NATIONAL QUALITY FORUM

Web Meeting Agenda

Measure Applications Partnership (MAP)

Joint Meeting of the Medicaid Adult and Child Task Forces

Friday, April 1, 2016

1:00-3:00 pm ET

Participant Instructions:

- Please log in 10 minutes prior to the scheduled start to allow time for troubleshooting
- Direct your browser to: http://nqf.commpartners.com for slides and streaming audio
- Under "Enter a Meeting," type in the meeting number **927528** and click "Enter"
- In the "Display Name" field, type in your first and last name and click "Enter Meeting"
- Task force members dial **(877) 331-3815** to access the audio platform.
- Public participants dial **(855) 500-8563** to access the audio platform.

Meeting Objectives:

- Welcome and orient new members to the MAP Medicaid Adult and Child Task Forces
- Review MAP's previous recommendations and the measures currently planned for use in both measure sets
- Introduce and discuss the topic of care coordination as an umbrella issue encompassing community linkage and health and well-being as an introduction to the in-person meeting discussion

1:00 pm **Welcome and Review of Meeting Objectives**

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

1:10 pm **Introductions of Task Force Members and Disclosures of Interest**

Ann Hammersmith, General Counsel, NQF

1:20 pm **Review MAP's Charge to Provide Input to Strengthen and Identify Priority Gaps in the Adult and Child Quality Measurement Programs**

Marsha Lillie-Blanton, Senior Policy Advisor, CMCS
Foster Gesten

- Review of the Task Forces' Charge
- Introduction of Karen Matsuoka, CMCS Chief Quality Officer & Director, Division of Quality and Health Outcomes
- CMS goals for the Adult Core Set and Child Core Set

- CMS consideration of MAP's 2015 recommendations
- Questions from task force members

1:40 pm **Child Core Set: Prior Recommendations and Updated 2016 Core Set of Measures**

Shaconna Gorham, Senior Project Manager, NQF
Foster Gesten

- Summarize MAP's 2014 and 2015 measure and gap recommendations for the Child Core Set
- Review measure properties and CMS updates for FFY 2016
- Questions and comments from task force members related to opportunities to further strengthen the Child Core Set

2:00 pm **Adult Core Set: Prior Recommendations and Updated 2016 Core Set of Measures**

Severa Chavez, Project Analyst, NQF
Harold Pincus

- Summarize MAP's 2013-2015 measure and gap recommendations for the Adult Core Set
- Review measure properties and CMS updates for FFY 2016
- Questions and comments from task force members related to opportunities to further strengthen the Adult Core Set

2:20 pm ***Opportunities* for Further Strengthening the Measure Sets**

Debjani Mukherjee, Senior Director, NQF
Harold Pincus

- Preview objectives for the in-person meeting
- Resonant Themes and policy discussion
- What additional information do the task forces need to support their deliberations?

2:50 pm **Opportunity for Public Comment**

2:55 pm **Next Steps**

Shaconna Gorham

3:00 pm **Adjourn**

NATIONAL QUALITY FORUM

Final Roster

MAP Medicaid Adult Task Force

TASK FORCE CHAIR

Harold Pincus, MD

Professor and Vice Chair, Department of Psychiatry at Columbia University's College of Physicians and Surgeons
New York, NY

Harold Alan Pincus is Professor and Vice Chair of the Department of Psychiatry at Columbia University's College of Physicians and Surgeons, Director of Quality and Outcomes Research at New York Presbyterian Hospital and Co-Director of Columbia's Irving Institute for Clinical and Translational Research. Dr. Pincus also serves as a Senior Scientist at the RAND Corporation. Previously he was Director of the RAND-University of Pittsburgh Health Institute and Executive Vice Chairman of the Department of Psychiatry at the University of Pittsburgh. He is the National Director of the Health and Aging Policy Fellows Program (funded by Atlantic Philanthropies), and directed the Robert Wood Johnson Foundation's National Program on Depression in Primary Care and the John A. Hartford Foundation's national program on Building Interdisciplinary Geriatric Research Centers. Dr. Pincus was also the Deputy Medical Director of the American Psychiatric Association and the founding director of APA's Office of Research and Special Assistant to the Director of the NIMH and also served on White House and Congressional staffs. Dr. Pincus was Vice Chair of the Task Force on Diagnostic and Statistical Manual, Fourth Edition (DSM IV) and has been appointed to the editorial boards of ten major scientific journals. He has authored or co-authored over 400 scientific publications on health services research, science policy, research career development and the diagnosis and treatment of mental disorders. Among other recent projects, he led the national evaluation of veterans' mental health services, the redesign of primary care/ behavioral health relationships in New Orleans, a National Institutes of Health-funded national study of research mentoring and evaluation of major federal and state programs to integrate health and mental health care. He has also been a consultant to federal agencies and private organizations, including the U.S. Secret Service, John T. and Catherine D. MacArthur Foundation. He has served on multiple Institute of Medicine and other national and international committees and chairs the WHO/ICD 11 Technical Advisory Group on Quality and Patient Safety. For over 22 years he worked one night a week treating the severely mentally ill at a community clinic.

TASK FORCE MEMBERS

George Andrews, MD, MBA, CPE, FACP, FACC, FCCP

Corporate Chief of Quality, Humana, Inc.
Louisville, KY

George A. Andrews serves as Humana's Corporate Chief of Quality. He oversees Clinical Quality strategy development, Quality Improvement Activities and Patient Safety initiatives. He works

closely with the National Network Operations to engage the provider community and enhance provider collaboration with Humana's clinical programs that would lead to improvements in member health outcomes and well-being. Dr. Andrews, a former Fulbright scholar, is a diplomat with the National Board of Medical Examiners. He is board certified in the areas of internal medicine and cardiovascular disease and is a fellow of the American College of Physicians, American College of Cardiology and the American College of Chest Physicians. He also is a certified physician executive of the American College of Physician Executives. Before joining Humana in 2008 as the Mid-South Region's Chief Medical Officer, Dr. Andrews served as the SVP/Chief Medical Officer at Cariten Healthcare, a Covenant Health Affiliate for 5 years. Prior to that, Dr. Andrews served as the medical director of health services for CIGNA HealthCare's Florida and North Carolina territories. He began working with CIGNA HealthCare in September 1998. Trained as a cardiologist, Dr. Andrews was medical director of cardiology and had a consultative cardiology / internal medicine clinical practice with Coral Springs Cardiology Associates in Coral Springs, Fla., for more than 15 years. Andrews received a master's degree in business administration from the University of South Florida. His medical training includes a cardiology fellowship at Jackson Memorial Hospital at the University of Miami School of Medicine in Florida and an internal medicine residency at Columbia Presbyterian Hospital in New York. He earned his doctor of medicine degree from Mount Sinai School of Medicine in New York and completed his undergraduate studies with a magna cum laude bachelor's degree at Columbia University in New York.

Jennifer Babcock, MPH

Vice President for Medicaid Policy and Director of Strategic Operations, Association of Community Affiliated Plans (ACAP)
Washington, DC

Jennifer McGuigan Babcock is ACAP's Vice President for Medicaid Policy and Director of Strategic Operations. She was recently appointed to direct ACAP's Medicaid policy work after spending over four years as ACAP's Vice President for Exchanges. And this is her second tour at ACAP; in 2010, she served the Eligibility and Enrollment team within the Office of Health Insurance Exchanges in the Department of Health and Human Service's Office of Consumer Information and Insurance Oversight (OCIIO, now known as CCIIO), focusing primarily on the interplay between Medicaid and Exchange coverage. Before joining OCIIO, she served as ACAP's Director of Policy, working primarily on Medicaid and CHIP health plan issues. Previously, Jennifer worked on policy related to Medicaid, CHIP, the uninsured, and private health insurance in the Office of Health Policy for the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services. She has also held positions with CHIP at the Centers for Medicare & Medicaid Services as special assistant to the Deputy Secretary of Health Care Financing at the Maryland Department of Health and Mental Hygiene, and as an associate consultant with The Lewin Group in Falls Church. Jennifer also served as an MPH Fellow at the Consumer Health Foundation in Washington, D.C., and as Executive Director of the Lovelight Foundation, an anti-poverty organization in Detroit. She has a Masters of Public Health from the University of Michigan, Department of Health Management and Policy, and a Bachelor of Arts in English from Kalamazoo College in Michigan.

Randolph Desonia, MHSA

Executive Director of Medicaid Policy, America's Health Insurance Plans
Washington, DC

Randolph Desonia is Executive Director of Medicaid Policy at America's Health Insurance Plans where he is responsible for analyzing and commenting on proposed federal regulations, federal legislation, and research on Medicaid health plans. In working on these issues he has worked with Medicaid health plan experts in the fields of state and federal policy, pharmacy, actuarial soundness, program compliance and health quality reporting. He worked extensively on such federal legislation as the DRA of 2005, CHIPRA of 2009 and the ACA of 2010. Prior to AHIP, Mr. Desonia served as director of the health policy division of the National Governors Association, was a member of the research and evaluation unit of the Robert Wood Johnson Foundation, and worked for the National Health Policy Forum on Medicaid and long term care issues. Mr. Desonia has a Masters of Health Services Administration and a Masters of Applied Economics from the University of Michigan.

