NATIONAL QUALITY FORUM

Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2015

DRAFT REPORT FOR PUBLIC COMMENT

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Executive Summary

Medicaid, the primary health insurance program for low-income Americans, served 72.8 million individuals in 2013.[1] This figure is expected to grow as it includes an increasing number of people newly eligible for Medicaid under the low-income adult group established by the Affordable Care Act (ACA).[2] Medicaid has also traditionally offered healthcare coverage to many of the individuals with the highest medical and social needs, many of whom could not obtain commercial insurance in the past. Among current working age Medicaid enrollees—the segment of the Medicaid population growing most rapidly—an estimated 57% of adults are overweight, have diabetes, hypertension, high cholesterol, or a combination of these conditions.[3] Understanding the needs of the adult Medicaid population in order to improve health and the quality of health care is paramount.

The ACA called for the creation of a core set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid and provided for a process of annual updates. The version of the Adult Core Set being used in 2015 contains 26 measures, spanning many clinical conditions and related to other quality programs and reporting initiatives. Changes to the Adult Core Set of measures are informed by the Measure Applications Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF). MAP provides input to the Department of Health and Human Services (HHS) on the use of performance measures to assess and improve the quality of care. Guided by MAP's Measure Selection Criteria and feedback from two years of state implementation, MAP is providing its latest round of annual recommendations to HHS for strengthening and revising measures in the Adult Core Set and identifying high-priority measure gaps.

MAP supports all but one of the current measures for continued use in the Adult Core Set. MAP recommends the removal of #0648 Care Transition – Timely Transmission of Transition Record due to reports of low feasibility and lack of reporting by states. In addition, MAP supported or conditionally supported nine measures for phased addition to the measure set. MAP is aware that additional federal and state resources are required for each new measure; therefore recommended measures are ranked to provide a clear sense of priority.

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

Rank	Measure Name and NQF Number, if applicable
1	Use of Contraceptive Methods by Women Aged 21-44 Years (not NQF endorsed)
2	#2602: Controlling High Blood Pressure for People with Serious Mental Illness
3/4/5 (tie)	#1927: Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications #1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications Not NQF Endorsed: Effective Postpartum Contraception Access

Rank	Measure Name and NQF Number, if applicable
6	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multiple-provider, high dosage (not NQF endorsed)
7	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multiple prescribers and multiple pharmacies (not NQF endorsed)
8/9 (tie)	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage (not NQF endorsed) #1799: Medication Management for People with Asthma

MAP recognizes many important priorities for quality measurement and improvement do not yet have metrics available to address them. MAP documented these gaps in the Core Set as a starting point for future discussions. They will guide annual revisions to further strengthen the Adult Core Set.

Introduction and Purpose

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

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

Guided by the MAP Measure Selection Criteria (MSC) (Appendix C), MAP considered states' experiences voluntarily implementing the Adult Core Set in making its recommendations. To inform MAP's review, the Centers for Medicare & Medicaid Services (CMS) provided summaries of the number of states reporting each measure, deviations from the published measure specifications, the number and type of technical assistance requests submitted, and actions taken in response to questions and challenges. This report summarizes select states' feedback on collecting and reporting measures as it was presented to MAP during the Task Force's deliberations. It also includes measure-specific recommendations to fill high-priority gaps (Appendix D). In addition, MAP identified several strategic issues related to the programmatic context for the Adult Core Set and its relationship to the Child Core Set.

This report is MAP's third set of annual recommendations on the Adult Core Set. It evaluates the measures in CMS' Adult Core Set being used in FFY 2015 and recommends changes that would be effective for FFY 2016 reporting. The annual process has allowed for a deeper understanding of the Medicaid landscape, the measures in use, and how states engage with the program. HHS uses MAP's findings, including the state perspectives, to inform the statutorily required annual update of the Adult Core Set.

Background on Medicaid and the Adult Core Set

Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals. Medicaid is financed through a federal-state partnership, in which each state designs and operates its own program within federal guidelines. Medicaid is a longstanding program that served 72.8 million individuals in 2013, about half of whom were adults.[4] This figure is expected to grow as it includes an increasing number people newly eligible for Medicaid under the low-income adult group established by the Affordable Care Act.[5] Medicaid also provides coverage for low-income individuals with disabilities and those that are elderly, along with supplemental coverage for Medicare enrollees, also known as dual eligible beneficiaries.[6]

Medicaid covers a broad range of services to meet the diverse needs of its enrollees, and performance measurement should also be designed to address these diverse needs. Federal law requires many

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

Medicaid Adult Population

Medicaid offers healthcare coverage to many of the individuals with the highest medical and social needs, many of whom could not obtain commercial insurance in the past. As a result, adults with Medicaid are both poorer and sicker than low-income adults with private health insurance. Even among adults with similarly low incomes, those with Medicaid report both worse health and worse mental health.[7] Adults with Medicaid also have higher rates of both multiple chronic conditions and functional activity limitations than those of the same income levels with employer sponsored insurance or even those that are uninsured.[8]

Among current working age adult Medicaid enrollees—the segment of the Medicaid population growing most rapidly—an estimated 57% of adults are overweight, have diabetes, hypertension, high cholesterol, or a combination of these conditions.[9] Behavioral health conditions are prevalent and often complicate the course of other medical conditions.[10] Racial and ethnic minority populations are disproportionately represented among Medicaid enrollees, warranting attention to addressing health disparities. All of these factors, and others, contributed to MAP's understanding of the healthcare needs of the adult Medicaid population and influenced its recommendations on the most important measures of quality.

