechnology centers and related organizations across the United States and in more than 30 other nations. BIO members are involved in the research and development of innovative healthcare, agricultural, industrial, and environmental biotechnology products. BIO membership includes both current and future vaccine developers and manufacturers who have worked closely with the public health community to support policies that help ensure access to innovative and life-saving vaccines for all individuals. We feel that the development and testing of quality measures for immunizations across the life span will have a significant impact on immunizations rates for all. BIO strongly supports expansion of NQF #0039 to include Medicaid enrollees ages 18-49 as a way to bolster influenza immunization rates in this population. We are concerned, however, that references in the measure specification to flu "shots" could be misinterpreted as limiting the use of the measure to influenza vaccinations delivered via injection. As NQF may be aware, influenza vaccines are available in alternate routes of administration, including a nasal spray. To ensure that the measure does not inadvertently limit patient access to a choice of routes of administration, we recommend that NQF ensure that references throughout the measure specification refer to "influenza vaccination," rather than "flu shot," and that any other parameters that could be misread as referring only to injectable influenza vaccines are similarly revised. Use of the term "vaccination" is consistent with terminology in the HEDIS 2014 Summary Table of Measures, Product Lines and Changes (see page 7 http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2014/List%20of%20HEDIS%202014%20Measures.pdf.) Conclusion: BIO appreciates the opportunity to comment on this important set of measures. Please do not hesitate to contact us for further information or clarification of our comments. Thank you for your attention to this very important matter.

Comment Category	Commenter Name and Organization	Comment
Comments on MAP's General Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Thomas James AmeriHealth Caritas	We have comments under several categories: Disparities of care: None of the 26 measures address disparities of care despite the availability of such measures in the NQF portfolio and inclusion within the MAP Measure Selection Criteria. AmeriHealth Caritas recommends MAP re-evaluate the inclusion of measures that address disparities of care. CAHPS Survey: The listed CAHPS Health Plan Survey measure includes Version 4.0 whereas health plans are currently on Version 5.0. We encourage MAP to revise listing to include Version 5.0. OB Measures: We support inclusion of the two OB measures in the core measure set, and urge MAP to consider measures specific to premature deliveries, where this is of greater concern for the Medicaid population. Such measures as percent of women delivering at term would be important to include within the core measure set. Determinants of health: The core measure set includes measures that improve health outcomes for chronic conditions such as heart disease and diabetes; however there is no inclusion of measures for the social determinants of health, something especially important for this population. Measures such as NQF #0011 Oregon's Promoting Health Development Survey would be models for future measure development. Risk adjustment: There are measures for which health plans do not have data (e.g. flu shots) and ones where it is very much dependent upon which Medicaid programs are enrolled by any one health plan. For example, the TANF population is quite different than the ABD population, so comparing health plans (or providers who see one group disproportionately) can give a biased view of quality. There must be risk adjustment if the measures are to be meaningful.
Comments on MAP's General Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Carmella Bocchino America's Health Insurance Plans	We believe that NQF-endorsed measures should be used to the extent possible, however, in clinical areas where NQF-endorsed measures are not available, we support the use of alternative measures while those measures are considered for NQF endorsement. Additionally, every effort needs to be made to minimize burden of data collection. Measures collected via administrative methodologies should be prioritized over measures that require hybrid data sources – administrative and medical chart review data. While a single measure that requires chart review may not significantly increase burden, a collection of measures that use hybrid data sources can add tremendous burden to providers and health plans. The burden associated with a given measure set needs to be assessed, e.g., using a gradient or scale, prior to implementation. As health information technology is broadly adopted, measures that rely on clinical data sources can be added, if captured in the electronic medical record or other systems, such as clinical registries.

Comment Category	Commenter Name and Organization	Comment
Comments on MAP's Measure-Specific Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Kathy Gans-Brangs AstraZeneca	Page 7: Flu Shots for Adults Ages 18-49. MedImmune, Specialty Care Division of AstraZeneca strongly supports expansion of NQF #0039 to include Medicaid enrollees ages 18-49 as a way to bolster influenza immunization rates in this population. We are concerned, however, that references in the measure specification to flu "shots" could be misinterpreted as limiting the use of the measure to influenza vaccinations delivered via injection. As NQF may be aware, influenza vaccines are available in alternate routes of administration, including a nasal spray. To ensure that the measure does not inadvertently limit patient access to a choice of routes of administration, we recommend that NQF ensure that references throughout the measure specification refer to "influenza vaccination," rather than "flu shot," and that any other parameters that could be misread as referring only to injectable influenza vaccines are similarly revised. Use of the term "vaccination" is consistent with terminology in the HEDIS 2014 Summary Table of Measures, Product Lines and Changes (see http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2014/List%20of%20HEDIS%202014%20Measures.pdf, page 7).
Comments on MAP's Measure-Specific Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Thomas James AmeriHealth Caritas	Seven measures were specifically called out on by the MAP Work Group: • NQF #0031 Breast Cancer Screening—AmeriHealth Caritas supports this measure • NQF #0403 Annual HIV/AIDS Medical Visit—We agree with the Work Group that of the NQF endorsed HIV measures #2083 Prescription of HIV Antiretroviral Therapy is the best measure as it counts visits and Rx. • NQF #0021 Annual Monitoring of patients of persistent medications—We agree with the Work Group that this measure looks at Medicaid enrollees with chronic conditions on long-term therapy. • NQF #0039 Flu Shots for Adults Ages 50-64—We disagree with this measure because of the variety of sources of flu shots so data is not easily available, requiring chart review; and the importance of this measure for this population may be less than other measures especially the AFDC subpopulation. • NQF #1690 Adult Body Mass Index Assessment—We agree with the work group that this is not a good measure for a Medicaid measure. Other measures of obesity management may have a greater impact • NQF #1769: Plan All-Cause Readmission—Considering the wide variations in Medicaid subgroups, this measure is not helpful since it is not risk adjusted • NQF #0648 Timely Transmission of transition records—This is very important but is not part of data captured by Medicaid nor health plans. It is appropriate at the IDS or facility level as recommended

