

MEASURE APPLICATIONS PARTNERSHIP

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

FINAL REPORT

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NATIONAL
QUALITY FORUM

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EXECUTIVE SUMMARY

Medicaid is the single largest source of health insurance in the United States and a vital support for low-income Americans. States' Medicaid programs enroll a large—and increasing—share of the country's population, from 15 percent in 2010 to a projected 25 percent in 2020.¹ About half of the people covered by Medicaid are adults, many of whom have significant healthcare needs associated with pregnancy, chronic conditions, behavioral health, disability, and other factors. Medicaid is a major payer, financing about 16% of total personal health spending in the U.S. and a core source of financing for providers that serve low-income communities.² When measuring the quality of healthcare provided to adults with Medicaid, it is essential to focus on their unique needs and the context in which they receive care.

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

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

maternal/reproductive health, complex healthcare needs, and mental health and substance use.

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

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

- **MAP supports the continued use of most measures in the Medicaid Adult Core Set.**

MAP recommends that 22 of 26 measures continue to be used to provide stability and the opportunity to gain additional experience and data. No serious feasibility challenges were identified among these measures.

- **MAP conditionally supports the continued use of three measures.**

- NQF #2371 Annual Monitoring for Patients on Persistent Medications: Pending the renewed NQF endorsement of this measure, MAP conditionally supports the continued use of this measure as an important indicator of safety. It is currently undergoing review and is expected to pass. MAP also recommended the addition of NQF# 0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category because of its focus on medication adherence.
- NQF #1768 Plan All Cause Readmission: MAP conditionally supported the continued use of this measure or an alternative measure of all-cause readmission. HHS should determine which measure is the best fit for the specific goals of this program.
- NQF #2372 Breast Cancer Screening: MAP's support is conditional upon this measure regaining NQF endorsement. It is currently undergoing review and is expected to pass.

- **MAP suggests the removal of one measure.**

The measure NQF #0063 Comprehensive Diabetes Care: LDL-C Screening should be retired because clinical guidelines underpinning this measure are currently in flux. In addition, NCQA has removed it from HEDIS 2015.

- **MAP recommends three measures for phased addition to the Medicaid Adult Core Set.**

Because of the high prevalence of diabetes in the adult Medicaid population, MAP prioritized NQF #0059 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

as the most urgent addition to the measure set. In future iterations, HHS should consider the addition of measures NQF #1799 Medication Management for People with Asthma and NQF #0647 Transition Record with Specified Elements Received by Discharged Patients to fill other gaps in the measure set.

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

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

INTRODUCTION AND PURPOSE

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

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

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

BACKGROUND ON MEDICAID AND THE ADULT CORE SET

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

Medicaid Adult Population

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

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

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

Medicaid covers many of the highest-need populations in the nation. When combined with the fact that there is a strong correlation between poverty and poor health, one observes a poorer health profile among Medicaid beneficiaries than in privately insured and uninsured populations.¹¹ Adults with Medicaid report both worse overall health and worse mental health than their peers with similar income. Medicaid beneficiaries also experience multiple chronic conditions and activity limitations at higher rates than other populations.¹² A recent analysis by the Healthcare Cost and Utilization Project (HCUP) found that nonelderly adult Medicaid beneficiaries experienced a total all-cause, 30 day hospital readmission rate of 14.6 per 100 admissions, in contrast to 8.7 per 100 admissions among privately insured adults 18 to 64. The cost of these 700,000 readmissions of adult Medicaid enrollees totaled approximately \$7.6 billion in 2011.¹³ MAP’s understanding of the healthcare needs of the adult Medicaid population influenced its recommendations on the most important measures of quality.

Role of Medicaid in Covering Services for Low-Income Adults

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

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

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

Medicaid Adult Core Set

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

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

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

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

Characteristics of the Medicaid Adult Core Set

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

EXHIBIT 1. NQS AND CMS QUALITY STRATEGY PRIORITIES

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

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

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

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

STATE EXPERIENCE COLLECTING AND REPORTING THE CORE SET

MAP values implementation and impact information about measures and uses this feedback to inform its decisionmaking. MAP received feedback on the implementation of the Adult Core Set from CMS and states in three formats: 2013 Medicaid Adult Core Set implementation information, presentations from states that participated in reporting, and communication of barriers from nonreporting states. These valuable inputs informed the measure-specific and strategic recommendations for the Medicaid Adult Core Set to achieve CMS' three-part goal.