Medicaid Adult Core Set

The ACA called for the creation of a core set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid. HHS established the Adult Core Set to standardize the measurement of healthcare quality across state Medicaid programs, assist states in collecting and reporting on the measures, and facilitating the use of the measures for quality improvement.[11] HHS published the initial Adult Core Set of measures in January 2012 in partnership with a subcommittee to the Agency for Healthcare Research and Quality's (AHRQ's) National Advisory Council.[12] It has been updated annually since that time, with recent iterations reflecting input from MAP.

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

The Adult Core Set is often regarded as providing a snapshot of quality within Medicaid. It is not comprehensive, but prior to its creation and implementation performance measurement varied greatly by state and it was not possible to discern an overall picture of quality. Statute requires CMS to release

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

Characteristics of the Current Adult Core Set

The 2015 version of the Adult Core Set contains 26 measures that are a mix of structure, process, outcome, and experience of care measures (Exhibit 1, below, and Appendix D). There has been an increase in uptake of measure reporting by states, particularly measures they perceive as straightforward to collect. For example, the most frequently submitted measures are generally claims-based and aligned with other quality programs and reporting initiatives, such as the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS). Out of the 26 measures, 23 are used in one or more other federal programs.

EXHIBIT 1: CHARACTERISTICS OF MEASURES IN THE 2015 ADULT CORE SET

Medicaid Adult Core Set Characteristics		# of Measures
NQF Endorsement Status	Endorsed	24
	Not Endorsed	2
Measure Type	Structure	0
	Process	19
	Outcome	6
	Consumer Experience of Care	1
Data Collection Method	Administrative Claims	21
	Electronic Clinical Data	18
	eMeasure Available	8
	Survey Data	3
Alignment	In use in one or more Federal Programs	23
	In the Child Core Set	3*

The measures in the Adult Core Set cover all six of the National Quality Strategy (NQS) Priorities (Exhibit 2). Additionally, the Adult Core Set measures span many clinical conditions to represent the diverse health needs of Medicaid enrollees (Exhibit 3).

EXHIBIT 2: MEASURES IN THE ADULT CORE SET BY NQS PRIORITY

National Quality Strategy Priorities	Number of Measures (n = 26)

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

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

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

State Experience Collecting and Reporting the Adult Core Set

MAP values implementation information about measures and uses it to inform its decisionmaking. MAP received feedback on the implementation of the Adult Core Set in several formats, including summary statistics on 2014 reporting rates from CMS and presentations from participating states. Medicaid agency representatives from Pennsylvania and Washington shared their experiences with implementation, measure-specific challenges, and quality improvement strategies related to the Adult Core Set. States also provided feedback on strategic issues and measure gap areas to guide MAP's decisionmaking. These perspectives are a sample and not necessarily representative of all state Medicaid programs, but they were informative to MAP's strategic and measure-specific recommendations for the Medicaid Adult Core Set.

Washington

Washington selects measures for reporting that are most straightforward to submit, meaning that they use administrative data, are clearly defined, and have had adequate lead time for data specification updates. Administrative measures are favored because measures derived from survey, hybrid claims-chart data, and medical records are more costly. The Medicaid agency is managing multiple reporting requirements, including the Child Core Set, Health Homes, and a State Innovation Model. Other data collection barriers include low response rates for CAHPS surveys administered by managed care plans and challenges with granularity of data for services that are reimbursed as a bundle. CAHPS data would be more useful to the state if the methodology was enhanced to include the geographic location and healthcare provider(s) of the respondent.

Washington's medical and mental health delivery systems are currently operated through separate managed care plans. Long-term care and home and community-based services (HCBS) are outside the managed care plans, and therefore dual eligible beneficiaries are mainly in fee-for-service programs. Among the state's quality improvement activities are a focus on building cross system integration, including reducing re-hospitalizations from both psychiatric facilities and nursing homes. Both initiatives have resulted in system-wide savings and fewer readmissions by targeting consumers with repeat readmissions and engaging them in care.

Washington's representative recommended that measure specifications be examined to ensure that inclusion/exclusion criteria are clear and fairly constructed. Additionally, MAP's discussion centered on the importance of risk adjusting measures used for comparative performance assessment to account for the complexity of consumers being served across facilities/providers and to direct quality improvement energy and incentives appropriately. Washington identified HCBS and psychiatric outcome measures as two measure gaps in the Adult Core Set.

Pennsylvania

The state of Pennsylvania primarily uses Medicaid managed care organizations across all of its counties. The current landscape includes 8 plans and a total of 1.6 million enrollees in their Health Choices Program, which is expected to grow due to the state's Medicaid expansion. Since most of Pennsylvania's managed care plans are currently NCQA-accredited and using a statewide core set called the Pennsylvania Performance Measures, they do not experience many reporting inconsistencies. As a result of the Adult Medicaid Quality Grant from CMS, the state has been able to improve measurement and quality outcomes on behavioral health and obstetrical care.

The representative from Pennsylvania discussed the future state of measurement, emphasizing that claims data is not going to remain the most significant source of performance improvement information. Pennsylvania encouraged that all of the Adult Core Set measures be converted into eMeasures and be reported using the Quality Reporting Data Architecture (QRDA) standardized format. Barriers to reporting and extraction should be reduced by state and federal collaboration with electronic health record vendors on data extraction abilities. Pennsylvania has had success with electronic extraction of certain measures. Measures that require robust chart audit, particularly those in the hospital or physician office settings, are less feasible for states. Finally, Pennsylvania's representative

recommended that any measures added to the Core Set be consistently implemented across all states, aligned with Medicare programs and Meaningful Use requirements, and be able to be reported through electronic extraction to reduce data collection burden.