Comment Category	Commenter Name and Organization	Comment
Comments on MAP's Measure-Specific Recommendations on the Initial Core Set of Measures for Medicaid-Eligible Adults	Carmella Bocchino America's Health Insurance Plans	*NQF #0403: Annual HIV/AIDS Medical Visit* - We are supportive of the MAP recommendation as it relates to the inclusion of HIV/AIDS as a high-impact condition in the Medicaid population; however, we are concerned with MAP's recommendation to replace #0403 (Annual HIV/AIDS Medical Visit) with #2082 (Viral Load Suppression) or #2083 (Prescription of HIV Antiretroviral Therapy Regardless of Age). Significant barriers currently exist with being able to identify patients with HIV and to ensure that they seek treatment. Given these challenges, initial measurement could focus on early diagnosis and receipt of care, rather than measuring optimal treatment. *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. *NQF #1690: Adult Body Mass Index (BMI) Assessment)* – While we recommend using the updated version of this NCQA measure once it has been revised, we caution that this measure is burdensome to health plans as it requires electronic health record data extraction or medical chart review. CPT-II codes are available for use; however, industry experience shows that codes are not always submitted. Until the updates on #1690 are completed, we recommend using a currently available measure on this same topic. *NQF #0648: Timely Transmission of Transition Record* –This measure is important for the Medicaid population, as they are highly dependent on communication among facilities, providers, and families or caregivers. Industry experience shows that health plans use this measure in pay-for-performance programs; however, as a hospital-centric measure it is burdensome and difficult to collect as it may require electronic health record data extraction or medical chart review.

Comment Category	Commenter Name and Organization	Comment
General Comments	E. Clarke Ross American Association on Health and Disability	AAHD has coordinated our comments with Leo Cuello, workgroup member and National Health Law Project (NHeLP); Jamie Kendall and Shawn Terrill, Administration for Community Living (ACL); and Maureen Fitzgerald, the Arc and a co-chair of the Consortium for Citizens with Disabilities (CCD) Task Force on Long Term Services and Supports. As observed by the NHeLP, we 1. Commend the general recommendation for broader mental health screening (2nd para page 6). 2. Commend the access to care concept (3rd para page 6). 3. Commend but needed are expansions to patient-centeredness (4th para page 6). 4. Need for more care coordination measures and acitivites (in context of #0648, page 8), and tying this to care management for vulnerable populations. 5. Need to more explicitly address Gaps. As discussed on the September 27 call: The NQF tentative report attempts to address a major CMS omission - the consumer (patient) experience. CAPHS and the findings from the CMS HCBS experience survey, when available, should be stressed in the report. [Although, the disability community has concerns with the prohibition of proxy responses for some individuals in the HCBS experience survey.] Page 6 of the public comment document acknowledges a major gap: "goal-directed, person-centered care, and outcomes that matter to individuals enrolled in Medicaid." We commend the observation and ask that this acknowledgement also expressly "include a focus on community integration." We believe that a frequent medication monitoring process be expected. Page 7 of the public comment document recommends an "annual" medication monitoring. This is not sufficient. We do not have a suggested alternative measure but this an annual requirement is inadequate. We believe that the Medicaid adult measures must reference the July-August NQF recommended 15 starter-set measures for persons dually eligible for Medicare and Medicaid. NQF and CMS should clearly explain why any of these 15 measures are not appropriate for inclusion in the Medicaid adult measures. We reinforce the observations made on our September 27 call: The NQF report should emphasize personal experience, personal preference, functional status, community integration, social determinants of health, and why the mental health measures were narrowly focused on a few distinct diagnoses. We appreciate that page 6 of the public comment document identified most these area as gaps. We suggest that the NQF and CMS measures reference and use the SAMHSA behavioral health quality framework. However, the SAMHSA framework contains many of the same gaps and omissions contained in these measures.

Comment Category	Commenter Name and Organization	Comment
General Comments	Thomas James AmeriHealth Caritas	AmeriHealth Caritas appreciates the opportunity to reinforce our belief that Measures of Quality, especially for vulnerable populations must address the five determinants of population health (as adapted from Beltran VM et al, Public Health Reports, 126, Sup 3 Pg41, 2011): Biology and Genetics (Gender, ethnicity, intellectual, behavioral and physical conditions, etc.) Individual Behavior (risky behaviors) Social determinants of health (education, income, discrimination, etc.) Physical Environment (Safety, crowding, exposures) Access to appropriate health services, including physical and behavioral. The five determinants are cross functional with impacts on one determinant coming from others. These Adult Core Measures for Medicaid address only number 5 (access to appropriate health services), placing results of the efforts by physicians, hospitals, health plans and other providers as dependent upon the other for determinants. MAP should encourage the development of measures for communities to address how they can manage their own populations.