Kathleen Dunn, RN, MPH

Associate Director & Medicaid Director, NH Department of Health & Human Services
Concord, NH

Kathleen (Katie) Dunn has spent the last 22 years of her career with the NH Department of Health and Human Services beginning as the bureau chief of communicable diseases and then as a nurse consultant in maternal and child health. During her tenure she has been promoted and served as the Director of Public Health for the State of New Hampshire from 1999 – 2003 and the Deputy Medicaid Director from 2003 – 2008. In 2008 she was appointed to the position of State Medicaid Director and in 2012 was promoted to Associate Commissioner and Medicaid Director. Prior to working for the State of NH, Katie was a critical care nurse. In addition to being a registered nurse Katie received her Master's degree in Public Health from Boston University with a concentration in Health Services Administration. She is also a Robert Wood Johnson Foundation Fellow having been selected to participate in and completing the Medicaid Leadership Institute fellowship in 2011. During Ms. Dunn's tenure as Medicaid Director she co-founded the NH Medicaid Quality Unit, and has overseen the publication of numerous reports focusing on a variety of quality metrics including but not limited to administrative measures such as access to care measures to health outcome measures. The information gleaned from this work has informed NH policy makers decision making regarding the strategic direction that NH would take in improving the health of its citizens and moving towards incentive, outcome, value-based purchasing. Ms. Dunn is currently providing executive oversight of the implementation of the NH DHHS 1115 Medicaid Transformation Waiver which includes the development and measurement of a set of metrics that will be monitored by CMS and is the basis of risk based financial agreement with CMS.

Sue Kendig, JD, MSN, WHNP-BC, FAANP

American Association of Nurse Practitioners
Austin, TX

Biography is forthcoming.

Cynthia Pellegrini

Senior Vice President, March of Dimes
Washington, DC

Cynthia Pellegrini is Senior Vice President for Public Policy and Government Affairs at the March of Dimes. In this capacity, Ms. Pellegrini oversees all March of Dimes advocacy efforts at the federal level and in all 50 States, the District of Columbia and Puerto Rico. She also guides the organization's research on maternal and child health policy issues. Key March of Dimes policy priorities include access to health care for all women of childbearing age and children; research into prematurity, birth defects, and other aspects of reproductive and child health and development; prevention and health promotion issues, such as tobacco cessation and nutrition; and issues of concern to the operation of not-for-profit organizations. Ms. Pellegrini is a voting member of the CDC's Advisory Committee on Immunization Practices, which determines the annual child and adult immunization schedules. Prior to joining March of Dimes, Ms. Pellegrini served as Associate Director for Federal Affairs at the American Academy of Pediatrics, where she covered a range of issues including genetics, bioethics, child abuse and neglect, environmental health, nutrition, obesity, and injury and violence. In this capacity, Ms. Pellegrini worked with AAP leadership to develop and execute strategies to advance AAP priorities through both Congress and the Administration. Ms. Pellegrini worked on Capitol Hill for over eleven years.

Marissa Schlaifer, RPh, MS

Head of Policy, CVS Health
Washington, DC

Marissa Schlaifer joined CVS Health as Head of Policy in April 2013. Based out of the CVS Health Washington, D.C., office, Marissa leads the team responsible for creating policy positions that help shape the laws and regulations impacting CVS Caremark business, and she also serves as a key contact with federal agencies. Marissa brings deep experience with policy analysis and issue advocacy, having spent ten years as Director of Pharmacy and Regulatory Affairs at the Academy of Managed Care Pharmacy (AMCP). Marissa was involved in providing input to the Centers for Medicare & Medicaid Services (CMS) on the development and implementation of the Medicare prescription drug benefit and aspects of the Affordable Care Act. In addition, she served on various Part D Medication Measures technical expert panels (TEPs), providing input on the development of quality measures, served on the Department of Defense Uniform Formulary Beneficiary Advisory Panel, and represented AMCP in many capacities within the Pharmacy Quality Alliance (PQA. Marissa currently serves on the National Quality Forum Measure Application Partnership (MAP) representing the Academy of Managed Care Pharmacy. Marissa brings experience in both the managed care pharmacy and community pharmacy segments of the profession as well as leadership experience in several pharmacy organizations. Prior to joining AMCP, Marissa was Healthy Outcomes Director at H-E-B Grocery Company, where she was responsible for disease management and health improvement programs, immunization programs and new business opportunities. Previously, Marissa worked for PacifiCare of Texas and Prescription Solutions as a clinical pharmacist, and for Eckerd Drug Company as pharmacy manager and a regional manager for managed care sales. She received her B.S. in Pharmacy and M.S. in Pharmacy Administration from The University of Texas at Austin College of Pharmacy. Marissa has been active in leadership positions within AMCP, the American Pharmacists Association and the Texas Pharmacy Association.

Michael Sha, MD, FACP

Assistant Professor of Clinical Medicine, Indiana University School of Medicine
Indianapolis, IN

Michael Sha, a board certified internist and geriatrician, is an Assistant Professor of Clinical Medicine at the Indiana University School of Medicine with primary duties at the Richard L. Roudebush VA Medical Center in Indianapolis where he provides clinical care and has teaching responsibilities for residents and geriatric medicine fellows. He serves as the Medical Director for the Geriatric Primary Care Clinic and for the Home-Based Primary Care program. He is board certified in internal medicine and geriatrics. Additionally, Dr. Sha serves on the Board of Directors for the Indiana Geriatrics Society and as Chair of the Therapeutics Committee, which is a component of the State of Indiana's Office of Medicaid Policy and Planning and develops recommendations for the Indiana Medicaid's Preferred Drug List. He also serves as a member of the American Board of Internal Medicine's Geriatric Medicine Board and on the Credentials Committee for the American College of Physicians (ACP). Previously, Dr. Sha served as Governor for the Indiana ACP Chapter and, prior to that, served as chair for ACP's Council of Early Career Physicians and Council of Resident/Fellow Members and as an ex-officio member of the ACP's Board of Regents. Dr. Sha has also served as a Trustee for the Indiana State Medical Association. He is a past recipient of ACP's Walter J. McDonald Award for Early Career Physicians and Indiana University Trustees' Teaching Award.

Brock Slabach, MPH, FACHE

Senior Vice-President, National Rural Health Association
Leawood, Kansas

Brock Slabach currently serves as the Senior Vice-President of Member Services for the National Rural Health Association (NRHA), a membership organization with over 21,000 members nationwide. Mr. Slabach has over 25 years of experience in the administration of rural hospitals. From 1987 through 2007, he was the administrator of the Field Memorial Community Hospital in Centreville, Mississippi. He earned his Bachelor of Science from Oklahoma Baptist University and his Master of Public Health in Health Administration from the University of Oklahoma.

SUBJECT MATTER EXPERTS (VOTING)

Kim Elliott, PhD, CPHQ

Administrator, Clinical Quality Management, Arizona Health Care Cost Containment System
Phoenix, AZ

Kim Elliott is the QQM Administrator of AHCCCS. Kim leads Agency quality initiatives including, quality strategy, quality and performance measures, quality improvement, care coordination, evidence-based policy decisions, and integration. Kim leads the Agency's Quality Assurance/Management, EPSDT/Maternal, Child and Oral Health, Prevention and Wellness, Quality Improvement and the Behavioral Health programs. Kim has participated in CMS Expert Panels including Medicaid Access to Care and in the development of Core Measure sets. Kim has also participated in the National Quality Forum MAP and Subject Matter Expert work groups on Long Term Care and Respiratory/Pulmonary Care. Prior to her role at AHCCCS, she worked for Medicaid, commercial and Medicare health plans where she designed and implemented initiatives for preventive health, special needs, chronic disease, developmental screening and

childhood obesity.

Ann Marie Sullivan, MD

Commissioner, New York State Office of Mental Health
New York, NY

Ann Marie Sullivan was confirmed by the New York State Senate as Commissioner for the New York State Office of Mental Health on June 20, 2014. New York State has a large, multi-faceted mental health system that serves more than 700,000 individuals each year. The Office of Mental Health (OMH) operates psychiatric centers across the State, and also oversees more than 4,500 community programs, including inpatient and outpatient programs, emergency, community support, residential and family care programs. As Commissioner, she has guided the transformation of the state hospital system in its emphasis on recovery and expansion of community based treatment, reinvesting over 60 million dollars in community services. Working closely with all mental health providers and health plans, she is responsible for the movement of the health benefit for the seriously mentally ill into managed care beginning October 2015. This new Health and Recovery Plan (HARP) benefit will embed in the Medicaid benefit critical recovery services such as crisis respite, peer, educational and employment supports. She has also been instrumental in expanding services for the mentally ill in prisons and in expanding the much needed community based continuum of care for the seriously mentally ill leaving prison and returning to their community. Dr. Sullivan is an active advocate for her patients and her profession, is a Distinguished Fellow of the American Psychiatric Association and has served as the Speaker of the American Psychiatric Association's Assembly and on its Board of Trustees. She is a fellow of the New York Academy of Medicine, a member of the American College of Psychiatrists and the Group for the Advancement of Psychiatry.