MAP Review of the Adult Core Set

MAP reviewed the measures in the Adult Core Set to provide recommendations to strengthen the measure set in support of CMS' goals for the program. Guided by MAP's Measure Selection Criteria (MSC) (Appendix C) and feedback from the most recent year of state implementation, MAP carefully evaluated current measures. The MSC are not absolute rules, rather, they provide general guidance for selecting measures that would contribute to a balanced measure set. The MSC dictate that the measure set should address the National Quality Strategy's three aims, be responsive to specific program goals, and include an appropriate mix of measure types, among other factors.

MAP also used the MSC to review currently available measures and identify those with the best potential to fill gaps in the current set. Using measure gap areas identified in the 2014 review as a starting place, NQF staff compiled and presented measures in the following topic areas: access, behavioral health, and maternal/perinatal care. MAP specifically discussed a small number of measures staff judged to be a good fit for the Core Set largely based on their specifications, and the MSC, and the feasibility of implementing them for statewide quality improvement. All MAP Task Force members also had the opportunity to raise other available measures for discussion and consideration.

MAP examined NQF-endorsed measures and other measures in the development pipeline. MAP generally favored measures that are able to be implemented at the state level, promote parsimony and alignment, and address prevalent and/or high-impact health conditions for adults enrolled in Medicaid. NQF endorsed measures were also favored because they have been successfully evaluated through a separate consensus-based process for importance, evidence, scientific acceptability of measure properties, and other rigorous criteria. Following discussion of each measure, MAP voted to determine if there was sufficient support from Task Force members to consider it for addition to the Core Set.

NQF-endorsed measures are not available in all relevant topic areas. Understanding this, MAP did not restrict its review to endorsed measures. Public commenters participating in the process helped to bring measures in the development and endorsement pipeline forward. For example, MAP examined numerous measures related to maternal/perinatal care and safe prescribing of opioid medication that have not yet been reviewed for endorsement. Monitoring the development of new measures will continue to be relevant for future annual reviews.

Measure-Specific Recommendations

Current Measures and Recommendation for Removal

MAP noted that states' participation in reporting the Adult Core Set participation is strong, though there is much room for improvement in both the total number of states submitting measurement data and the number of states reporting each measure. Given the relative newness of the program, participation is expected to be lower than the Child Core Set, but ideally would increase each year. Not finding many

significant implementation problems with the current measures, MAP was comfortable supporting all but one for continued use. Maintaining stability in the measure set will allow states to continue to gain experience reporting the measures, potentially increasing the number of states submitting quality information to CMS and using the measures locally to drive quality improvement.

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

- Consistently high levels of performance (e.g., >95%), indicating little opportunity for additional gains in quality
- Multiple years of very few states reporting a measure, indicating that it is not feasible or a priority topic for improvement
- Change in clinical evidence and/or guidelines have made the measure obsolete
- Measure does not yield actionable information for the state Medicaid program or its network of providers
- Superior measure on the same topic has become available and a substitution would be warranted

Multiple state representatives gave negative feedback about their attempts to collect and use measure #0648 Care Transition – Timely Transmission of Transition Record. While generally supportive of the need to measure care coordination, this measure was thought to be too facility-centric for the state Medicaid agency to influence quality improvement. States also faced difficulty collecting all of the data required for the measure. Low feasibility is evident in the consistently low levels of state reporting of the measure, with just four states submitting data for the past two years. MAP recommends CMS remove this measure from the Adult Core Set since doing so many free up bandwidth to use more effective measures.

Measures for Phased Addition to the Adult Core Set

MAP recommends that CMS consider up to nine measures for phased addition to the Adult Core Set (Exhibit 4, below, and Appendix D). These measures passed consensus threshold to gain MAP's support or conditional support for phased addition by receiving more than 60 percent approval by voting MAP Task Force members. Measures that are not currently NQF endorsed are supported conditionally; MAP recommends that CMS add them to the programs once endorsement review is complete.

MAP is aware that additional federal and state resources are required for each new measure; immediate addition of all nine recommended measures supported by MAP is highly unlikely. MAP members decided to support a larger than usual number of measures to highlight the existence of measures beyond the Adult Core Set that the states and other entities could use in other quality improvement work. In particular, NQF has recently endorsed a bundle of measures that monitor care for co-occurring mental illness and other chronic conditions (e.g., diabetes, cardiovascular disease).

EXHIBIT 4: MEASURES RECOMMENDED FOR PHASED ADDITION TO THE ADULT CORE SET

Ranking	Measure Number and Title	MAP Recommendation
1	*Not NQF endorsed*: Use of Contraceptive Methods by Women Aged 21-44 Years	Conditional Support, pending successful NQF endorsement
2	#2602: Controlling High Blood Pressure for People with Serious Mental Illness	Support
3/4/5 (tie)	#1927: Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	Support
	#1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Support
	Not NQF endorsed: Effective Postpartum Contraception Access	Conditional Support, pending successful NQF endorsement
6	*Not NQF endorsed:* Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multi-provider, High Dosage	Conditional Support, pending successful NQF endorsement
7	*Not NQF endorsed:* Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multiple Prescribers and Multiple Pharmacies	Conditional Support, pending successful NQF endorsement
8/9 (tie)	#1799: Medication Management for People with Asthma (MMA)	Conditional Support, pending update from NQF annual review
	Not NQF endorsed: Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage	Conditional Support, pending successful NQF endorsement

The use of recommended measures would strengthen the measure set by promoting measurement of a variety of high-priority quality issues, including reproductive health, chronic disease management for people with serious mental illness, and the prevention of substance abuse. Further explanation and rationale regarding MAP's support for these measures follows, in order of topic area beginning with maternal/perinatal care.