Participation in Reporting Measures

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

CMS replaced the measure Annual HIV/AIDS Medicaid Visit with NQF #2082 HIV Viral Load Suppression in the 2014 Adult Core Set update.¹⁹ MAP recommended this substitution because the original measure had NQF endorsement removed and it had too much of a process focus rather than the intermediate outcome focus of viral load suppression. As a result, FFY 2014 is the first year in which the measure of viral load suppression

will be reported. No other additions, deletions, or substitutions were made in this first update.^{20,21}

Implementation Feedback from Reporting States

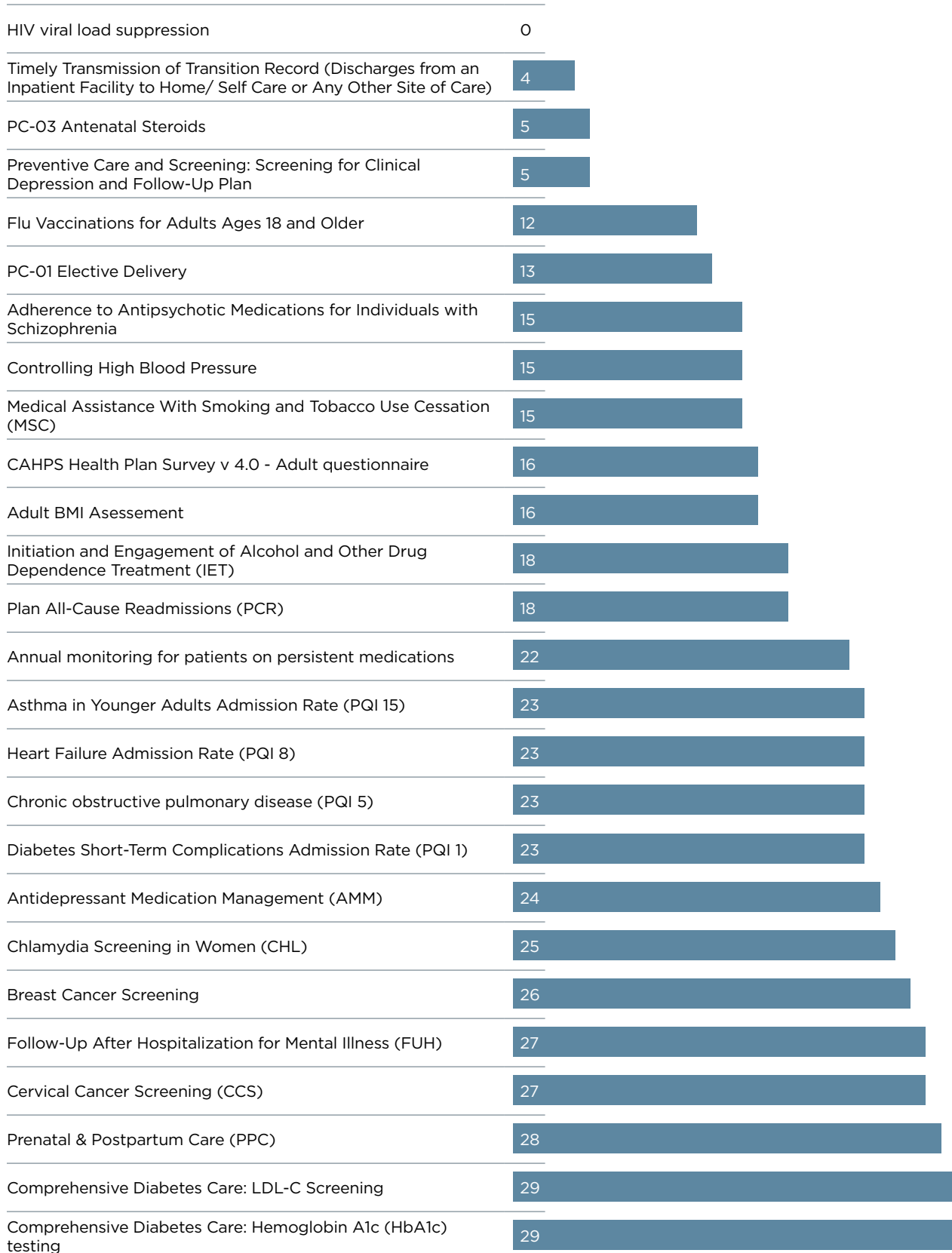
Three states—Louisiana, New Hampshire, and Virginia—shared their implementation experiences collecting and reporting measures to CMS to inform the MAP review of the Adult Core Set. These perspectives are a sample and not representative of all state Medicaid programs. This dialogue was highly informative,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