FEDERAL GOVERNMENT MEMBERS (NON-VOTING)

William Kassler, MD, MPH

Chief Medical Officer, New England Region of the Centers for Medicare and Medicaid Services
Concord, NH

William Kassler currently serves as Chief Medical Officer for the New England Region of the Centers for Medicare and Medicaid Services (CMS), where his major focus is to implement value-based purchasing initiatives to improve health care quality. Dr. Kassler also works with the Preventive and Population Health Care Models Group at the Center for Medicare and Medicaid Innovation. Prior to his current position, Dr. Kassler served as State Health Officer and Medical Director for the New Hampshire Department of Health and Human Services. His responsibilities included both public health and Medicaid, and his priorities were strengthening the system of community safety net providers, and integrating population-based public health strategies and preventive services into clinical care through programmatic collaboration between public health and Medicaid. He also worked at the Centers for Disease Control and Prevention (CDC) as an EIS Officer, a medical epidemiologist in HIV prevention, he directed a health services research and evaluation unit, and later served as Senior Advisor for health policy in the CDC/Washington Office.

Lisa Patton, PhD

Director of the Division of Evaluation, Analysis, and Quality, Substance Abuse and Mental Health Services Administration
Washington, DC

Lisa Patton is the Director of the Division of Evaluation, Analysis, and Quality within the Center for Behavioral Health Statistics and Quality at SAMHSA. She oversees SAMHSA's quality measures activities, serving as the SAMHSA representative for the HHS Measures Policy Council and other federal and private-sector behavioral health quality workgroups. Dr. Patton joined the federal government in 2011, working on quality measures and overseeing a behavioral health portfolio at ASPE, the Assistant Secretary for Planning and Evaluation. Prior to that, she directed mental health services research and evaluation, primarily for the federal government. A clinical psychologist, Dr. Patton worked as a therapist in community mental health, with a trauma specialty as well as a focus on underserved populations, including older adults. She received her A.B. from Harvard University, her Ph.D. from the University of Maryland, College Park.

Measure Applications Partnership

Joint Web Meeting of the Medicaid Adult and Child Task Forces

April 1, 2016

NATIONAL QUALITY FORUM

Welcome and Review of Meeting Objectives

Meeting Objectives

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

Introductions of Task Force Members and Disclosures of Interest

Medicaid Child Task Force Membership

Task Force Chair (*Voting*): Foster Gesten, MD, FACP

Organizational Members (*Voting*)

American Academy of Pediatrics	Terry Adirim, MD, MPH, FAAP
American Nurses Association	Susan Lacey, RN, PhD, FAAN
America's Essential Hospitals	Kathryn Beattie, MD
Association for Community Affiliated Plans	Meg Murray
Blue Cross and Blue Shield Association	Reed Melton
Children's Hospital Association	Andrea Benin, MD
Kaiser Permanente	Robert Riewerts
March of Dimes	Cynthia Pellegrini
National Partnership for Women and Families	Carol Sakala, PhD, MSPH
Patient-Centered Primary Care Collaborative	Fatema Salam, MPH

Medicaid Child Task Force Membership

Subject Matter Experts (*Voting*)

Richard Antonelli, MD
Luther Clark, MD

Organizational Member (*Non-Voting*)

National Association of Medicaid Directors	Deidre Gifford, MD, MPH

Federal Government Members (*Non-voting*)

Agency for Healthcare Research and Quality (AHRQ)	Kamila Mistry, PhD, MPH
Health Resources and Services Administration (HRSA)	Gopal Singh, PhD
Office of the National Coordinator for Health IT (ONC)	David Hunt, MD

Medicaid Adult Task Force Membership

Task Force Chair (*Voting*): Harold Pincus, MD

Organizational Members

Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh
American Association of Nurse Practitioners	Sue Kendig, JD, WHNP-BC, FAANP
American College of Physicians	Michael Sha, MD, FACP
America's Health Insurance Plans	Randolph Desonia
Association for Community Affiliated Health Plans	Jenny Babcock
Humana, Inc.	George Andrews, MD, MBA, CPE, FACP
March of Dimes	Cynthia Pellegrini
National Association of Medicaid Directors	Kathleen Dunn, RN, MPH
National Rural Health Association	Brock Slabach, MPH, FACHE

Medicaid Adult Task Force Membership

Subject Matter Experts

Ann Marie Sullivan, MD
Kim Elliott, PhD, CPHQ

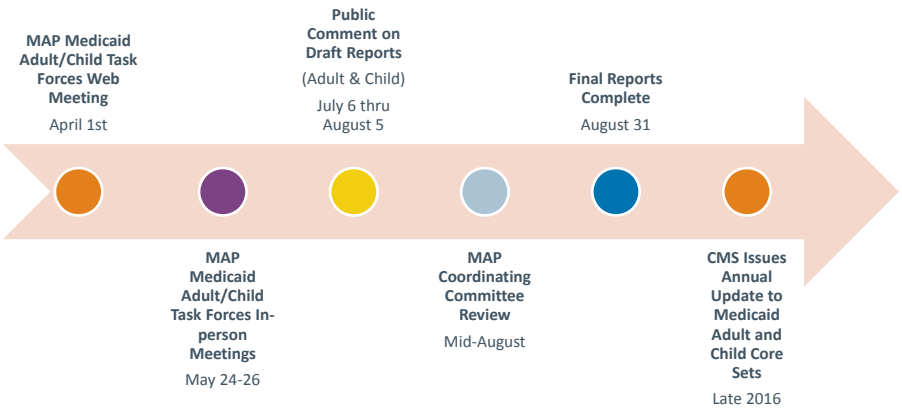
Federal Government Members

Centers for Medicare & Medicaid Services (CMS)	William Kassler, MD, MPH
Substance Abuse and Mental Health Services Administration (SAMHSA)	Lisa Patton, PhD

MAP Medicaid Child and Adult Task Forces Charge

- For this review, the charge of the MAP Medicaid Child and Adult Task Forces is to:
  - Review states' experiences reporting measures to date
  - Refine previously identified measure gap areas and recommend potential measures for addition to the set
  - Recommend measures for removal from the set that are found to be ineffective
- The task force consists of current MAP members from the MAP Coordinating Committee and MAP workgroups with relevant interests and expertise.
- MAP will convene the task forces beginning April 2016, with a report due to CMS by August 2016.

2016 Timeline



Overview of the Child and Adult Core Sets

NQF Medicaid MAP Web Meeting

April 2016

Marsha Lillie-Blanton

Center for Medicaid and CHIP Services (CMCS)

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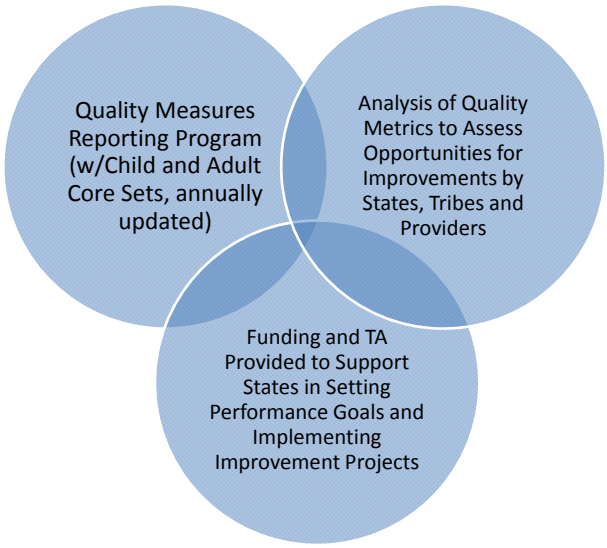
Building a Foundation for Quality Measurement and Improvement in Medicaid and CHIP



CMCS Goals for Measurement and Reporting

- Increase number of states reporting Core Set measures
- Maintain or increase number of measures reported by each state
- Improve the quality of the data reported (completeness, accuracy)
- Streamline data collection and reporting processes
- Support states to drive improvements in health care quality and health outcomes using Core Set data

Child and Adult Core Set: In Different Stages of Maturity

- Child Core Set:
  - Initial Core Set released in 2011
  - Recently completed 6th year of voluntary reporting
- Adult Core Set:
  - Initial Core Set released in 2012
  - CMS launched two-year grant program December 2012 to support Medicaid agencies in testing the collection and reporting of the Core Set
  - Recently completed 3rd year of voluntary reporting
- Core Sets must be updated annually