Comment Category	Commenter Name and Organization	Comment
General Comments	Emily Spitzer National Health Law Program	The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We write to provide comments to the draft report "Expedited Review of the Initial Core Set of Measures for Medicaid-Eligible Adults." In addition to our comments, provided below, we would like to support the recommendations regarding annual medication monitoring (annual is insufficient), measurement gaps, and SAMHSA's behavioral health quality framework filed on behalf of the American Association on Health and Disability. We strongly commend the general recommendation, on page 6 of the report, for measures of broader mental health screening. We believe this is critical because mental health conditions are insufficiently diagnosed (and treated), they present serious health conditions in and of themselves, and they act as a major and costly barrier to adequate physical and functional health care access and delivery. We also strongly commend the general recommendation, on page 6, for measures related to access to care. Such measures are vital to assessing systemic causes of health disparities and will be particularly important as large numbers of vulnerable enrollees transition to new care management models changing the way care is accessed. With delivery system reform, we must be able to answer the question: are people accessing the care they need? Similarly, we strongly support the general recommendation, on page 6, for measures that promote patient-centeredness. We urge development of measures that assess whether individuals feel like they have a say in their own care, whether their rights are respected and promoted, and whether they are well integrated into the larger community. We also believe that patient-centered care is a gateway to achieving other challenging health system objectives, such as promoting quality of life and maximizing function. The discussion of measure #0648 on page 8 raises the broad concern about whether we have the measurement tools to effectively measure care coordination. We agree that, in the narrow but important context of discharges, it is also important to provide consumers (in addition to providers) with a timely transition record – we support this recommendation and believe it is a prerequisite to providing patient-centered care. But we also agree that even both the provider and consumer measures together represent only a small piece of the care coordination puzzle. Millions of vulnerable Medicaid enrollees are being transitioned into new care management models, and we desperately need measures to assess whether their care is being well-managed. If new delivery systems achieve savings, we need broad care coordination measures which can tell us whether the savings are the result of care efficiently coordinated or repeatedly denied. While this is a core set for "adults" broadly, we believe great care coordination measures would benefit all Medicaid recipients, particularly seniors and persons with disabilities who may have complex medical conditions that need well-coordinated care to be well managed.

Comment Category	Commenter Name and Organization	Comment
General Comments	Emily Spitzer National Health Law Program	[continued] Finally, we urge aggressive focus on measures targeting the many measurement gaps that exist today. Some of these have already been alluded to above. But it bears repeating that millions of consumers will undergo major changes to their health care delivery, and to the extent measurement can protect them, we urge the MAP to address measure gap areas including: care coordination, access to care, patient experience, patient-centeredness, patient preferences, functional status, community integration, quality of life, and broad screening and treatment for mental health needs. In sum, we are encouraged that many issues that are important to health care consumers are addressed in the draft report, and we hope our suggestions will be of use for addressing additional issues in on-going measure development. Thank you for consideration.

Comment Category	Commenter Name and Organization	Comment
General Comments	Julie Kuhle on behalf of Laura Cranston Pharmacy Quality Alliance, Inc.	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. Established in 2006, PQA is a multi-stakeholder, consensus-based membership organization that collaboratively promotes appropriate medication use and develops strategies for measuring and reporting performance information related to medications. Assessment of quality in medication use and management throughout the healthcare delivery continuum leads to improved health. With only two NQF endorsed measures in the Initial Core Set having a focus on medication use (Adherence to Antipsychotics for Individuals with Schizophrenia and Antidepressant Medication Management), PQA suggests that the MAP consider the following additional medication measures. • Certain measures included in the original list of 43 measures that did not make the final Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid should be reconsidered for inclusion. PQA recommends adding three PQA and NQF-endorsed medication adherence measures: Adherence to Renin Angiotensin System (RAS) Antagonists, Adherence to Oral Medications for Diabetes and Adherence to Statin Medications. These measures are focused on cardio-vascular disease, are NQF-endorsed and are used by CMS in the Medicare Part D Star Ratings program. Other measures for consideration include the following: • NQF endorsed measure - Appropriate Treatment of Hypertension in Patients with Diabetes assesses the percentage of patients who are receiving appropriate therapy per the American Diabetes Association guidelines with either an ACE-Inhibitor, ARB or direct renin inhibitor medication. • NQF endorsed measure - Medication Therapy for Persons with Asthma. Two measures have been developed for patients with asthma to assess the percentage of patients with suboptimal asthma control and percentage of patients lacking controller therapy. All above PQA measures are calculated using prescription claims data and therefore add little to the burden of data collection. PQA uses a rigorous consensus-driven process to develop, test, and endorse high-priority measures of medication-use quality. We would welcome the opportunity to discuss the inclusion of the PQA measures in the Adult Medicaid Core Set of measures.

Appendix E: The Adult Medicaid Population

Since 1965, Medicaid has been an important source of health coverage for low-income adults and children. Following Medicaid expansion under the Affordable Care Act (ACA), enrollment is projected to rise from 15 percent of the country's population in 2010 to 25 percent in 2020.[1] At last count (2009), 62.7 million people were covered by Medicaid, including 30.7 million children, 16.3 million adults, and 15.6 million elderly or disabled individuals.[2]

Average Medicaid spending per enrollee varies sharply by eligibility group. In 2009, average annual payments totaled $2,300 per child, $2,900 per non-elderly adult, $15,840 per disabled enrollee, and $13,150 per elderly enrollee.[3] While non-elderly, non-disabled adults consume relatively fewer resources than individuals who receive long-term supports and services, their healthcare needs can still be significant. In particular, adults' access to high-quality preventive care and chronic disease management can greatly affect lifetime health outcomes.