Louisiana

In the state of Louisiana, nearly 500,000 adults received Medicaid services in 2010.²² Until 2011, Louisiana Medicaid operated in a fee-for-service model; since 2012 almost all beneficiaries have been enrolled in a managed care benefit with one of the five participating health plans across the state. Louisiana is a recipient of an Adult Medicaid Quality Grant and reported 19 of the 26 measures in the core set. Prior to the grant program, Louisiana Medicaid collected 18 HEDIS measures and 10 Children's Core Set measures.

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

EXHIBIT 3. NUMBER OF STATES REPORTING MEASURES IN MEDICAID ADULT CORE SET IN FFY 2013²³



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

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

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

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

Measurement Driving Improvement: Representatives from Louisiana identified several

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

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

New Hampshire

The State of New Hampshire provided Medicaid-funded healthcare services to approximately 68,000 adults in 2010.²⁴ In 2014, New Hampshire chose to expand Medicaid coverage through provisions in ACA.²⁵ As a result, 30 percent of the currently uninsured adult population is expected to gain Medicaid eligibility. During the first year of participation in the quality reporting program, New Hampshire submitted 16 measures in the Adult Core Set to CMS. To select and report these measures, state officials balanced political, logistical, and financial realities. Three key features influenced the selection of measures to report: feasibility, efficiency, and capacity building.

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

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

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

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

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

Virginia

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

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

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

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

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

Nonreporting States

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

be informed by additional discussions with nonreporting Medicaid programs. Several themes arose from their feedback, some of which are congruent with opinions of reporting states:

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

MAP REVIEW OF THE MEDICAID ADULT CORE SET

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

The MSC are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements. The criteria favor the selection of high-quality measures that optimally address the NQS, fill critical measurement gaps, and increase alignment across programs. In the application of the MSC to the Adult Core Set, MAP noted the following:

- The composition of the Medicaid Adult Core Set is well-matched with CMS' stated goals for the program;
- The Adult Core Set's strong alignment with other program sets and parsimonious number of measures should continue;
- While the mix of measure types is satisfactory, MAP encourages the inclusion of relevant outcome measures in future iterations of the set;
- MAP strongly prefers that the set contain the most current NQF-endorsed® measures to ensure validity and reliability.

- MAP observed changes had been made to several measures to enable state-level reporting, including the use of a more restricted age range, setting a specific date for age calculation, and changing denominator populations from "enrollees" to "member-months." These minor edits are not expected to have a significant impact on the scientific properties of the measure. However, deviations from a measure's risk adjustment methodology would constitute a material change and warrant additional testing to ensure reliability and validity are not damaged.
- For measures that have not been endorsed or have had endorsement removed, CMS should consider updates or substitutions.

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

Measure-Specific Recommendations

MAP supported the majority of the measures in the Adult Core Set for continued use in the program. [Appendix D](#) provides further details

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

Measures for Phased Addition to the Adult Core Set

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

1. First, MAP prioritized the addition of [#0059](#) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) to the Adult Core Set to address the highly prevalent condition of diabetes and facilitate state efforts to drive quality improvement on the risk factor of poor HbA1c control. A measure of HbA1c testing is currently a part of the measure set, but MAP is more interested in measuring the intermediate outcome than the process.
2. Second, MAP recommended the addition of [#1799](#) Medication Management for People with Asthma as a complement to [#0283](#) Asthma in Younger Adults Admission Rate (PQI 15) because it focuses on upstream activities to control asthma symptoms. The Centers for Disease Control and Prevention (CDC) estimates the

national prevalence of asthma among adults to be 8.6 percent.²⁹ It is a common health condition, but not as widespread as diabetes.

3. Third, consistent with prior recommendations, [#0647](#) Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) was supported for addition to the Adult Core Set. This measure is paired and intended to be used with [#0648](#) Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care), which had relatively low levels of reporting by states because of data collection challenges. Care coordination is an important topic area, and using these paired measures together may improve the feasibility of the measures.