Reporting of Core Set Measures

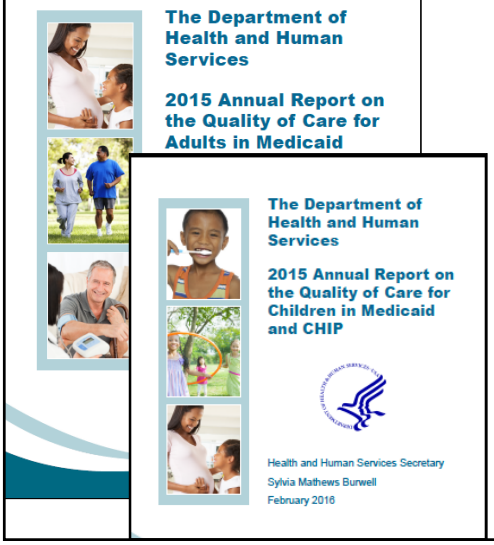
- Voluntary reporting of measures occurs at state-level
  - CMS launched two-year grant program December 2012 to support Medicaid agencies in testing the collection and reporting of the Adult Core Set
  - States currently submit Child and Adult Core set data to CMCS through MACPro
- Technical Assistance to States
  - Technical Assistance and Analytic Support Program for all States
  - CMS annually updates technical specifications manual
  - Targeted grant opportunities
  - Other (FAQ, webinars, TA mailbox)

Strengthening the Core Sets

- CHIPRA of 2009 and Affordable Care Act of 2010 requires the core set of measures to be "improved" annually
- In the past, CMCS partnered with AHRQ's Subcommittee to the National Advisory Committee for multi-stakeholder input
- Updates to the Child Core Set
  - 2012: Retired 1, added 3 measures
  - 2013: Retired 3 measures
  - 2014: Retired 1 measure , added 2 measures
  - 2015: Added 2 measures
- Updates to the Adult Core Set
  - 2013: Retired 1 measure
  - 2014: Retired 1, added 1 measure
  - 2015: Added 2 measures

Progress Made in Measuring and Reporting on Access and Quality

2015 Annual Secretary's Reports



- The 2015 Secretary's Reports present an update on the quality of health care furnished to Medicaid/CHIP enrollees, as well as information gathered from the external quality reviews of managed care organizations. CMS gathers this information by :
  - Reviewing findings on the Core Sets
  - Summarizing information on managed care quality from External Quality Review (EQR) Technical Reports
- Domain-specific reports present detailed analysis of state performance on Core Set measures reported by at least 25 states.
- Reports are available on Medicaid.gov.
  - Related Resources:
    - Overview of Core Set Measures, FFY 2014
    - Performance on Core Set Measures, FFY 2014
    - Findings from EQR Technical Reports, 2013-2014 Reporting Cycle

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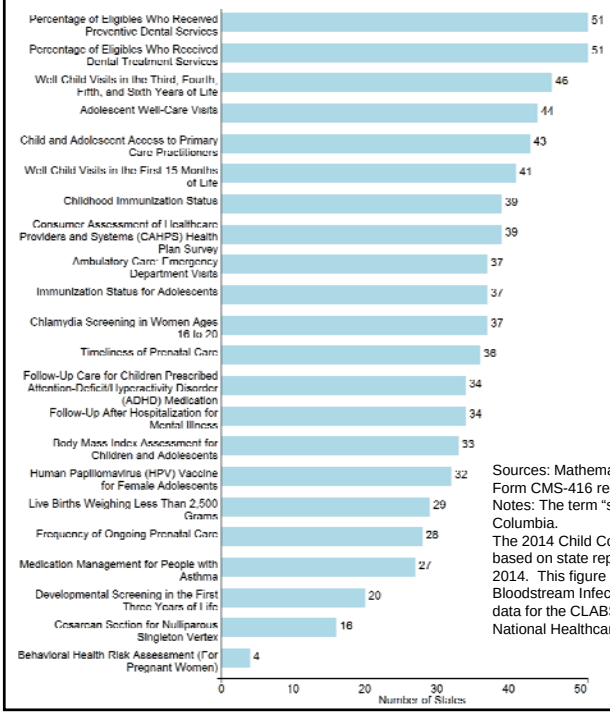

Number of States Reporting the Child Core Set Measures, FFY 2014

Sources: Mathematica analysis of FFY 2014 CARTS reports and Form CMS-416 reports.
Notes: The term "states" includes the 50 states and the District of Columbia.
The 2014 Child Core Set includes 23 measures. This figure is based on state reporting of 22 Child Core Set measures for FFY 2014. This figure excludes the Central Line-Associated Bloodstream Infection (CLABSI) measure. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC's National Healthcare Safety Network.

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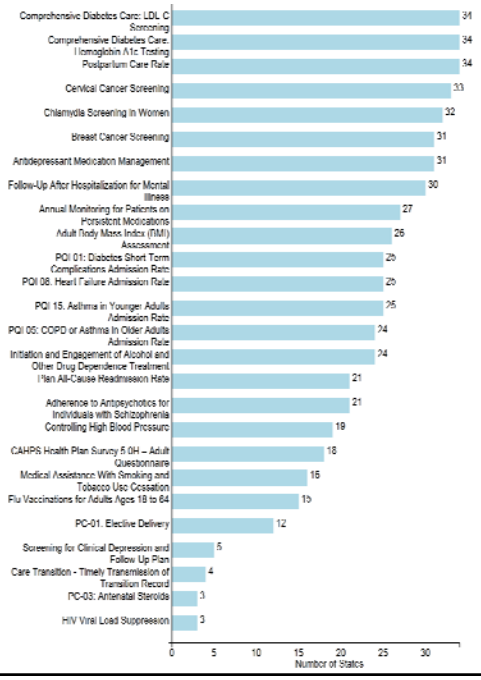

Number of States Reporting the Adult Core Set Measures, FFY 2014

Sources: Mathematica analysis of FFY 2014 CARTS reports.
Notes: The term "states" includes the 50 states and the District of Columbia.

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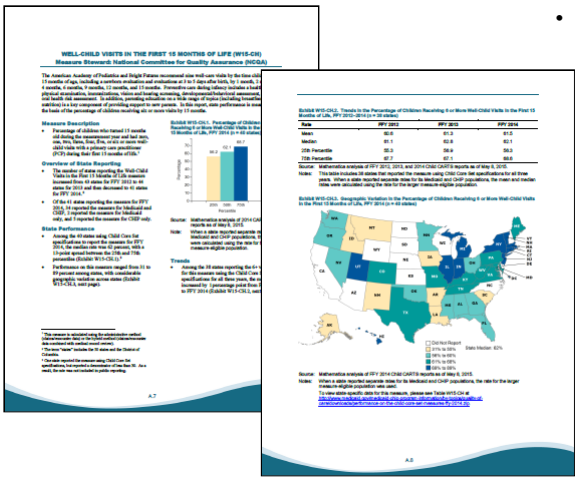
2015 Annual Secretary's Report: Domain-Specific Reports



- CMS conducted detailed analysis of state performance on Core Set measures reported by at least 25 states.
  - 19 Child Core Set Measures; 10 Adult Core Set Measures

Information is presented in five domain-specific reports: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, (4) behavioral health care, and (5) dental and oral health services.

- Includes information from EQRs of MCOs

The domain-specific reports are available on Medicaid.gov.

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2016 NQF Child & Adult MAPs

Input Requested from MAP

- Focus on incremental changes
  - CMS and states continuing to learn about reporting challenges on Child & Adult Core Set measures
  - Major changes to Core set will need to consider state staff time and resources to learn/incorporate a new measure
  - There is value to having trend data for core measures
- Assist in identifying ways to strengthen the Core Sets:
  - Which measures can be added to fill key gap areas
  - Which measures to retire
  - Ways to better align with other CMS/HHS programs

After MAP Feedback

- CMCS reviews MAP feedback with various internal/external stakeholders:
  - Internal discussions with CMCS components
  - Broader discussions with CMCS Quality TAG, other stakeholders, CMS's Quality Improvement Council
- CMS releases annual updates to both Core Sets by January 2017

Questions?

Child Core Set: Prior Recommendations and Updated 2016 Measure Set

Medicaid and the Child Core Set

Background

- Medicaid and the Children's Health Insurance Program (CHIP) covered more than 43 million children in FFY 2014
- >40% of births in the US are financed by Medicaid
- Children with complex health needs
  - Account for 6% of the total number of children covered by Medicaid
  - Incur nearly 40% of total Medicaid costs
- Health issues with a strong effect on children in Medicaid /CHIP
  - Poor birth outcomes
  - Behavioral health
  - Preventive care
  - Developmental disability

1. HHS. 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP. 2. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Pregnant-Women/Pregnant-Women.html. 3. https://www.childrenshospitals.org/Issues-and-Advocacy/Children-With-Medical-Complexity. 4. NQF. Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015.

Medicaid and the Child Core Set, Continued

- The Children's Health and Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for the identification of a core set of measures for children enrolled in Medicaid and CHIP
  - Beginning January 2013, CHIPRA required CMS to update the initial core set annually
- Measures in the Core Set are relevant to children ages 0-18 as well as pregnant women
- Annually, states **voluntarily** submit data to CMS
- 2016 Child Core Set measures were informed by MAP's 2015 review and input.