Recognizing that three-quarters of women enrolled in Medicaid are in their reproductive years, MAP conducted a lengthy discussion of the maternal and perinatal care measures.[13] Measures in this topic area are currently included in both the Child Core Set and Adult Core Set of measures. The group reviewed a large volume of available measures to determine which measures would be the most effective additions to state-level reporting. MAP conditionally supports two reproductive health measures related to contraception use.

Not NQF Endorsed: Use of Contraceptive Methods by Women Aged 21-44 Years

This measures the rate of contraceptive use among women who could experience unintended pregnancy. It complements a related measure of a different age group (15-20) that MAP conditionally supported for the Child Core Set. The measure captures use of both moderately (e.g., injectables) and highly (e.g., LARC) effective forms of contraception. After detailed discussion of potential ethical implications and strong agreement that the target rate for this measure would be well below 100%, MAP conditionally supported the measure and recommended that it be reviewed by NQF for endorsement.

Not NQF Endorsed: Effective Postpartum Contraception Access

This measure assesses the utilization of postpartum contraception for women who have had a live birth. Members noted the importance of family planning, specifically that pregnancy within a year of giving birth is associated with an increased risk of placental abruption, preterm birth, and other negative effects. MAP members commented that one strong suit of the measure is that it can be stratified by the time period during which the consumer was prescribed contraception, including during the hospital stay immediately following birth. Seeking alignment across programs, MAP also conditionally supported this measure for addition to the Child Core Set.

NQF #2602: Controlling High Blood Pressure for People with Serious Mental Illness

MAP had a robust conversation regarding measures for mental health conditions and substance use disorders this review, building on themes from the 2014 process. MAP supports the addition of three measures from National Committee for Quality Assurance (NCQA) about managing co-occurring chronic disease in individuals with serious mental illness. Cardiovascular disease and diabetes contribute to significant morbidity and early mortality in the behavioral health population. MAP favored the use of measures to integrate behavioral health and primary care and engage consumers in self-management. The first of these measures, #2602 Controlling High Blood Pressure for People with Serious Mental Illness, targets a very important intermediate clinical outcome. The measure is harmonized with other existing measures on related topics.

NQF #1927: Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications & NQF #1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Measures 1927 and 1932 assess the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who are using antipsychotic medication and who received a cardiovascular health and diabetes screening, respectively, during the measurement year. Antipsychotic medication has metabolic side effects that place individuals at increased risk for these co-occurring conditions. Similar to the other behavioral health measure supported by MAP, these measures were developed and are owned by NCQA and are harmonized with other existing measures.

Not NQF Endorsed: Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer; Opioid High Dosage, Multiple Prescribers and Multiple Pharmacies, and Multi-Provider/High Dosage

After hearing from states that early intervention for people who are prescribed opioid medications is important to prevent addiction and a pathway to illegal heroin use, MAP conditionally supported three measures recently developed by the Pharmacy Quality Alliance (PQA). They are three closely related measures of potential overuse that address the epidemic of narcotic morbidity and mortality.[14] All are supported conditionally pending successful NQF endorsement.

NQF #1799: Medication Management for People with Asthma (MMA)

MAP conditionally supports measure #1799 pending completion of the measure's annual update without significant changes being made to the measure. Annual update is expected to proceed smoothly, but MAP members wanted the opportunity to reconsider the measure if it diverges from the information they reviewed. The measure evaluates the percentage of patients who are identified as having persistent asthma and who were dispensed and used appropriate medications during the treatment period. MAP initially recommended this measure during its 2014 review, but CMS has not yet added it to the Adult Core Set. MAP continues to recommend it be considered for phased addition. This measure also supports MAP alignment goal, as it is also included in the Child Core Set.

Recommendations to Address High Priority Gaps

MAP recommended that the Core Set be strengthened by the addition of measures in key areas. Gap areas were identified from state feedback, review of 2014 reporting, and data on prevalent conditions affecting the adult Medicaid population. Although the Core Set includes measures pertaining to some of these topics, MAP did not perceive them as comprehensive. Some gaps identified during this review were also identified during MAP's 2014 deliberations. An asterisk (*) denotes newly identified gap areas. This list of measure gaps will be a starting point for future discussions and will guide MAP's input on strengthening the Adult Core Set.

Adult Core Set Measure Gaps

- Access to primary, specialty and behavioral health care
- Beneficiary-reported outcomes
    - Health-related quality of life*
- Care coordination
    - Integration of medical and psychosocial services
    - Primary care and behavioral health integration
- Cultural competency of providers
- Efficiency
    - Inappropriate emergency department utilization
- Long-term supports and services
    - Home and Community-Based Services*
- Maternal health
    - Inter-conception care to address risk factors
    - Poor birth outcomes (e.g. premature birth)
    - Postpartum complications

    - Support with breastfeeding after hospitalization*
- Promotion of wellness
- Treatment outcomes for behavioral health conditions and substance use disorders
    - Psychiatric re-hospitalization*
- Workforce
- New chronic opiate use (45 days)*
- Polypharmacy*
- Engagement and activation in healthcare*
- Trauma-informed care*

Strategic Issues

For its 2015 review of the Child and Adult Core Sets, MAP conducted joint deliberations of the Medicaid Adult Task Force and the Medicaid Child Task Force to better explore shared issues of strategic importance. These included alignment of measures across programs, the approach to selecting measures that will maximize health outcomes, and enabling quality improvement activities within states.