MAP considered the overall health status of adult Medicaid enrollees and conditions that are common in the population to ensure that measures in the Adult Core Set were appropriately tailored. Overall, it is important to note that approximately one in five adults younger than 65 on Medicaid reports fair or poor physical health; approximately one in seven reports fair or poor mental health.[4,5] In addition, Medicaid plays a dominant role in covering reproductive health services. Nearly two in three adult women on Medicaid are in their reproductive years (19-44) and an estimated 48 percent of births in the U.S. were paid for by Medicaid in 2010.[6] Finally, an estimated 57% of adults covered by Medicaid are overweight, diabetic, hypertensive, have high cholesterol, or a combination of these conditions.[7]

New adult Medicaid enrollees have a slightly different profile, and MAP also considered this in its review. Potentially eligible adults under ACA expansion are projected to have better or equal health status than current enrollees, with lower rates of obesity and depression.[8] However, the prevalence of other behavioral health conditions may be higher. In addition, 49% of potentially eligible adults report using tobacco and 22% report high or moderate alcohol use.[9] These use rates are significantly higher among new enrollees than current enrollees and underline the importance of addressing these and other modifiable risk factors.

MAP also considered demographic factors and social determinants of health. Adults covered by Medicaid tend to be non-white, unmarried, and to have less than a high school level of education.[10] Medicaid enrollees are affected by disparities in health and healthcare, often facing barriers to accessing needed services.

Appendix F: Overview of the Medicaid Adult Core Set Program

Statutory Authority

The Affordable Care Act (ACA, section 1139B) requires that the Secretary of HHS identify and publish for public comment a recommended initial core set of health care quality measures for Medicaid-eligible adults.[11] The statute requires the initial core set to be comprised of "existing adult health care quality measures in use under public and privately sponsored health care coverage arrangements or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time and that may be applicable to Medicaid-eligible adults."[12]

To assess the quality of care for adults enrolled in Medicaid, the law calls for HHS to:

1. Develop a standardized reporting format for the core set of measures;
2. Establish an adult quality measurement program;
3. Issue an annual report by the Secretary on the reporting of adult Medicaid quality of care information and a Report to Congress every three years; and
4. Publish updates to the initial core set of adult health quality measures that reflect new or enhanced quality measures.[13]

Process for Compiling the Initial Core Set of Measures for Medicaid-Eligible Adults

In 2010, the Centers for Medicare & Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ), and developed a subcommittee to the National Advisory Council for Healthcare Research and Quality. The subcommittee was charged with considering the health care quality needs of adults ages 18 and older enrolled in Medicaid. Members represented a broad range of experts and stakeholders, including multiple individuals who also serve on MAP.

The subcommittee focused on four dimensions of health care related to adults enrolled in Medicaid: adult health, maternal/reproductive health, complex health care needs, and mental health and substance use. Starting from approximately 1,000 measures drawn from nationally recognized sources, the group deliberated and identified 51 measures for public comment.

Public comments commonly remarked upon the large size of the measure set and suggested that it be aligned with existing reporting programs to reduce data collection and reporting burden. Other, less frequent comments suggested: 1) avoiding measures that require medical record review, 2) using only measures endorsed by NQF, 3) re-examining the appropriateness of some proposed measures, and 4) including measures related to the topics of patient safety and rehabilitation. Additionally, comments cumulatively suggested that 43 measures be considered for addition to the set, many of which had been previously considered.

Following public comment, CMS considered how to reduce the size of the measure set utilizing five criteria identified based on NQF's endorsement criteria: importance, scientific evidence supporting the measure, scientific soundness of the measure, current use in and alignment with existing Federal programs, and feasibility for state reporting. In January 2012, CMS published the final rule with a total of 26 measures for voluntary use by states as the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid.[14]

State Experience in Collecting the Medicaid Adult Core Set Measures: Adult Medicaid Quality Grants

CMS has identified a three-part goal for this quality reporting program: increasing the number of states reporting Medicaid Adult Core Set measures, increasing the number of measures reported by each state, and increasing the number of states using Core Set measures to drive quality improvement.

To assist in understanding how well the Medicaid Adult Core Set measures and their technical specifications could be collected by states, CMS launched a two-year grant program in December 2012. All state were given an opportunity to participate, and grants were made to 26 Medicaid agencies for the development of staff capacity to collect, report, and analyze data on the Medicaid Adult Core Set. In addition, the grantees are required to conduct two quality improvement projects using measures from the Core Set. States receive technical assistance and analytic support as part of the grant program.

The 26 grantee states collectively enroll approximately 23 million adults, roughly 69% of the adults currently in Medicaid. Non-grantee states are also encouraged to voluntarily report the Medicaid Adult Core Set measures. Broad participation in the program will provide better understanding of the experience of applying measures and allow for sharing of best practices among state Medicaid agencies.