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

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

MAP conditionally supported the continued use of three measures.

Medication Management and NQF [#2371](#) Annual Monitoring for Patients on Persistent Medications

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

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

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

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

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

NQF has endorsed two measures related to all-cause hospital readmissions. The two measures differ in their approach and underlying specifications due to the purposes for which they were designed. Measure **#1768** Plan All-Cause Readmissions (PCR) is currently included in the Medicaid Adult Core Set. However, CMS is

considering whether measure **#1789** Hospital-Wide All-Cause Unplanned Readmission Measure would offer greater fit-for-purpose in the program. MAP urges CMS to consider the many potential uses of the measurement information and determine which one is primary because different “use cases” lead to different conclusions about which measure would be superior in this context. In particular, issues of alignment with other programs and the feasibility of data collection are critical factors to consider. The methodology for **#1789** is aligned with CMS’ other facility-level, condition-specific measures for readmission, while the methodology for **#1768** is part of HEDIS and used for multiple types of health plans.

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

NQF #2372 Breast Cancer Screening

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

Measures for Removal from the Adult Core Set

NQF #0063 Comprehensive Diabetes Care: LDL-C Screening

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

Recommendations to Address High Priority Gaps

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

- Access to primary and specialty care
- Beneficiary-reported outcomes
- Care coordination

- Integration of medical and psychosocial services
- Primary care and behavioral health integration
- Cultural competency of providers
- Efficiency
 - Inappropriate emergency department utilization
- Long-term supports and services
- Maternal health
 - Inter-conception care to address risk factors
 - Poor birth outcomes (e.g., premature birth)
 - Postpartum complications
- Promotion of wellness
- Treatment outcomes for behavioral health conditions and substance use disorders
- Workforce

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

Maternal Health

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

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

Behavioral Health

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

MAP learned of joint efforts of the National Committee for Quality Assurance (NCQA) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to address measure gaps related to comorbid conditions among the behavioral health population. Currently in its third year, the project is developing measures that assess screening and follow-up care for adults with

serious mental illnesses such as schizophrenia, bipolar disorder, major depression, alcohol and other drug dependence. MAP members discussed the lack of ambulatory services available to the behavioral health population and will continue to monitor these measure development efforts for their potential to address measure gaps.

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

Access to Primary Care

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

STRATEGIC ISSUES

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

Building State Capacity

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

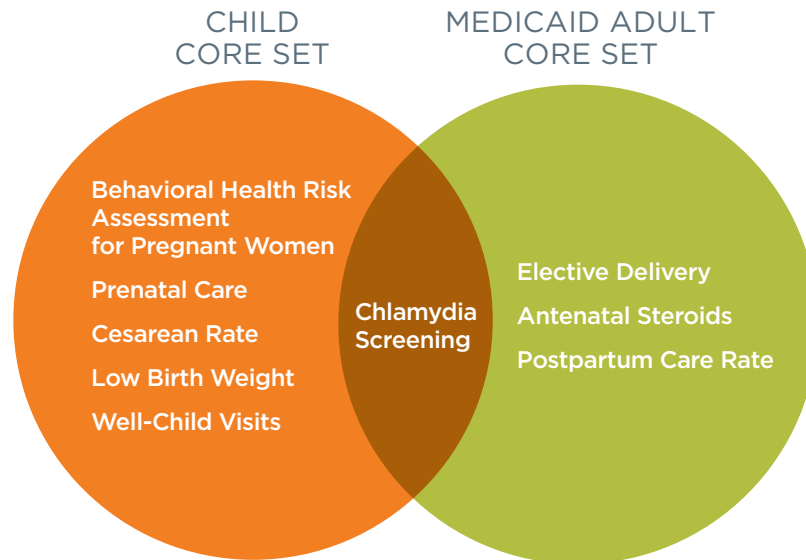
State representatives described the benefit of CMS' grant program in providing funding that allowed the Medicaid agencies to form data-sharing partnerships with the public health system and other key stakeholders. Developing linkages to vital records systems, for example, assisted with the calculation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

Alignment of Measures Across Adult and Child Core Sets

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

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

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



Impact of Payment Models

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

merit continued consideration. The variation in state payment models and implications for data collection could affect the future comparability of measure results across states.