Alignment

The Child Core Set and Adult Core Set reporting programs were authorized by separate pieces of legislation, at separate times, but CMS and states generally regard them as working together to provide a picture of quality across Medicaid. The two sets differ in the measures they include because of the distinctly different health and medical needs of the pediatric and adult populations, but as we increasingly adopt a lifespan view of wellness, it becomes especially clear that the two measurement efforts should be synchronized to the extent possible.

Alignment of measures has macro-level considerations. Across the health system, but especially in the context of resource-constrained state Medicaid programs, investments in quality measurement and improvement have a finite budget. Often this forces trade-offs between competing priorities. When measures in the Adult and Child Core Sets are also used in other programs relevant to Medicaid, efficiencies are gained by reducing the number of measures that need to be collected. State panelists emphasized the importance of alignment with HEDIS, health insurance exchanges, Medicaid health homes, and Meaningful Use incentive programs, in particular. Another essential aspect of alignment is the use of the same measurement specifications in each of the programs, unless there are compelling reasons why they should be different. When measures are edited by one program and not others, it has the effect of reducing comparability and potentially adding burden and complexity to data collection and reporting.

MAP's discussion also acknowledged that if alignment is over-emphasized, it could lead to a few measures having an outsized effect on provider behavior. For example, if a small number of measures become part of multiple influential programs, it could have the effect of sharpening focus on them to the detriment of other opportunities. When measures are used across multiple programs simultaneously, it is especially important that they warrant the compounded incentives. Measures best

suited for widespread use should be able to influence desirable health outcomes, as opposed to minute process steps.

The choice of measures for the Child and Adult Core Sets has specific consequences for CMS and for states. The CMS technical specifications manual for state-level reporting is released once annually. Following its release, states need time to program systems and plan for data collection. MAP members heard that this can involve negotiation with one or more contractors and potentially greater expense. For these and other reasons, states prefer to use measures that can satisfy multiple reporting requirements. Program experience to date demonstrates that it takes at least two years, and often longer, for a measure to experience significant uptake across states. CMS refrains from publishing performance data publicly until they have at least 25 states reporting on a given measure. As a result, the full utility of the measure is not realized until this threshold of participation is met.

Reproductive Health

One of Medicaid's core functions is to ensure that pregnant women and young children have access to health services that are vital for a healthy birth and lifelong wellness. Female reproductive health care continues from puberty to menopause, and the health outcomes of a woman and her child or children are highly intertwined. As a result, MAP considered measurement of reproductive health across the lifespan and its implications for both the Child and Adult Core Sets.

The measure of chlamydia screening appears in both core sets, with different age groups reported in each one. The placement of other measures in the maternal and perinatal health area reflects the historical artifact that the creation of the Child Core Set preceded the Adult Core Set. As a general but imperfect rule of thumb, measures relating more to the mother's health appear in the Adult Core Set and those that relate more to the infant's health are in the Child Core Set. MAP conducted extensive discussion to ensure that the division of measures in this manner was not artificially limiting quality measurement. Age ranges captured in both core sets should include all relevant populations impacted by the care being measured. For example, MAP advised that adult core set measures need to include all pregnancies, even if the Medicaid enrollee is a teenager outside of the age range that would otherwise be considered part of adult measurement.

Reproductive health is already the most frequently measured topic across the Child and Adult Core Sets, and MAP's 2015 recommendations would further expand it. Measures of contraceptive access and use gained strong, albeit conditional, support from MAP because of the robust and growing evidence that well-timed, intentional pregnancies are associated with better health outcomes for both the mother and the infant. Additionally, there is significant opportunity for improvement and cost effectiveness in this area. For example, eleven states have made specific policy changes to encourage placement of long-acting reversible contraception immediately postpartum, with the potential for others to follow.

Increasing State-Level Capacity for Quality Improvement

Peer-to-Peer Learning and Collaboration

State panelists' presentations of lessons learned from participation in reporting yielded strategic information that is potentially relevant to others. For example, "data not available" was the most

frequently reported reason for not reporting the majority of measures. States cited budget constraints, lack of staff capacity, data sources that are not easily accessible, or information is required for the measure that is not routinely collected. However, states that have made investments in building information infrastructure have overcome this barrier by creating a variety of data linkages. Leadership and political will are necessary precursors, as are savvy partnerships with the public health sector, academia, providers, and others in the delivery system. MAP encourages CMS to enhance states' abilities to communicate with each other through the technical assistance available in the reporting program.

Strategies to Understand and Address Disparities

MAP discussed the nature of health disparities within the Medicaid-enrolled population and observed several types: across states, across enrollee sub-populations including racial/ethnic groups and people with disabilities, and across diagnosis groups such as individuals with mental illness. Medicaid enrollees, by virtue of their low income, are already a group that experiences inequities in health and healthcare, and the other factors only compound the situation.

Stratification of measures by such factors of interest is one strategy that can be used to better understand and address disparities. For example, MAP members suggested that states and CMS more deeply examine the performance of certain measures, such as screenings for breast and cervical cancer, to ensure care is equitable. Different strata could be created for other measures, as appropriate. Once made transparent, any disparities discovered are better able to be understood and addressed with targeted action.