CMS. Medicaid by topic: quality of care: CHIPRA initial core set of children's health care quality measures website. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html. Last accessed July 2015

MAP 2015 Assessment of the Child Core Set

- MAP's 2015 review informed the 2nd set of recommendations on the Child Core Set for HHS.
- Not finding any significant implementation problems with the current measure set, MAP supported all of the FFY 2015 Child Core Set for continued use. No measures were recommended for removal.
- MAP encourages continued focus on data fidelity and strategies to improve the completeness of data reported by states on an annual basis.
- Strategic and policy issues as well as newly endorsed measures in critical gap areas will be reviewed during the May 2016 meeting.

Medicaid Child Core Set Measures for FFY 2016 Use

NQF #	Measure Name	Measure Steward
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/Adolescents	NCQA
0033	Chlamydia Screening in Women	NCQA
0038	Childhood Immunization Status	NCQA
0108	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA
0139	Pediatric Central-line Associated Bloodstream Infections–Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CDC
0471	Cesarean Rate for Nulliparous Singleton Vertex (PC-02)	Joint Commission
0576	Follow-up After Hospitalization for Mental Illness	NCQA
1360	Audiological Evaluation No Later Than 3 Months of Age (AUD)*	CDC
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)**	AMA-PCPI
1382	Live Births Weighing Less than 2,500 Grams	CDC
1391	Frequency of Ongoing Prenatal Care	NCQA
1392	Well-Child Visits in the First 15 Months of Life	NCQA
1407	Immunization Status for Adolescents	NCQA

* This measure was added to the 2016 Child Core Set based on MAP's 2015 recommendation.
** This measure was added to the 2015 Child Core Set based on MAP's 2014 recommendation.
AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CDC = Centers for Disease Control and Prevention; NCQA = National Committee for Quality Assurance

Medicaid Child Core Set Measures for FFY 2016 Use - Continued

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

* This measure was added to the 2016 Child Core Set based on MAP's 2015 recommendation.
** This measure was added to the 2015 Child Core Set based on MAP's 2014 recommendation
n/a denotes measure is not NQF endorsed
DQA (ADA) = Dental Quality Alliance (American Dental Association); OHSU = Oregon Health and Science University.

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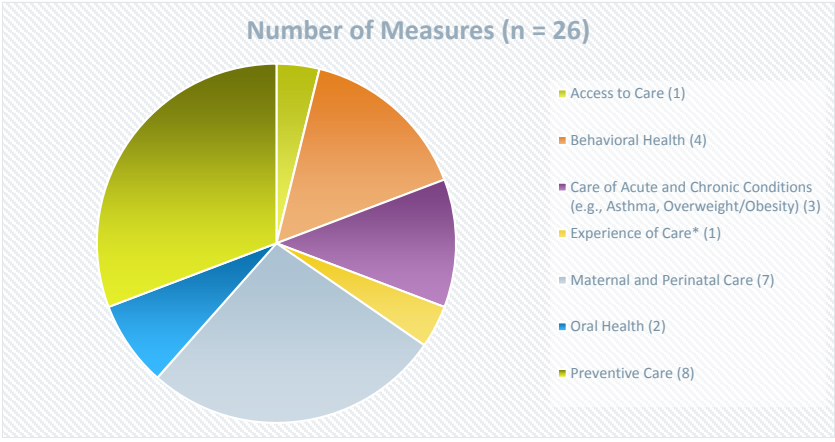
Medicaid Child Core Set Properties: Conditions



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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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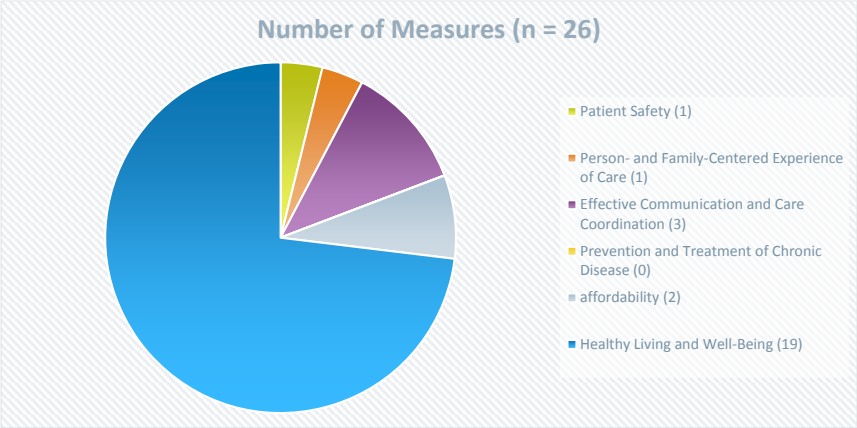
Medicaid Child Core Set Properties: NQS



Medicaid Child Core Set Properties: Measure Characteristics

Medicaid Child Core Set Characteristics		Number of Measures (n = 26)
NQF Endorsement Status	Endorsed	19
	Not Endorsed	7
Measure Type	Structure	0
	Process	23
	Outcome	3
Data Collection Method	Administrative Claims	20
	Electronic Clinical Data	16
	eMeasure Available	6
	Survey Data	2
Alignment	In use in one or more other federal programs	9
	In the Medicaid Adult Core Set	3*

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

Overview of Medicaid Child Core Set FFY 2014 Reporting (most recent data available)

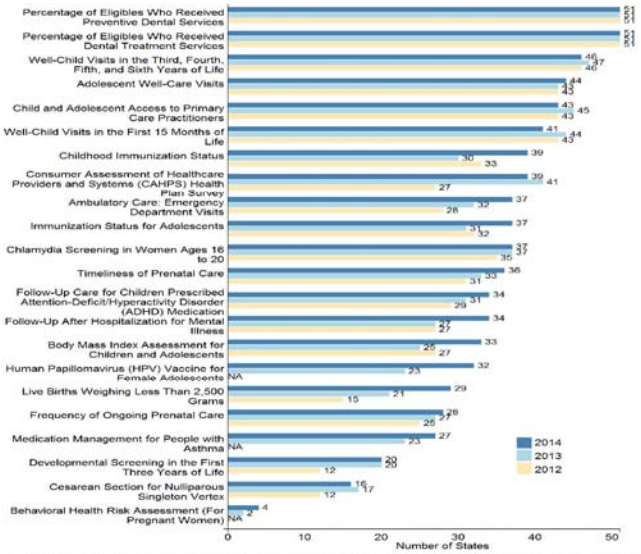
All states voluntarily reported two or more of the Child Core Set measures

- The term "states" includes the 50 states and the District of Columbia
- Median number of measures reported was 16
- 41 states reported at least 11 of the 22 core measures
- Data completeness improved; 44 states now report measures for both Medicaid and CHIP enrollees
- Most frequently reported measures assess children's access to primary care, well-child visits, use of dental services, receipt of childhood immunizations, and satisfaction with care received

Overview of Medicaid Child Core Set FFY 2014 Reporting

- First year reporting of four newest measures was encouraging
  - 32 states reported the Human Papillomavirus (HPV) Vaccine for Female Adolescents measure
  - 29 states reported the Low Birth Weight (LBW) measure
  - 27 states reported the Asthma Medication Management measure
  - 37 states reported the Emergency Department (ED) Visits measure

Changes in the Number of States Reporting the Medicaid/CHIP Children's Health Care Quality Measures, FY 2012-2014



Sources: Mathematica analysis of FFY 2012–2014 Child CARTS reports and FFY 2012–2014 Form CMS-416 reports.

Notes: The term "states" includes the 50 states and the District of Columbia. The 2014 Child Core Set includes 23 measures. This figure is based on state reporting of 22 Child Core Set measures for FFY 2014. This figure excludes the Central Line-Associated Bloodstream Infection (CLABSI) measure. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC's National Healthcare Safety Network.

High-Priority Gaps in Child Core Set

- Care coordination
  - Home- and community-based care
  - Social services coordination
  - Cross-sector measures that would foster joint accountability with the education and criminal justice systems*
- Screening for abuse and neglect
- Injuries and trauma
- Mental health
  - Access to outpatient and ambulatory mental health services
  - ED use for behavioral health
  - Behavioral health functional outcomes that stem from trauma-informed care*

Asterisk (*) denotes newly identified gap areas during MAP's 2015 deliberations.

High-Priority Gaps in Child Core Set - Continued

- Overuse/medically unnecessary care
  - Appropriate use of CT scans
- Durable medical equipment (DME)
- Cost measures
  - Targeting people with chronic needs
  - Families' out-of-pocket spending
- Sickle-cell disease*
- Patient-reported outcome measures*
- Dental care access for children with disabilities – could stratify current measures*

Task Force Measure-Specific Recommendations

- MAP supported continued use of the current Child Core Set; no measures recommended for removal.
- MAP recommended CMS consider up to six measures for phased addition. Measures not yet reviewed by NQF for endorsement received conditional support.