Early feedback from the grantees has provided better understanding of the feasibility of implementing the measures in the Medicaid Adult Core Set. Specific challenges have included reporting physician-level and hospital-level measures at the state level, difficulties with measures that require medical record review, and the need for more detailed and straightforward technical specifications. Grantee feedback will continue to be monitored and shared with MAP for future decision-making.

Future Activities

Voluntary reporting of Medicaid Adult Core Set measure data to CMS is scheduled to begin at the end of 2013.[15] By January 1, 2014, HHS will annually publish recommended changes to the Core Set that reflect the results of the testing, validation, and consensus process for the development of adult health quality measures. By September 30, 2014, HHS will collect, analyze, and make publicly available the information reported by the states as required in section 1139B(d)(1) of the Act.[16] HHS will also include information on adult health quality in a mandated report to Congress, to be published every 3 years in accordance with the statute.

Appendix G: MAP Measure Selection Criteria

(Version used at time of Workgroup Review)

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 decision-making, 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)

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Contract HHSM-500-2012-00009I
Task order 11

ISBN 978-1-933875-56-9

MAP MEASURE SELECTION CRITERIA

NATIONAL QUALITY FORUM

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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.

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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)

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CMCS Informational Bulletin

DATE: December 19, 2013

FROM: Cindy Mann
Director

SUBJECT: **2014 Updates to the Child and Adult Core Health Care Quality Measurement Sets**

This informational bulletin describes the 2014 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 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 as measures have a life cycle based on many factors including changes in clinical guidelines and challenges with reporting.

2014 Child Core Set

Since the release of the initial core set of children's health care quality measures 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.[1]

For the 2014 Child Core Set update, CMCS partnered with the Agency for Healthcare Research and Quality (AHRQ) to conduct a multi-stakeholder review of the measures. The review focused solely on identifying which, if any, of the Child Core Set measures should be considered for retirement. Using four criteria,[2] the multi-stakeholder group reviewed 20[3] of the Child Core measures. Additional information about the review process can be found at: http://www.ahrq.gov.

[1] 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

[2] Criteria: importance, scientifically acceptability, feasibility, and usability.

[3] The six Child Core Set measures not considered for retirement in 2014 were three measures that had just been added in 2013; two measures that are tied to the CMS Oral Health Initiative; and the CAHPS survey. Beginning December 2013, Title XXI (CHIP) Programs are required report the CAHPS survey to CMS.

CMCS will retire three measures from the Child Core Set:[4] 1. Appropriate Testing for Children with Pharyngitis (two to 18 years)[5]; 2. Annual Pediatric Hemoglobin A1C Testing (five to 17 years)[6]; and 3. Annual Percentage of Asthma Patients who are two to 20 years old with one or more Asthma-related Emergency Department Visits.[7]

2014 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.

CMCS worked with the National Quality Forum's (NQF) Measures Application Partnership (MAP)[8] to review the Adult Core Set and identify ways to improve it. Based on that feedback, one measure, Annual HIV/AIDS Medical Visit,[9] will be retired and replaced by HIV Viral Load Suppression.[10] After consulting with states, CMCS decided not to pursue additional replacements for 2014. Additional information about the MAP review process 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 Federal Fiscal Year 2014 reporting cycle, which will begin no later than December 2014. To support states in making these changes, CMCS will release updated technical specifications for both Core Sets in spring 2014 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 about the Child and Adult Core Sets can submit them to: MACQualityTA@cms.hhs.gov.

If you have questions about this bulletin, please contact Karen LLanos, Children and Adults Health Programs Group, at Karen.Llanos@cms.hhs.gov.

[4] The multi-stakeholder group also suggested retiring the Child Core measure *Child and Adolescent Access to Primary Care Practitioners*. Due to the importance of this measure for monitoring access, it will remain part of the 2014 Child Core Set.
[5] Measure steward: National Committee for Quality Assurance, NQF#0002
[6] Measure steward: National Committee for Quality Assurance, NQF#0060
[7] Former measure steward: Alabama Medicaid, NQF#1381. CMCS is retiring this measure based on concerns about data quality. In addition, the measure lacks an active measure steward, making updates challenging.
[8] MAP is a public-private partnership that reviews measures for potential use in federal public reporting.
[9] Measure steward: National Committee for Quality Assurance, NQF #0403
[10] Measure steward: Health Resources and Services Administration, NQF #2082

NQF # 0028 **Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention**

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Aug 10, 2009

Last Updated Date: Mar 11, 2014

Measure Under Review: Annual Update

eMeasure Available: Yes

Measure Details

Measure Steward: American Medical Association - convened Physician Consortium for Performance Improvement (AMA-convened PCPI)

Measure Description: Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user

Numerator Statement: Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user

*Includes use of any type of tobacco

** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy

Denominator Statement: All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two year measurement period

Exclusions: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Prevention and Treatment of Cardiovascular Disease

Use in Federal Program: Meaningful Use Stage 2 (EHR Incentive Program) - Eligible Professionals, Medicare Shared Savings Program, Physician Quality Reporting System (PQRS)

Actual/Planned Use: Professional Certification or Recognition Program, Public Reporting, Quality Improvement (Internal to the specific organization)

Care Setting: Ambulatory Care: Clinician Office/Clinic, Behavioral Health/Psychiatric: Inpatient, Behavioral Health/Psychiatric: Outpatient, Other

Condition: Prevention, Prevention: Tobacco Use

Cross-Cutting Area: Prevention

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Medical Records

Level of Analysis: Clinician: Group/Practice, Clinician: Individual, Clinician: Team

Measure Type: Process

Target Population: Populations at Risk, Populations at Risk: Individuals with multiple chronic conditions, Senior Care

Measure Steward Contact Information

Organization Name: American Medical Association - convened Physician Consortium for Performance Improvement (AMA-convened PCPI)

Email Address: mark.antman@ama-assn.org

Website URL (general):

Measure Disclaimer

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Measure Steward Copyright

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NQF # 0039 Flu Vaccinations for Adults Ages 18 and Older

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Aug 10, 2009

Last Updated Date: Jan 06, 2014

eMeasure Available: No

Measure Details

Measure Steward: National Committee for Quality Assurance

Measure Description: 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.