Incorporating Beneficiaries' Perspectives on Quality

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

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

Balancing Rigor and Voluntary Participation

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

measures or the way in which they were presented discouraged any states from participating in reporting. Further outreach to representatives of nonparticipating states could be conducted to inform subsequent reviews.

Ultimate Uses of Measurement Information

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

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

provided to states on the Core Set reporting. Measure results will be publicly reported in 2015. Some states have already expressed a strong desire to rate their own performance against others. CMS should consider the analytic supports

necessary to enable valid cross-state comparisons or national benchmarking, such as risk adjustment to account for differences in states' enrolled populations.

CONCLUSION

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

States' perspectives on the use of measures during their first year of implementation contributed greatly to MAP's discussion and decisionmaking process. State representatives enthusiastically described the value of participating in the Medicaid Adult Quality grant program and how they have used information to inform direct quality

improvement efforts. MAP encourages further state efforts to report additional measures and capitalize upon the infrastructure and partnerships being developed. MAP endeavored to maintain a measure set that is feasible for states' continued engagement and reflective of the diversity found in state Medicaid programs, including variability in enrolled populations, capacity for data analysis, and quality issues of interest.

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

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APPENDIX A: MAP BACKGROUND

Purpose

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

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

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

MAP’s objectives are to:

1. **Improve outcomes in high-leverage areas for patients and their families.** MAP encourages the use of the best available measures that are high-impact, relevant, and actionable. MAP has adopted a person-centered approach to measure

selection, promoting broader use of patient-reported outcomes, experience, and shared decisionmaking.

2. **Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy based on value.** MAP promotes the use of measures that are aligned across programs and between public and private sectors to provide a comprehensive picture of quality for all parts of the healthcare system.
3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden.** MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers,

groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare. Foundational to the success of all of these efforts is a robust quality enterprise that includes:

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

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

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

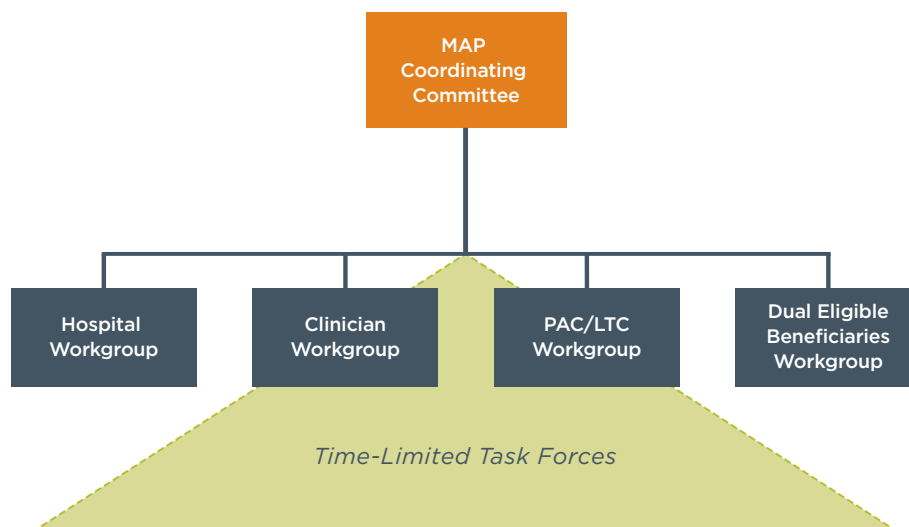
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP’s role within the quality enterprise is to consider and recommend measures for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

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

Structure

MAP operates through a two-tiered structure (see Figure A1). The MAP Coordinating Committee

FIGURE A1. MAP STRUCTURE



provides direction to the MAP workgroups and task forces and final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with developing “families of measures”—related measures that cross settings and populations—and a multiyear strategic plan provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

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

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see [MAP 2014 Pre-Rulemaking Report](#)).