Rank	Measure Name and NQF Number	MAP Recommendation
1/2 (tie)	NQF #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care	Support
	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Conditional Support, pending NQF endorsement
3	Effective Postpartum Contraception Access	Conditional Support, pending NQF endorsement
4	Use of Contraceptive Methods by Women Aged 15-20 Years	Conditional Support, pending NQF endorsement
5/6 (tie)	NQF #1360: Audiological Evaluation No Later Than 3 Months of Age	Support
	NQF #2393: Pediatric All-Condition Readmission Measure	Support

CMS - Child Core Set Update for 2016 Reporting

Issued December 30, 2015

- Informed by MAP's recommendations, CMS updated the Child Core Set:
  - Added two measures:
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents
    - Audiological Evaluation no later than 3 months of age
  - In addition, CMS will continue to pilot a reporting process for the child version of the Hospital Consumer Assessment of Healthcare Providers and Systems survey (Child HCAHPS) in order to determine whether or not to include HCAHPS in a future Child Core Set.
- These updates correspond well to MAP's suggested course of action.

Source: CMCS Informational Bulletin "2016 Updates to the Child and Adult Core Health Care Quality Measure Sets."

Strategic Issues for State-Level Medicaid Reporting

- Alignment of measures across programs
  - Between Child and Adult Core Sets and HEDIS, health insurance exchanges, Medicaid health homes, MACRA/MIPS, payment incentive programs
  - Use of same measurement specifications in each of the programs
- Reproductive health
  - Most frequently measured area in both Core Sets providing opportunity for improvement
  - Improving health outcomes for both mother and child
- Increasing state-level capacity for quality improvement
  - Enhance peer-to-peer learning and collaboration by increasing states' opportunities to collaborate
  - Strategies to understand and address disparities
  - Setting appropriate performance benchmarks

Child Task Force Discussion and Questions

- Questions or comments about the data presented?
- Observations about the updates that CMS made based on MAP's 2015 review?
- Have any measure gap areas been satisfied or emerged as a result of the most recent update?
  - Measures suggested by MAP for addition but not yet added by CMS may need to be re-evaluated in 2016 along with other priorities for updates.

Adult Core Set: Prior Recommendations and Updated 2016 Measure Set

Medicaid Adult Population Background

- Medicaid provided coverage to 44.3 million adults in FFY 2014
- Medicaid served 27.1 million non-elderly adults, 6.3 million adults age 65 and over, and 10.9 million individuals who are blind/disabled.
- Working age adult Medicaid enrollees are the most rapidly growing segment of the Medicaid population
- 57% of adults ages 21-64 covered by Medicaid are overweight, have diabetes, hypertension, high cholesterol, or a combination of these conditions
- 2 of 3 adult women on Medicaid are in their reproductive years (19-44)

[1] http://kff.org/health-reform/issue-brief/low-income-adults-under-age-65-many-are-poor-sick-and-uninsured/ and http://www.gao.gov/assets/300/294002.pdf

Additional information

- For FFY 2015, Medicaid and CHIP remained the central sources of coverage for low-income children and pregnant women nationwide
- As of January 2016
  - 48 states cover children with incomes at or above 200% FPL (19 states extend eligibility to at least 300% FPL)
  - 33 states cover pregnant women with incomes at or above 200% FPL
  - 31 states expanded Medicaid eligibility to parents and other non-disabled adults with incomes up to at least 138% FPL

Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey. Kaiser Family Foundation. Last Accessed March 2016. http://kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey/

Medicaid Adult Core Set

- The Affordable Care Act (ACA) called for the creation of a core set of quality measures for adults enrolled in Medicaid.
  - Initial Adult Core Set of measures was published in 2012
- The Core Set is a relatively new program, the early years focused on helping states understand the set of measures and refine the reporting guidance provided.
- Annually, states **voluntarily** submit data to CMS
- MAP's 2015 report is its third set of annual recommendations on the Adult Core Set for HHS.

Centers for Medicare and Medicaid Services (CMS). Adult health care quality measures website. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html. Last accessed June 2015.

MAP 2015 Assessment of the Adult Core Set

- MAP noted states' participation in reporting the Adult Core Set is strong, though there is room for improvement in the total number of states submitting data and the number of states reporting each measure.
- The composition of the Medicaid Adult Core Set is well-matched with CMS' stated goals for the program
- The Core Set's strong alignment with other program sets and parsimonious number of measures should continue
- MAP encourages the inclusion of relevant outcome measures in future iterations of the set
- MAP strongly prefers that the set contain NQF-endorsed measures to ensure scientific acceptability of measure properties
- MAP favored measures that address prevalent and/or high impact health conditions for adults enrolled in Medicaid

Medicaid Adult Core Set Measures for FFY 2016 Use

NQF #	Measure Name	Measure Steward
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA
0006	CAHPS Health Plan Survey v 4.0—Adult Questionnaire with CAHPS Health Plan Survey v 5.0 (Medicaid)	AHRQ
0018	Controlling High Blood Pressure	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA
0032	Cervical Cancer Screening	NCQA
0033	Chlamydia Screening in Women Ages 21-24	NCQA
0039	Flu Vaccinations for Adults Age 18 and Older	NCQA
0057	Comprehensive Diabetes Care: Hemoglobin A1c Testing	NCQA
0059	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)*	NCQA
0105	Antidepressant Medication Management	NCQA
0272	PQI 01: Diabetes, Short-Term Complications Admission Rate	AHRQ
0275	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	AHRQ
0277	PQI 08: Congestive Heart Failure (CHF) Admission Rate	AHRQ
0283	PQI 15: Adult Asthma Admission Rate	AHRQ

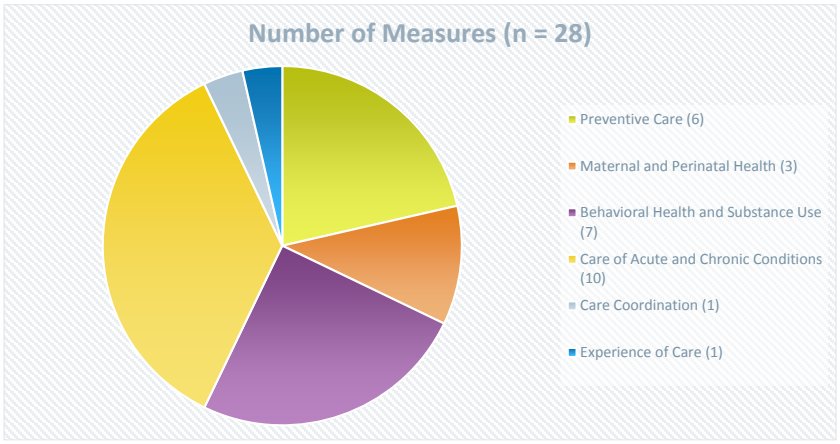
* This measure was added to the 2015 Adult Core Set.

Medicaid Adult Core Set Measures for FFY 2016 Use - Continued

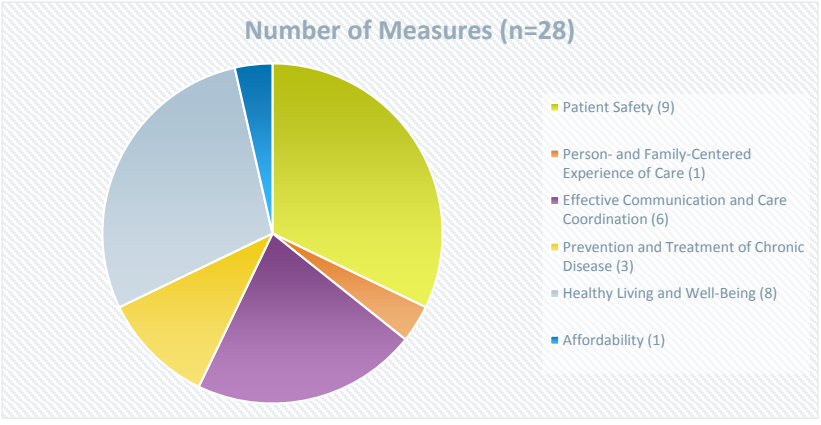
NQF #	Measure Name	Measure Steward
0418	Screening for Clinical Depression and Follow-Up Plan	CMS
0469	PC–01: Elective Delivery	Joint Commission
0476	PC–03 Antenatal Steroids	Joint Commission
0576	Follow-Up After Hospitalization for Mental Illness	NCQA
0648	Care Transition—Transition Record Transmitted to Health Care Professional	AMA-PCPI
1517	Prenatal and Postpartum Care: Postpartum Care Rate	NCQA
1768	Plan All-Cause Readmission Rate	NCQA
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)**	NCQA
2082	HIV Viral Load Suppression	HRSA
2371	Annual Monitoring for Patients on Persistent Medications	NCQA
2372	Breast Cancer Screening	NCQA
n/a	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA
n/a	Adult Body Mass Index (BMI) Assessment	NCQA
n/a	Use of Opioids at High Dosage (OHD)**	PQA