Numerator Statement: This measure is reported as two rates:

Flu Vaccination for Adults age 18-64 – Respondents to the Medicaid or commercial CAHPS survey who report having received an influenza vaccination since July of the previous year.

Flu Vaccination for Adults age 65+ - Respondents to the Medicare CAHPS survey who report having received an influenza vaccination since July of the previous year.

Denominator Statement: Flu Vaccinations for Adults Ages 18-64 – CAHPS respondents age 18-64

Flu Vaccination for Adults Age 65 and Older – CAHPS respondents age 65 and older.

Exclusions: N/A

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Health and Well-Being

Use in Federal Program:

Actual/Planned Use:

Care Setting: Ambulatory Care: Clinician Office/Clinic, Hospital/Acute Care Facility, Pharmacy, Post Acute/Long Term Care Facility: Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Condition: Infectious Diseases, Prevention

Cross-Cutting Area: Prevention

Data Source: Patient Reported Data/Survey

Level of Analysis: Health Plan, Integrated Delivery System

Measure Type: Process

Target Population: Populations at Risk: Dual eligible beneficiaries, Populations at Risk: Individuals with multiple chronic conditions, Senior Care

Measure Steward Contact Information

Organization Name: National Committee for Quality Assurance

Email Address: nqf@ncqa.org

Website URL (general):

Measure Disclaimer

Measure Steward Copyright

NQF # 0097 Medication Reconciliation

Measure Status

Endorsement Type: Endorsed

Endorsement Date: May 01, 2007

Last Updated Date: Apr 01, 2014

eMeasure Available: No

Measure Details

Measure Steward: National Committee for Quality Assurance

Measure Description: Percentage of patients aged 18 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days of discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist who had reconciliation of the discharge medications with the current medication list in the outpatient medical record documented. This measure is reported as two rates stratified by age group: 18-64 and 65+.

Numerator Statement: Patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented*

*The medical record must indicate that the physician, prescribing practitioner, registered nurse, or clinical pharmacist is aware of the inpatient facility discharge medications and will reconcile the list with the current medications list in the medical record.

Denominator Statement: All patients aged 18 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care. This measure is reported as two rates with age-specific denominators: 18-64 and 65+.

Exclusions: N/A

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Effective Communication and Care Coordination

Use in Federal Program: Medicare Shared Savings Program, Physician Quality Reporting System (PQRS)

Actual/Planned Use:

Care Setting: Ambulatory Care: Clinician Office/Clinic, Home Health

Condition:

Cross-Cutting Area: Care Coordination, Safety: Medication Safety

Data Source: Administrative claims, Electronic Clinical Data

Level of Analysis: Clinician: Group/Practice, Clinician: Individual

Measure Type: Process

Target Population: Populations at Risk: Dual eligible beneficiaries, Populations at Risk: Individuals with multiple chronic conditions, Senior Care

Measure Steward Contact Information

Organization Name: National Committee for Quality Assurance

Email Address: nqf@ncqa.org

Website URL (general):

Measure Disclaimer

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NQF # 0419 Documentation of Current Medications in the Medical Record

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Jul 31, 2008

Last Updated Date: Jul 02, 2013

Measure Under Review: Annual Update

eMeasure Available: Yes

Measure Details

Measure Steward: Centers for Medicare & Medicaid Services

Measure Description: Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

Numerator Statement: ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.

Eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route

NUMERATOR NOTE: By reporting G8427, the eligible professional is attesting the documented medication information is current, accurate and complete to the best of his/her knowledge and ability at the time of the patient encounter. This code should also be reported if the eligible professional documented that the patient is not

currently taking any medications. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.

Denominator Statement: ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.

All visits occurring during the 12 month reporting period for patients aged 18 years and older on the date of the encounter where one or more CPT or HCPCS codes are reported on the claims submission for that encounter. All discussed coding is listed in "2a1.7. Denominator Details" section below.

Exclusions: ALL MEASURE SPECIFICATION DETAILS REFERENCE THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM MEASURE SPECIFICATION.