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall to inform MAP’s pre-rulemaking input. To date MAP has issued a [series of reports](#) that:

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

ENDNOTE

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

APPENDIX B:

Rosters for the MAP Medicaid Task Force and MAP Coordinating Committee

Roster for the MAP Medicaid Task Force

| CHAIR (VOTING) | |
|---|---|
| Harold Pincus, MD | |
| ORGANIZATIONAL MEMBERS (VOTING) | REPRESENTATIVE |
| American Academy of Family Physicians | Alvia Siddiqi, MD, FAAFP |
| Humana, Inc. | George Andrews, MD, MBA, CPE, FACP |
| L.A. Care Health Plan | Jennifer Sayles, MD, MPH |
| March of Dimes | Cynthia Pellegrini |
| National Association of Medicaid Directors | Foster Gesten, MD, FACP |
| National Consumer Voice for Quality Long-Term Care | Lisa Tripp, JD |
| National Rural Health Association | Brock Slabach, MPH, FACHE |
| EXPERTISE | INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING) |
| 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 (NON-VOTING, EX OFFICIO) | REPRESENTATIVE |
| Centers for Medicare & Medicaid Services (CMS) | Marsha Smith, MD, PhD, FAAP |
| MAP COORDINATING COMMITTEE CO-CHAIRS (NON-VOTING, EX OFFICIO) | |
| George Isham, MD, MS | |
| Elizabeth McGlynn, PhD, MPP | |

Roster for the MAP Coordinating Committee

| CO-CHAIRS (VOTING) | |
|---|---|
| George Isham, MD, MS | |
| Elizabeth McGlynn, PhD, MPP | |
| ORGANIZATIONAL MEMBERS (VOTING) | REPRESENTATIVES |
| AARP | Joyce Dubow, MUP |
| Academy of Managed Care Pharmacy | Marissa Schlaifer, RPh, MS |
| AdvaMed | Steven Brotman, MD, JD |
| AFL-CIO | 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 (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 | Shari Davidson |
| National Partnership for Women and Families | Alison Shippy |
| Pacific Business Group on Health | William Kramer, MBA |
| Pharmaceutical Researchers and Manufacturers of America (PhRMA) | Christopher Dezii, RN, MBA,CPHQ |
| 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) | Chesley Richards, MD, MPH |
| 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) | Kevin Larsen, MD, FACP |

| 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 |

NQF Staff

| | |
|-----------------------------|------------------------|
| Megan Duevel Anderson | Project Manager |
| Elizabeth Carey | Project Manager |
| Laura Ibragimova | Project Analyst |
| Sarah Lash | Senior Director |
| Allison Ludwig | Senior Project Manager |
| Yetunde Alexandra Ogungbemi | Project Analyst |

APPENDIX C: MAP Measure Selection Criteria

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

Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Sub-criterion 6.1** Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)
- Sub-criterion 6.2** Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

7. Program measure set promotes parsimony and alignment

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

- Sub-criterion 7.1** Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)
- Sub-criterion 7.2** Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

APPENDIX D: Medicaid Adult Core Set and MAP Recommendations

In January 2012, HHS published a final notice in the *Federal Register* to announce the initial core set of healthcare quality measures for Medicaid-Eligible adults; a **2014 version** followed. The table below lists the measures included in the Core Set along with their current NQF endorsement number and status.

States voluntarily collect the Medicaid Adult Core Set measures using the **2014 Technical Specifications and Resource Manual**. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF’s Quality Positioning System.

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

| Measure & NQF Endorsement Status | Measure Description | Number of States Reporting to CMS and Alignment | Recommendations and Rationale |
|---|--|---|--|
| <p>0018 Endorsed Controlling High Blood Pressure Measure Steward: NCQA</p> | <p>The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.</p> | <p>15 states reported FFY 2013 Alignment: Meaningful Use Stage 2 - Eligible Professionals, Medicare Shared Savings Program, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System</p> | <p>Support for continued use in the program Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report Addresses NQS and CMS Quality Strategy priority area Prevention and Treatment of Chronic Conditions</p> |
| <p>0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation Measure Steward: NCQA</p> | <p>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.</p> | <p>15 states reported FFY 2013 Alignment: PQRS, HEDIS, Health Insurance Marketplace Quality Rating System</p> | <p>Support for continued use in the program</p> |

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

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

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

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

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

| Measure & NQF Endorsement Status | Measure Description | Number of States Reporting to CMS and Alignment | Recommendations and Rationale |
|--|--|--|--|
| <p>1768 Endorsed</p> <p>Plan All-Cause Readmissions</p> <p>Measure Steward: NCQA</p> | <p>For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:</p> <ol style="list-style-type: none"> 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/ Denominator) 5. Total Variance <p>Note: For commercial, only members 18-64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.</p> | <p>18 states reported FFY 2013</p> <p>Alignment: HEDIS, Health Insurance Marketplace Quality Rating System</p> | <p>Conditional support for continued use in the program</p> <p>MAP recommends the development and application of a risk-adjustment model for the Medicaid population</p> |
| <p>1879 Endorsed</p> <p>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</p> <p>Measure Steward: CMS</p> | <p>The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).</p> | <p>18 states reported FFY 2013</p> <p>Alignment: HEDIS</p> | <p>Support for continued use in the program</p> <p>Addresses the needs of vulnerable population at greater risk of readmissions and nonadherence to medications</p> <p>Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report</p> <p>MAP recommends the steward consider refining this measure to simplify the data collection methodology</p> |