** This measure was added to the 2016 Adult Core Set
n/a denotes Not NQA endorsed.

Medicaid Adult Core Set Properties: Conditions



Medicaid Adult Core Set Properties: NQS



Medicaid Adult Core Set Properties: Measure Characteristics

Medicaid Adult Core Set Characteristics		# of Measures
NQF Endorsement Status	Endorsed	25
	Not Endorsed	3
Measure Type	Structure	0
	Process	21
	Outcome	6
	Patient Experience of Care	1
Data Collection Method	Administrative Claims	21
	Electronic Clinical Data	18
	eMeasure Available	8
	Survey Data	3
Alignment	In use in one or more Federal Programs	23
	In the Child Core Set	3*

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

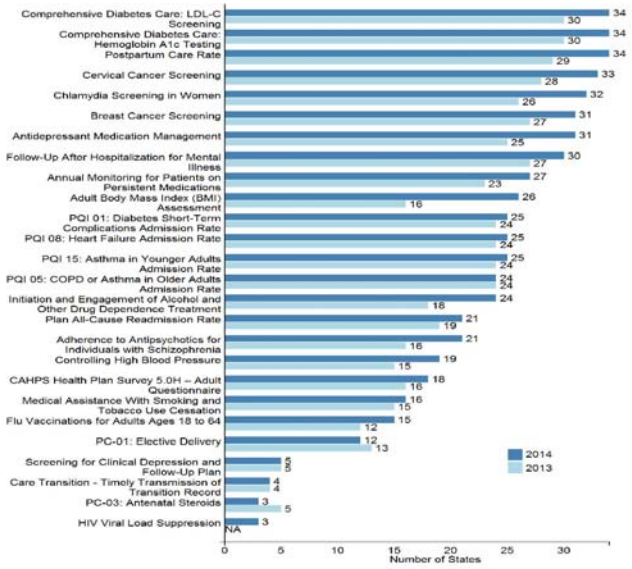
Overview of Medicaid Adult Core Set FFY 2014 Reporting

Adult Core Set participation is strong, with room for improvement

- The term "states" includes the 50 states and the District of Columbia
- 31 states reported data on at least half of the 26 Core Set measures, a median of 16.5 measures were reported
- The number of states voluntarily reporting measures increased from 30 states for FFY 2013 to 34 states for FFY 2014.
- The frequently reported measures focused on:
  - Postpartum care visits
  - Diabetes care management
  - Women's preventive health care

Source for slides 42-44: The Department of Health and Human Services 2015 Annual report on the Quality of Health Care for Adults Enrolled in Medicaid

Changes in the Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2013–2014



Source: Based on Mathematica analysis of FFY 2013–2014 Adult CARTS reports as of May 8, 2015.

The FFY 2013 and FFY 2014 Medicaid Adult Core Sets both include 26 measures. The Annual HIV Medical Visit measure was included in the FFY 2013 Core Set, but was retired for FFY 2014 reporting. This measure was replaced by the HIV Viral Load Suppression measure for FFY 2014.
NA = measure was not collected for FFY 2013.

MAP's 2015 Recommendations to Address High Priority Gaps

- MAP identified gaps in measures in the Adult Core Set, including:
  - New chronic opiate use (45 days)*
  - Polypharmacy*
  - Engagement and activation in healthcare*
  - Trauma-informed care*
  - Treatment outcomes for behavioral health conditions and substance use disorders
    - Psychiatric re-hospitalization*
  - Maternal health
    - Inter-conception care to address risk factors
    - Poor birth outcomes (e.g. premature birth)
    - Postpartum complications
    - Support with breastfeeding after hospitalization*
  - Long-term supports and services
    - Home and community-based services*

MAP's 2015 Recommendations to Address High Priority Gaps

- MAP identified gaps in measures in the Adult Core Set, including:
  - Beneficiary-reported outcomes
    - Health-related quality of life*
  - Access to primary, specialty, and behavioral health care
  - Care coordination
    - Integration of medical and psychosocial services
    - Primary care and behavioral health integration
  - Cultural competency of providers
  - Efficiency
    - Inappropriate emergency department utilization
  - Promotion of wellness
  - Workforce

An asterisk (*) denotes newly identified gap areas during MAP's 2015 deliberations.

Task Force Measure- Specific Recommendations

- MAP supports 25 of 26 measures in the FFY 2015 Adult Core Set for continued use
- MAP recommends the removal of one measure:
  - NQF #0648 – Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)
    - Low feasibility evident in consistently low levels of state reporting
    - Too facility-centric for the state Medicaid agency to take action
- MAP recommended 9 measures for phased addition:
  - Recommended measures would fill gaps in the measure set
  - Measures not yet reviewed by NQF for endorsement received conditional support, pending successful endorsement review

Measures for Phased Addition: Prioritized Additions to Fill Gaps

Rank	Measure Name and NQF Number, if applicable
1	Use of Contraceptive Methods by Women Aged 21-44 Years *(Conditional Support, not NQF endorsed)*
2	#2602: Controlling High Blood Pressure for People with Serious Mental Illness
3/4/5 (tie)	#1927: Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
	#1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
	Effective Postpartum Contraception Access *(Conditional Support, not NQF endorsed)*
6	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multiple-provider, high dosage *(Conditional Support, not NQF endorsed)*
7	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multiple prescribers and multiple pharmacies *(Conditional Support, not NQF endorsed)*
8/9 (tie)	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage *(Conditional Support, not NQF endorsed)*
	#1799: Medication Management for People with Asthma *(Conditional Support, pending update from NQF annual review)*

CMS– Adult Core Set Update for 2016 Reporting

Issued December 11, 2015

- Based on MAP's recommendations, CMS updated the 2016 Adult Core Set:
  - Added two measures:
    - NQF #1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
    - Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage (*not NQF endorsed*)
- These updates correspond well to MAP's suggested course of action.

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

Strategic Issues for State-Level Medicaid Reporting

- Alignment of measures across programs
  - Between Child and Adult Core Sets and HEDIS, health insurance exchanges, Medicaid health homes, Meaningful Use incentive programs
  - Use of same measurement specifications in each of the programs
- Reproductive health
  - Most frequently measured topic across the Child and Adult Core Sets
  - Improve health outcomes for both mother child
- Increasing State-Level Capacity for Quality Improvement
  - Enhance peer-to-peer learning and collaboration by increasing states' opportunities to communicate
  - Strategies to understand and address disparities
  - Set appropriate performance benchmarks

Adult Task Force Discussion and Questions

- Questions or comments about the data presented?
- Observations about the updates that CMS made based on MAP's 2015 review?
- Have any measure gap areas been satisfied or emerged as a result of the most recent update?
  - Measures suggested by MAP for addition/removal but not yet added/removed by CMS may need to be re-evaluated in 2016 along with other priorities for updates.

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

May In-Person Meeting Objectives

- Consider states' experiences implementing the Medicaid Adult and Child Core Sets
  - Panelists from states will join MAP's meetings again in 2016
- Develop concrete recommendations for strengthening the Medicaid Adult and Child Core Sets through identification of:
  - Most important measure gaps and potential measures to address them
  - Measures found to be ineffective, for potential removal
  - Other strategic, implementation and or policy issues

Institute of Medicine's (IOM) Vital Signs

- NQF staff conducted a strengths, weaknesses, opportunities, and threats (SWOT) analysis of the domains and key elements in the IOM report with the Adult and Child Core Set measures.
- The SWOT analysis results are presented in the following slides.

SWOT Analysis Results: Adult Core Set

Adult Core Set	**S**trengths • Almost all of the Adult Core Set measures are included in the Care Quality domain, with the exception of one. These include important topic areas such as screening, immunizations, diabetes, asthma, behavioral health, perinatal care and preventable admissions.	**W**eaknesses • Limited number of outcome measures. • The need to balance measurement burden with the addition of new measures • Resource allocation issues related to measure reporting
	Opportunities • Re-visit gaps in the Core Set, including focus on NQS priority areas as stronger measures are developed • Monitor AHRQ-CMS Pediatric Quality Measures Program (PQMP) development of maternal and perinatal health measures.	**T**hreats • Proliferation of measures can result in measure burden, causing states to only report on successful measures. • Limited federal and state resources and infrastructure to report new measures added to the Adult Core Set.

SWOT Analysis Results: Child Core Set

Child Core Set	**S**trengths • Majority of the Child Core Set measures are in the Care Quality domain, including immunization, screening, oral health, perinatal care, asthma, behavioral health, and primary care measures	**W**eaknesses • Limited number of measures in the healthy people, care cost, and engaged people domains. • Limited number of outcome measures. • The need to balance measurement burden with the addition of new measures
	Opportunities • Re-visit the gaps identified in the Child Core Set and identify outcome measures to fill those gaps. • Monitor AHRQ-CMS Pediatric Quality Measures Program (PQMP) development and enhancement of children's health care quality measures.	**T**hreats • Limited federal and state resources and infrastructure to report new measures added to the Child Core Set. • Reporting on the Child Core Set is voluntary and not required. • More measures can result in measure burden. • States are experiencing issues with hospital measures including CAHPS.