Appropriate Performance Benchmarks

States requested support from CMS and other partners in the measurement enterprise to better understand and set performance benchmarks for their measures. This is especially relevant for states implementing pay-for-performance models with contracted health plans. Benchmarks that are too high or too low fail to motivate quality improvement action. Incentives need to be designed to be achievable, but enough of a stretch to produce meaningful change. Furthermore, MAP members suggested that setting a reasonable benchmark in place of highly complex denominator exclusions—especially those that require medical record review to derive—would be a less burdensome way to implement a variety of measures.

MAP discussed that setting appropriate performance expectations is especially important for measures where 100% compliance is either unrealistic or potentially harmful. This is the case for the conditionally supported measures of contraceptive use, though it applies to other topics as well. The framing of how the measures should be interpreted is both important and sensitive to many stakeholder groups. It must be abundantly clear that by measuring rates of contraceptive use, the program would not be setting a universal expectation that all women should use contraceptives. Many women, in collaboration with their healthcare providers, choose to forego contraception for a variety of reasons. It is imperative that this choice be honored. However, far too many women who are interested in avoiding or delaying pregnancy lack access to effective family planning education and resources. To use a less politically charged example, measurement of emergency department utilization would be expected to operate in

much the same way. The expectation of the measure is not to reach zero percent; rather, it is to ensure that consumers are able to have routine health needs met in less costly and less acute environments before conditions are exacerbated to the point that urgent treatment is required.

Conclusion

As more adults enroll in Medicaid, the need for measures in the Medicaid Adult Core Set to drive quality improvement has become increasingly important. MAP's recommendations to HHS are intended to strengthen the program measure set to increase state participation in reporting and inform quality initiatives. In light of troublesome data collection and lack of actionability, MAP recommended a care transition measure for removal from the Adult Core Set. MAP supported all other current measures for continued use in the program. This year's recommendations for new measures focus on the high-impact conditions of reproductive and behavioral health. A total of nine measures have been supported for phased addition to the program measure set over time.

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

MAP also emphasized the importance of considering the overlap of the measures across the Child and Adult Core Sets, especially regarding high-impact conditions like reproductive and behavioral health. Aligned measures will result in less burdensome data collection, and ultimately better rates of state reporting. MAP will continue to collaborate with CMS as infrastructure is enhanced to support states' efforts to gather, report, and analyze data that informs quality improvement initiatives.

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Appendix A: MAP Background

Purpose

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

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

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

MAP's objectives are to:

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

Coordination with Other Quality Efforts

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

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

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

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

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

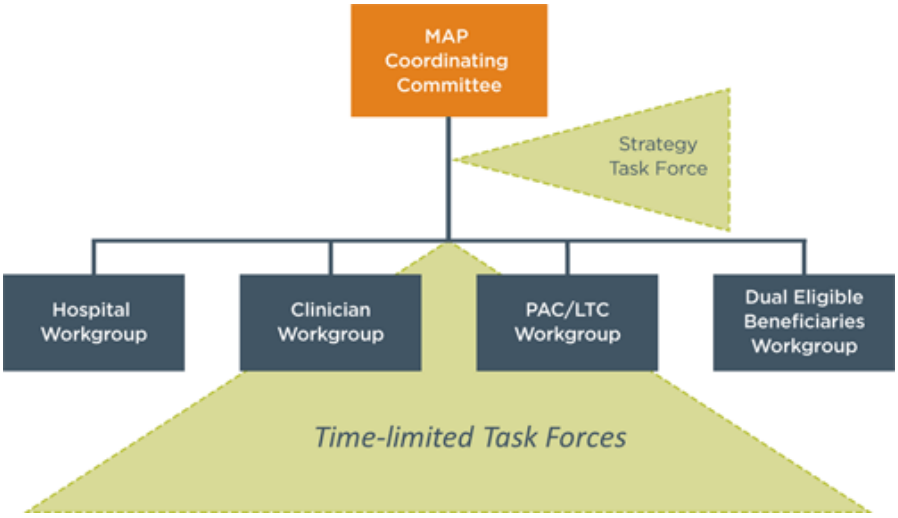
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for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

Impact and Evaluation. Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate whether measures are having their intended impact and are driving improvement, transparency, and value. Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements. MAP seeks to engage in bidirectional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

Structure

MAP operates through a two-tiered structure (see Figure A1). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and provides final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with specific topics provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

Figure A1. MAP Structure



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

Timeline and Deliverables

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

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

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

MAP Medicaid Adult Task Force

CHAIRS (VOTING)
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
Academy of Managed Care Pharmacy	Marissa Schlaifer
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
American Academy of Nurse Practitioners	Sue Kendig, JD, WHNP-BC, FAANP
America's Health Insurance Plans	Kirstin Dawson
Humana, Inc.	George Andrews, MD, MBA, CPE, FACP
March of Dimes	Cynthia Pellegrini
National Association of Medicaid Directors	Daniel Lessler, MD, MHA, FACP
National Rural Health Association	Brock Slabach, MPH, FACHE

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Anne Cohen, MPH
Nancy Hanrahan, PhD, RN, FAAN
Marc Leib, MD, JD
Ann Marie Sullivan, MD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Centers for Medicare & Medicaid Services	Marsha Smith, MD, MPH, FAAP
Substance Abuse and Mental Health Services Administration (SAMHSA)	Lisa Patton, PhD

NQF Project Staff

STAFF MEMBER	TITLE
Sarah Lash	Senior Director
Shaconna Gorham	Senior Project Manager
Zehra Shahab	Project Manager
Severa Chavez	Project Analyst