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

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

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

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

approximately \$7.6 billion and the 10 conditions with the most all-cause, 30-day readmissions accounted for 34.1% of all Medicaid readmissions.

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

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

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

ENDNOTE

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

APPENDIX F: NQF Member and Public Comments

State Experience Collecting and Reporting the Core Set

America's Health Insurance Plans

Carmella Bocchino

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

GlaxoSmithKline

Deborah Fritz

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

MAP's Measure Specific Recommendations and Gaps

ActualMeds Corporation

Joseph Gruber

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

American Heart Association

Madeleine Konig

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

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

America's Essential Hospitals

Ashley Ferguson

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

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

We appreciate the opportunity to comment on the above-captioned report. If you have any questions,

please contact Ashley Henske at ahenske@essentialhospitals.org.

America's Health Insurance Plans

Carmella Bocchino

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

O039: This measure could be subject to recall bias that may affect its reliability. Sample size may also be too small for meaningful health plan comparison. We recommend requiring all practitioners that administer immunizations to report vaccinations to state immunization registries, and also be required to release such data to hospitals, health plans, providers, etc.

O648: This measure is important for the Medicaid population, as it is highly dependent on communication among facilities, providers, and families or caregivers. Our experience shows that some plans use this measure in pay-for-performance programs. This measure is a hospital measure that is burdensome and difficult to collect as it may require EHR data extraction or chart review. Accurate information regarding whether the discharge record was sent within 24 hours may not be recorded and thus not available. Hospitals must be required to collect the exact transmission times of the transition record before this measure should be adopted.

O418: This measure is burdensome for health plans to collect as data are captured only through medical record review. It is difficult to obtain complete and consistent data due to providers using a variety of adult screening tools (e.g. PHQ-9), etc.) and follow-up plans are not captured by administrative data.

O476: This measure is burdensome for health plans to collect as it is not captured by administrative claims and complete data are difficult to obtain due to patients receiving antenatal steroids before delivery at a variety of locations (e.g. birthing center, hospital, etc.).

America's Health Insurance Plans

Carmella Bocchino

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

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

AstraZeneca

Kathy Gans-Brangs

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

AstraZeneca

Kathy Gans-Brangs

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

CVS/caremark

Kristin Garnett

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

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

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

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

Eli Lilly and Company

Dawn Blank

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

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

GlaxoSmithKline

Deborah Fritz

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

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

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

on a single point in time, or condition, or prescription fail to reflect the overall quality of medication management.

Highmark

Christine Pozar

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

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

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

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

MedHere Today

Richard Logan

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

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

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

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

Merck

Patrick Liedtka

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

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

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

NACDS

Alex Adams

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

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

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

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

NACDS

Alex Adams

Providing meaningful and transparent information around medication adherence is critically important to improve outcomes within Medicaid plans.

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

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

National Partnership for Women & Families

Alison Shippy

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

1. PC-02 Cesarean Section (NQF #0471): This outcome measure assesses the number of nulliparous women with a term, singleton baby in a vertex

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

2. PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother's Choice (NQF #0480): PC-05 assesses the number of newborns exclusively fed breast milk during the newborn's entire hospitalization and a second rate, PC-05a which is a subset of the first, which includes only those newborns whose mothers chose to exclusively feed breast milk. This process measure is also a part of the set of five nationally implemented measures that address perinatal care from TJC. Breast feeding is associated with reduced hypertension, heart disease, diabetes, and breast and ovarian cancer in women. Also, there are significant postpartum hormonal contributions to maternal adaptation to parenting and life in the postpartum period through the continued surges of oxytocin (offers "calm and connection") and prolactin associated with breastfeeding.