A patient is not eligible or excluded (B) from the performance denominator (PD) if one or more of the following reason exists:

• Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Effective Communication and Care Coordination

Use in Federal Program: Meaningful Use Stage 2 (EHR Incentive Program) - Eligible Professionals, Physician Quality Reporting System (PQRS)

Actual/Planned Use: Payment Program, Public Reporting, Quality Improvement (Internal to the specific organization)

Care Setting: Ambulatory Care: Clinician Office/Clinic, Behavioral Health/Psychiatric: Outpatient, Dialysis Facility, Home Health, Other, Post Acute/Long Term Care Facility: Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Condition: Prevention, Prevention: Development/Wellness, Prevention: Screening

Cross-Cutting Area: Prevention

Data Source: Administrative claims, Electronic Clinical Data: Registry

Level of Analysis: Clinician: Individual, Population: National

Measure Type: Process

Target Population: Senior Care

Measure Steward Contact Information

Organization Name: Centers for Medicare & Medicaid Services

Email Address: corette.byrd@cms.hhs.gov

Website URL (general):

Measure Disclaimer

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NQF # 0421 **Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up**

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Jul 31, 2008

Last Updated Date: Mar 12, 2014

eMeasure Available: Yes

Measure Details

Measure Steward: Centers for Medicare & Medicaid Services

Measure Description: Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.

Normal Parameters: Age 65 years and older BMI > or = 23 and < 30

Age 18 – 64 years BMI > or = 18.5 and < 25

Numerator Statement: Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters

Denominator Statement: All patients aged 18 years and older

Exclusions: A patient is identified as a Denominator Exclusions (B) and excluded from the Total Denominator Population (TDP) in the Performance Denominator (PD) calculation if one or more of the following reason (s) exist:

•Patient is receiving palliative care

• Patient is pregnant

• Patient refuses BMI measurement (refuses height and/or weight)

• Any other reason documented in the medical record by the provider why BMI calculation or follow-up plan was not appropriate

• Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Health and Well-Being

Use in Federal Program: Meaningful Use Stage 2 (EHR Incentive Program) - Eligible Professionals, Medicare Shared Savings Program, Physician Quality Reporting System (PQRS)

Actual/Planned Use:

Care Setting: Ambulatory Care: Clinician Office/Clinic, Ambulatory Care: Outpatient Rehabilitation, Behavioral Health/Psychiatric: Outpatient, Home Health, Other

Condition: Prevention, Prevention: Development/Wellness, Prevention: Obesity, Prevention: Screening

Cross-Cutting Area: Prevention

Data Source: Administrative claims, Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Registry, Paper Medical Records

Level of Analysis: Clinician: Group/Practice, Clinician: Individual, Population: County or City, Population: National, Population: Regional, Population: State

Measure Type: Process

Target Population: Senior Care

Measure Steward Contact Information

Organization Name: Centers for Medicare & Medicaid Services

Email Address: corette.byrd@cms.hhs.gov

Website URL (general):

Measure Disclaimer

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NQF # 0541 Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Aug 05, 2009

Last Updated Date: Jul 10, 2012

Measure Under Review: Endorsement Maintenance

eMeasure Available: No

Measure Details

Measure Steward: Pharmacy Quality Alliance

Measure Description: The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated seperately for the following medication categories: Beta-Blockers (BB), Renin Angiotensin System (RAS) Antagonists, Calcium-Channel Blockers (CCB), Diabetes Medications, Statins.

Numerator Statement: The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.

Step 1: Determine the patient´s measurement period, defined as the index prescription date to the end of the calendar year, disenrollment, or death.

Step 2: Within the measurement period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same drug (GCN) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

Step 3: Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

Step 4: Count the number of patients who had a PDC greater than 80% and then divide by the total number of eligible patients.

Denominator Statement: Patients who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year.

Exclusions: Exclusion criteria for the PDC category of Diabetes medications: Patients who have one or more prescriptions for insulin in the measurement period.

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Affordable Care

Use in Federal Program:

Actual/Planned Use: Payment Program, Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations), Regulatory and Accreditation Programs

Care Setting: Ambulatory Care: Clinician Office/Clinic, Pharmacy

Condition:

Cross-Cutting Area: Safety, Safety: Medication Safety

Data Source: Electronic Clinical Data: Pharmacy

Level of Analysis: Clinician: Group/Practice, Clinician: Team, Health Plan

Measure Type: Process

Target Population: Senior Care

Measure Steward Contact Information

Organization Name: Pharmacy Quality Alliance

Email Address: jkuhle@pqaalliance.org

Website URL (general):

Measure Disclaimer

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NQF # 0546 Diabetes: Appropriate Treatment of Hypertension

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Aug 05, 2009

Last Updated Date: Jul 10, 2012

Measure Under Review: Endorsement Maintenance

eMeasure Available: No

Measure Details

Measure Steward: Pharmacy Quality Alliance

Measure Description: The percentage of patients who were dispensed a medication for diabetes and hypertension that are receiving an angiotensin-converting -enzyme-inhibitor (ACEI) or angiotensin receptor blocker (ARB) or direct renin inhibitor (DRI) renin-angiotensin-antagonist medication.

Numerator Statement: The number of patients who receive an ACEI or ARB or DRI or ACEI/ARB/DRI Combination during the measurement year.

Denominator Statement: Patients who were dispensed at least one prescription for an oral hypoglycemic agent, insulin, incretion mimetics, and at least one prescription for an antihypertensive agent during the measurement year.

Exclusions:

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Effective Communication and Care Coordination

Use in Federal Program:

Actual/Planned Use: Payment Program, Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations), Regulatory and Accreditation Programs

Care Setting: Ambulatory Care: Clinician Office/Clinic, Pharmacy

Condition: Endocrine

Cross-Cutting Area:

Data Source: Electronic Clinical Data: Pharmacy

Level of Analysis: Clinician: Group/Practice, Clinician: Team, Health Plan

Measure Type: Process

Target Population: Senior Care

Measure Steward Contact Information

Organization Name: Pharmacy Quality Alliance

Email Address: jkuhle@pqaalliance.org

Website URL (general):

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NQF # 0548 **Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT)**

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Aug 05, 2009

Last Updated Date: Oct 17, 2013

eMeasure Available: No

Measure Details

Measure Steward: Pharmacy Quality Alliance

Measure Description: Rate 1 (SAC): The percentage of patients aged 5-50 years as of the last day of the measurement year with persistent asthma who were dispensed more than 3 canisters of a short-acting beta2 agonist inhaler during the same 90-day period.