MAP Coordinating Committee

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

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Shaun O'Brien
American Board of Medical Specialties	Lois Margaret Nora, MD, JD, MBA
American College of Physicians	Amir Qaseem, MD, PhD, MHA
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
America's Health Insurance Plans	Aparna Higgins, MA
Catalyst for Payment Reform	Shaudi Bazzaz, MPP, MPH
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip Kahn
Healthcare Financial Management Association	Richard Gundling, FHFMA, CMA
The Joint Commission	Mark R. Chassin, MD, FACP, MPP, MPH
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Steve Wojcik
National Committee for Quality Assurance	Margaret E. O'Kane, MHS
National Partnership for Women and Families	Alison Shippy
Pacific Business Group on Health	William Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher Dezii, RN, MBA,CPHQ

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
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)	Richard Kronich, PhD/Nancy J. Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD, FACP

Appendix C: MAP Measure Selection Criteria

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

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

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

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

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

Sub-criterion 1.3 Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

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

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

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

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

Sub-criterion 2.3 Affordable care

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

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

Sub-criterion 3.1 Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)

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

Sub-criterion 3.3 Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)

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

Sub-criterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

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

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

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

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

Sub-criterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

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

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

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

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

Sub-criterion 5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

Appendix D: Adult Core Set and MAP Recommendations

In January 2012, HHS published a final notice in the *Federal Register* to announce the initial core set of healthcare quality measures for Medicaid-Eligible adults; annual updates including a 2015 version followed. Exhibit D1 below lists the measures included in the 2015 Core Set along with their current NQF endorsement number and status, including rates of state participation in 2013 reporting. In FFY 2015, states are voluntarily collecting the Medicaid Adult Core Set measures using the 2015 Technical Specifications and Resource Manual. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's Quality Positioning System. Exhibit D2 lists the measures supported by MAP for potential addition to the Adult Core Set.

EXHIBIT D1. CURRENT ADULT CORE SET FOR FFY 2015

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0004 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Measure Steward: NCQA	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	18 states reported FFY 2013 Alignment: Meaningful Use Stage 2 – Eligible Professionals (MU-EP), PQRS, HEDIS, Health Insurance Marketplace Quality Rating System (HIX-QRS), Physician Value-Based Payment Modifier	Support for continued use in the program
0006 Endorsed CAHPS Health Plan Survey - Adult questionnaire Measure Steward: NCQA	30-question core survey of adult health plan members that assesses the quality of care and services they receive.	16 states reported FFY 2013 Alignment: Medicare Shared Savings Program (MSSP), HEDIS, HIX-QRS	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0018 Endorsed Controlling High Blood Pressure Measure Steward: NCQA	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	15 states reported FFY 2013 Alignment: MU-EP, MSSP, PQRS, HEDIS, HIX-QRS, Physician Compare, Physician Value-Based Payment Modifier	Support for continued use in the program
0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation Measure Steward: NCQA	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.	15 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program
0032 Endorsed Cervical Cancer Screening Measure Steward: NCQA	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	28 states reported FFY 2013 Alignment: MU-EP, PQRS, HEDIS, HIX-QRS, Physician Value-Based Payment Modifier	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0033 Endorsed Chlamydia screening in women [ages 21-24 only] Measure Steward: NCQA	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	26 stated reported FFY 2013 Alignment: MU-EP, PQRS, HEDIS, HIX-QRS, Physician Value-Based Payment Modifier, Medicaid Child Core Set (ages 16-20)	Support for continued use in the program
0039 Endorsed Flu Vaccinations for Adults Ages 18 and Over Measure Steward: NCQA	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.	12 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program
0057 Endorsed Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing Measure Steward: NCQA	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	30 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program
0059 Endorsed Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) Measure Steward: NCQA	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	0 states reported FY 2013 (New for 2015) Alignment: MU-EP, PQRS, MSSP, Physician Compare, Physician Value-Based Payment Modifier	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0105 Endorsed Antidepressant Medication Management (AMM) Measure Steward: NCQA	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	25 states reported FFY 2013 Alignment: MU-EP, PQRS, HEDIS, Physician Value-Based Payment Modifier, HIX-QRS	Support for continued use in the program
0272 Endorsed Diabetes Short-Term Complications Admissions Rate (PQI 1) Measure Steward: AHRQ	The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	24 states reported FFY 2013 Alignment: N/A	Support for continued use in the program
0275 Endorsed Chronic obstructive pulmonary disease (PQI 5) Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	24 states reported FFY 2013 Alignment: MSSP	Support for continued use in the program
0277 Endorsed Heart Failure Admission Rate (PQI 8) Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	24 states reported FFY 2013 Alignment: MSSP	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0283 Endorsed Asthma in Younger Adults Admission Rate (PQI 15) Measure Steward: AHRQ	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.	24 states reported FFY 2013 Alignment: N/A	Support for continued use in the program
0418 Endorsed Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan Measure Steward: CMS	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.	5 states reported FFY 2013 Alignment: MU-EP, MSSP, PQRS, Physician Compare, Physician Value-Based Payment Modifier	Support for continued use in the program
0469 Endorsed PC-01 Elective Delivery Measure Steward: The Joint Commission	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)	14 states reported FFY 2013 Alignment: Meaningful Use Stage 2 -Hospitals and CAHs	Support for continued use in the program
0476 Endorsed PC-03 Antenatal Steroids Measure Steward: The Joint Commission	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	5 states reported FFY 2013 Alignment: N/A	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0576 Endorsed Follow-Up After Hospitalization for Mental Illness Measure Steward: NCQA	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	27 states reported FFY 2013 Alignment: Medicaid Child Core Set, HEDIS, HIX-QRS	Support for continued use in the program
0648 Endorsed Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	4 states reported FFY 2013 Alignment: N/A	MAP recommends the removal of this measure from the program. Measure requires data exchange with facilities and discharge processes are not felt to be appropriate for state-level accountability. Additionally, only 4 states have reported on this measure for both FFY 2013 and FFY 2014.