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

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

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

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

OutcomesMTM

Jessica Frank

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

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

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

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

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

Parata Systems

Gayle Tuttle

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

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

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

PerformRx

Erica Potter

1. They use ICD-9 codes, they should also list out ICD-10 codes due to the impending conversion
2. The opioid measure lists cancer as exclusion. I think there are other disease states that require higher doses of opioids. Specifically thinking of Sickle Cell Disease.
3. I liked how the measures are framed and my comment on the last one DRAFT QUALITY IMPROVEMENT INDICATOR: Persons in a Patient-Centered Medical Home or Other Integrated Care Team Model Receiving a Timely Comprehensive Medication review:
4. I would like to have threshold percentage of completion in case there is a large population identified for MTM service it might not be possible to complete reviewing all the members within the specified 30, 60, 90 days.

Pharmacy Quality Alliance

Woody Eisenberg

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

Assessment of quality in medication use and management throughout the healthcare delivery continuum leads to improved health. PQA is pleased to see that MAP suggests further review of issues related to medication management and we support the inclusion of the NQF-endorsed medication adherence measure 0541, Proportion of Days

Covered (PDC): 3 rates by Therapeutic Category. This measure, as recently submitted to the NQF measure maintenance process is focused on renin-angiotensin antagonists, diabetes medications and statins. PQA uses a rigorous consensus-driven process to develop, test, and endorse high-priority measures of medication-use quality. The measure has been thoroughly tested, and is calculated using prescription claims data, so adds little to the burden of data collection.

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

PhRMA

Jennifer Van Meter

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

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

RxAnte

Aaron Mckethan

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

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

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

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

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

Adherence measure 0541 reinforces other federal

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

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

VoicePort LLC

Jeffery Maltese

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

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

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

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

Our thanks in advance for your continued efforts and support.

Strategic Issues

America's Health Insurance Plans

Carmella Bocchino

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

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

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

GlaxoSmithKline

Deborah Fritz

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

General Comments on the Report

American Association on Health & Disability

E. Clarke Ross

Recommendations to Address High Priority Gaps

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

National Quality Forum – MAP (Measures Application Partnership)

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

1. Goal-directed, person-centered care planning and implementation
2. Shared decision-making
3. Systems to coordinate healthcare with non-medical community resources and service providers
4. Beneficiary sense of control/autonomy/self-determination
5. Psychosocial needs
6. Community integration/inclusion and participation
7. Optimal functioning (e.g., improving when possible, maintaining, managing decline)

These are appropriate for the entire adult Medicaid population.

Beneficiary Experience and Beneficiary-Reported Outcomes

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

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

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

Building state capacity

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

Thank you for considering our views.

American Optometric Association

Kara Webb

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

The AOA understands that the implementation of Medicaid quality measures requires time and resources. As the MAP looks towards the future, the AOA recommends that the MAP continue to encourage a focus on measures related to diabetes care for the core measure set. As the MAP well knows, diabetes disproportionately affects low-income populations and Medicaid plays a critical role in supporting care for patients with diabetes.

The AOA encourages the MAP to consider recommending the Comprehensive Diabetes Care: Eye Exam measure (NQF 0055) for inclusion in the core measure set. People with diabetes are at a significantly higher risk for developing eye diseases including glaucoma, cataracts and diabetic retinopathy, one of the most serious sight-threatening complications of diabetes. Additionally, those with diabetes are 40 percent more likely to suffer from glaucoma than people without diabetes.

Many people without diabetes will get cataracts, but those with the disease are 60 percent more likely to develop this eye condition. People with diabetes also tend to get cataracts at a younger age and have them progress faster. For these reasons it is critical for patients with diabetes to receive annual eye exams. Including this measure in the core set would help to ensure that diabetic patients are getting necessary care that has a tremendous impact on future health care costs and quality of life.

America’s Essential Hospitals

Ashley Ferguson

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

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

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

preventable hospital-acquired conditions and 30-day readmissions.

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

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

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

America's Health Insurance Plans

Carmella Bocchino

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

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

Additionally, as the Medicaid Adult Core Set moves towards outcome measures, reporting of CPT Category II codes will be necessary to efficiency

collect outcomes for lab tests, body mass index, blood pressure, and other biometric information.

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

National Partnership for Women & Families

Alison Shippy

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

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

Parata Systems

Gayle Tuttle

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

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

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

NATIONAL QUALITY FORUM
1030 15TH STREET, NW, SUITE 800
WASHINGTON, DC 20005

www.qualityforum.org