Rate 2 (ACT): The percentage of patients aged 5-50 years as of the last day of the measurement year with persistent asthma who were dispensed more than 3 canisters of short acting beta2 agonist inhalers over a 90-day period and who did not receive controller therapy during the same 90-day period.

Numerator Statement: Rate 1 (SAC): Patients in the denominator who received more than 3 canisters of short-acting Beta2 Agonist Inhalers within 90 days of the initial fill. From the date of each prescription fill, count the total number of canisters of short acting Beta2 Agonist Inhalers dispensed at that fill and dispensed within 90 days of that fill. If the patient receives more than 3 canisters in at least one 90-day period, then the patient is compliant for the numerator. (Note: This is a count of canisters dispensed, not prescriptions filled. If a patient received 2 canisters at one fill, it counts as 2 canisters.)

Rate 2 (ACT): Patients in the denominator who were not dispensed a controller therapy medication during the same 90-day period where they received more than 3 canisters of short-acting beta-agonist medication.

Denominator Statement: Rate 1 (SAC): Patients aged 5-50 years as of the last day of the measurement year who were dispensed consecutive fills (consecutive fills = the dispensing of two asthma medications within four months of one another) for asthma medication during the measurement year, excluding those patients who were dispensed one or more prescriptions for a COPD medication or one or more prescriptions for a cystic fibrosis medication or one or more prescriptions for a nasal steroid medication during the measurement year.

Rate 2 (ACT): Patients aged 5-50 years as of the last day of the measurement year who were dispensed consecutive fills (consecutive fills = the dispensing of two asthma medications within four months of one another) for asthma medication during the measurement year, excluding those patients who were dispensed one or more prescriptions for a COPD medication, or one or more prescriptions for a cystic fibrosis medication, or one or more prescriptions for a nasal steroid medication during the measurement year.

Exclusions: For rates 1 & 2, exclude any patient who filled:

- One or more prescriptions for a COPD medication during the measurement year; or

- One or more prescriptions for a cystic fibrosis medication during the measurement year; or

- One or more prescriptions for a nasal steroid medication during the measurement year.

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Effective Communication and Care Coordination

Use in Federal Program:

Actual/Planned Use:

Care Setting: Pharmacy

Condition: Pulmonary/Critical Care: Asthma

Cross-Cutting Area:

Data Source: Administrative claims, Electronic Clinical Data: Pharmacy

Level of Analysis: Health Plan

Measure Type: Process

Target Population: Children's Health, Populations at Risk

Measure Steward Contact Information

Organization Name: Pharmacy Quality Alliance

Email Address: jkuhle@pqaalliance.org

Website URL (general):

Measure Disclaimer

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NQF # 1800 Asthma Medication Ratio (AMR)

Measure Status

Endorsement Type: Endorsed

Endorsement Date: Jul 31, 2012

Last Updated Date: Jan 06, 2014

eMeasure Available: No

Measure Details

Measure Steward: National Committee for Quality Assurance

Measure Description: The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Numerator Statement: The number of patients who have a medication ratio of 0.50 or greater during the measurement year.

Denominator Statement: Patients 5–64 years of age during the measurement year who were identified as having persistent asthma.

Exclusions: 1) Exclude patients who had any diagnosis of Emphysema (Emphysema Value Set, Other Emphysema Value Set), COPD (COPD Value Set), Chronic Bronchitis (Obstructive Chronic Bronchitis Value Set, Chronic Respiratory Conditions Due To Fumes/Vapors Value Set), Cystic Fibrosis (Cystic Fibrosis Value Set) or Acute Respiratory Failure (Acute Respiratory Failure Value Set) any time during the patient's history through the end of the measurement year (e.g., December 31).

2) Exclude any patients who have no asthma controller medications (Table AMR-A) dispensed during the measurement year.

Risk Adjustment: No

Harmonization Requested

Harmonization Action:

Measure(s) Considered in Harmonization Request:

Classification

National Quality Strategy Priorities: Effective Communication and Care Coordination

Use in Federal Program:

Actual/Planned Use:

Care Setting: Ambulatory Care: Clinician Office/Clinic, Post Acute/Long Term Care Facility: Inpatient Rehabilitation Facility, Post Acute/Long Term Care Facility: Long Term Acute Care Hospital, Post Acute/Long Term Care Facility: Nursing Home/Skilled Nursing Facility

Condition: Pulmonary/Critical Care, Pulmonary/Critical Care: Asthma

Cross-Cutting Area: Population Health

Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records

Level of Analysis: Health Plan, Integrated Delivery System

Measure Type: Process

Target Population: Populations at Risk: Dual eligible beneficiaries, Populations at Risk: Individuals with multiple chronic conditions, Senior Care

Measure Steward Contact Information

Organization Name: National Committee for Quality Assurance

Email Address: nqf@ncqa.org

Website URL (general):

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