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
1517 Endorsed Prenatal & Postpartum Care [postpartum care rate only] Measure Steward: NCQA	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	29 states reported FFY 2013 Alignment: Medicaid Child Core Set, HEDIS, HIX-QRS	Support for continued use in the program
1768 Endorsed Plan All-Cause Readmissions Measure Steward: NCQA	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/ Denominator) 5. Total Variance Note: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	18 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program In 2014 MAP recommended the development and application of a risk-adjustment model for the Medicaid population.

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
2082 Endorsed HIV Viral Load Suppression Measure Steward: HRSA	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.	17 states reported FFY 2013 Alignment: PQRS, Physician Value-Based Payment Modifier	Support for continued use in the program.
2371 Endorsed Annual Monitoring for Patients on Persistent Medications Measure Steward: NCQA	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the four rates separately and as a total rate : Rates for each: Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), Digoxin, diuretics, or anticonvulsants Total rate (the sum of the four numerators divided by the sum of the four denominators)	23 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program.
2372 Breast Cancer Screening Measure Steward: NCQA	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	27 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program.
Not NQF endorsed Adult Body Mass Index Assessment Measure Steward: NCQA	The percentage of Medicaid Enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	16 states reported FFY 2013 Alignment: HEDIS	Support for continued use in the program
Not NQF endorsed Adherence to Antipsychotic Medications for	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	16 states reported FFY 2013 Alignment: HEDIS	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
Individuals with Schizophrenia (SAA) Measure Steward: NCQA	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).		

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

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

Measure & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
Not NQF endorsed Use of Contraceptive Methods by Women Aged 21-44 Years Measure Steward: Centers for Disease Control and Prevention/Office of Population Affairs	The percentage of women aged 21-44 years who are at risk of unintended pregnancy and who: 1) Adopt or continue use of the most effective or moderately effective FDA-approved methods of contraception. 2) Adopt or continue use of a long-acting reversible method of contraception (LARC). The first measure is an intermediate outcome measure, and it is desirable to have a high proportion of women at risk of unintended pregnancy using most or moderately effective contraceptive methods. The second measure is an access measure, and the focus is on making sure that some minimal proportion of women have access to LARC methods.	N/A	Conditional Support, pending successful NQF endorsement. Enhances maternal/perinatal measures and would reduce the risk of unplanned pregnancy and pregnancy-related complications by increasing access to high-quality care before and between pregnancies.
2602 Controlling High Blood Pressure for People with Serious Mental Illness Measure Steward: NCQA	The percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.	N/A	Support Addresses behavioral health gap area with a focus on an intermediate clinical outcome that is important for managing co-occurring chronic conditions such as cardiovascular disease and diabetes.

1927 Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications Measure Steward: NCQA	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.	N/A	Support Addresses behavioral health gap area in the core set and focuses on the identification of cardiovascular disease, a leading cause of morbidity and mortality in this population.
1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Measure Steward: NCQA	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.	Alignment: HEDIS	Support Addresses behavioral health gap area in the core set and focuses on the identification of cardiovascular disease, a leading cause of morbidity and mortality in this population.
Not NQF endorsed Effective Postpartum Contraception Access Measure Steward: TBD	The percentage of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the utilization of postpartum contraception. Part A: Highly effective postpartum contraception access. The percentage of women who received contraceptives such as implants, intrauterine devices or systems (IUD/IUS), or female sterilization within 99 days after birthing. Part B: Moderately effective postpartum contraception access. The percentage of women who received contraceptives such as injectables, oral pills, patch, or ring within 99 days after birthing.	N/A	Conditional Support, pending successful NQF endorsement Enhances maternal/perintatal measures and intended to reduce the risk of unplanned pregnancy and pregnancy-related complications by increasing access to high-quality care between pregnancies.

Not NQF endorsed Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer: Multiple-provider, high dosage Measure Steward: Pharmacy Quality Alliance	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.	N/A	Conditional Support, pending successful NQF endorsement Addresses behavioral health gap and provides an opportunity to intervene in substance abuse pattern. Opioid overuse and addiction is more common in some minority groups, including Native Americans.
Not NQF endorsed: Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer: Multiple prescribers and multiple pharmacies Measure Steward: Pharmacy Quality Alliance	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.	N/A	Conditional Support, pending successful NQF endorsement Addresses behavioral health gap and provides an opportunity to intervene in substance abuse pattern. Opioid overuse and addiction is more common in some minority groups, including Native Americans.
1799 Medication Management for People with Asthma (MMA) Measure Steward: NCQA	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.	Alignment: HEDIS, Medicaid Child Core Set, HIX-QRS	Conditional Support, pending update from NQF annual review Aligns with the Child Core Set and addresses a high-impact condition in the Medicaid Adult population.

Not NQF endorsed Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer: Opioid High Dosage Measure Steward: Pharmacy Quality Alliance	The proportion (XX out of 1,000) of individuals without cancer receiving a daily dosage of opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	N/A	Conditional Support, pending successful NQF endorsement Addresses behavioral health gap and provides an opportunity to intervene in substance abuse pattern. Opioid overuse and addiction is more common in some minority groups, including Native Americans.