Resonant Themes

- Themes that cross and transcend both Adult & Child Core Set related gaps areas, strategic issues, and policy concerns:
  - Healthy people and engaged people
  - Patient and family centered care
  - Care coordination
  - Access to care
  - Resource-data collection and reporting
  - Measurement-alignment and data burden

Task Force Policy Issues for Consideration

- Alignment of measure concepts and measurement
- Alignment across multiple programs
- Alignment through standardization of definitions

Definition of Alignment from Coordinating Committee

- Alignment, or use of the same or related measures, is a critical strategy for accelerating improvement in priority areas, reducing duplicative data collection and enhancing comparability and transparency of healthcare information.
- MAP recognizes that there is a need for balance on this issue, while noting that the goals of parsimony and alignment should be pursued unless there is a compelling reason for multiple similar or narrowly-focused measures.

Technical Definition of Alignment

- Alignment: Encouraging the use of similar, standardized performance measures across and within public and private sector efforts.

  Note: Alignment is not synonymous to harmonization.

References: National Quality Forum (NQF), Guidance for Measure Harmonization: A Consensus Report, Washington, DC: NQF; 2010.
National Quality Forum (NQF), Guidance on Competing Measures, Washington, DC: NQF; 2011.

Task Force Homework Assignment-Policy Issues

- Please consider the following policy questions and submit your answers by April 22, 2016 on the SharePoint site.

- What do we mean by alignment?
- How do we operationalize the concept of alignment?
  - Is it the same concept being measured the same way?
  - Is it the same concept being measured across different programs?

Task Force Homework Assignment-Policy Issues

- Please consider the following policy questions and submit your answers by April 22, 2016 on the SharePoint site.

- What is feasible beyond claims data?
- How do we balance data collection burden as we move beyond claims data?
- When and where is stratification of data appropriate for the Medicaid population?
  - Stratification by sub-populations, i.e. race, gender, eligibility, level of poverty…etc.

Planned Sources of Information

- Evaluation of the current Medicaid Adult and Child Core Sets of measures against the MAP Measure Selection Criteria and the NQS
- Feedback from participating States to include:
  - Measures selected for reporting *and why they were selected*
  - Most common types of technical assistance requests
  - Data collection challenges and solutions
  - How states are using the measure results

Planned Sources of Information

- Measure-specific information collected by CMS
  - Analysis of data on the 19 Child Core Set measures
  - Analysis of data on 10 Adult Core Set measures
  - The analysis for both Core Sets is presented in five domain specific reports: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, (4) behavioral health care, and (5) dental and oral health services.
- Aggregated and ranked quality results for select measures, with a minimum threshold of reporting , to demonstrate low vs. high performing measures

Additional Information Sources

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

Discussion

Task Force Homework - Identifying Measures to Fill Gaps in the Core Sets

- Please send suggestions of new/potential measures to fill identified gaps in the Adult and Child Core Sets for discussion and consideration by April 22, 2016.
- Please enter measure(s) information on the SharePoint site via the Measure Survey link.
- Task Force members will deliberate on the appropriate measures to fill gaps during the in-person meeting on May 24-26.

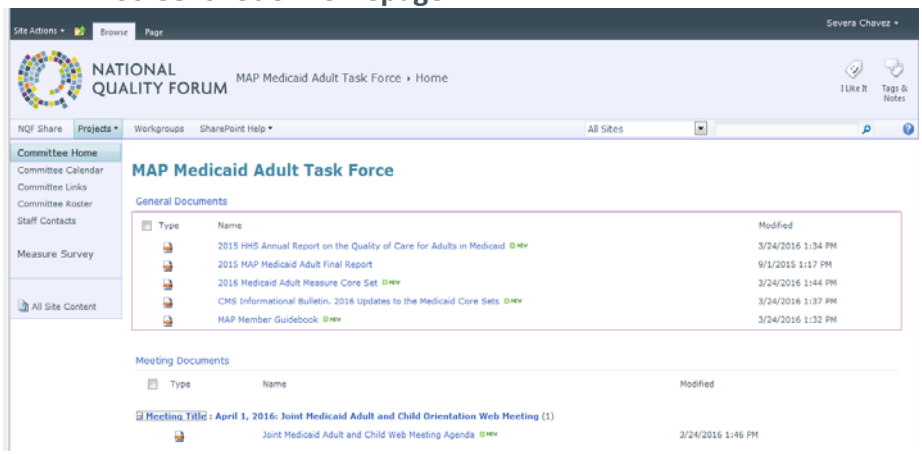
SharePoint Overview

http://share.qualityforum.org/Projects/MAP%20Medicaid%20Adult%20Task%20Force/SitePages/Home.aspx

- Accessing SharePoint
- MAP Member Guidebook
- Meeting and Call Documents
- Committee Roster and Biographies
- Calendar of Meetings
- Reference Materials

SharePoint Overview

- **Screenshot of homepage**



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MAP Medicaid Adult Task Force

General Documents

Type	Name	Modified
	2015 HHS Annual Report on the Quality of Care for Adults in Medicaid NEW	3/24/2016 1:34 PM
	2015 MAP Medicaid Adult Final Report	9/1/2015 1:17 PM
	2016 Medicaid Adult Measure Core Set NEW	3/24/2016 1:44 PM
	CMS Informational Bulletin. 2016 Updates to the Medicaid Core Sets NEW	3/24/2016 1:37 PM
	MAP Member Guidebook NEW	3/24/2016 1:32 PM

Meeting Documents

Type	Name	Modified
	Meeting Title : April 1, 2016: Joint Medicaid Adult and Child Orientation Web Meeting (1)	
	Joint Medicaid Adult and Child Web Meeting Agenda NEW	3/24/2016 1:46 PM

Opportunity for Public Comment

Next Steps

Structure of May Task Force Deliberations

May 24

Adult TF Only

- Adult Core Set Measures

May 25

Joint Attendance

- Shared Strategic Issues
- State feedback

May 26

Child TF Only

- Adult Core Set Measures

Important Dates

- April 22: Homework due (Identifying measures to fill gaps in the Core Sets and thoughts regarding policy questions)
- May 24 – 25: In-person meeting of Medicaid Adult Task Force
- May 25 – 26: In-person meeting of Medicaid Child Task Force
- July 6 – August 5: 30-day public comment period on draft reports
- August, Date TBD: MAP Coordinating Committee review of draft reports
- August 31: Final reports due to HHS and made available to the public

Project Contact Info

- Email
  - Adult Task Force: mapmedicaidadult@qualityforum.org
  - Child Task Force: mapmedicaidchild@qualityforum.org
- NQF Phone: 202-783-1300
- Project page: http://www.qualityforum.org/MAP_Task_Forces.aspx
- SharePoint site
  - Adult Task Force: http://share.qualityforum.org/Projects/MAP%20Medicaid%20Adult%20Task%20Force/SitePages/Home.aspx
  - Child Task Force: http://share.qualityforum.org/Projects/MAP%20Medicaid%20Child%20Task%20Force/SitePages/Home.aspx


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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

DATE: December 11, 2015

FROM: Vikki Wachino
Director
Center for Medicaid and CHIP Services

SUBJECT: 2016 Updates to the Child and Adult Core Health Care Quality Measurement Sets

This informational bulletin describes the 2016 updates to the core set of children's health care quality measures for Medicaid and the Children's Health Insurance Program (CHIP) (Child Core Set) and the core set of health care quality measures for adults enrolled in Medicaid (Adult Core Set).

Background

The Center for Medicaid and CHIP Services (CMCS) has worked with stakeholders to identify two core sets of health care quality measures that can be used to assess the quality of health care provided to children and adults enrolled in Medicaid and CHIP (see http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-–-performance-measurement.html). The core sets are tools states can use to monitor and improve the quality of health care provided to Medicaid and CHIP enrollees. The goals of this effort are to:

- Encourage national reporting by states on a uniform set of measures; and
- Support states in using these measures to drive quality improvement.

Part of implementing an effective "quality measures reporting program" is to periodically reassess the measures that comprise it since many factors, such as changes in clinical guidelines and experiences with reporting and performance rates, may warrant modifying the measure set. In addition, CMCS continues to prioritize working with federal partners to promote quality measurement alignment across programs (e.g., Meaningful Use, Hospital Inpatient Quality Reporting Program, Physician Quality Reporting System) recognizing that this reduces burden on states reporting data to multiple programs and helps to drive quality improvement across payers and programs.

For the 2016 updates to the Child and Adult Core Sets, CMCS, once again, worked with the National Quality Forum's (NQF) Measure Applications Partnership (MAP),[1] a public-private partnership that reviews measures for potential use in federal public reporting, to review and identify ways to improve the core sets. Collaborating with NQF's MAP process for core set updates promotes measure alignment across CMS since NQF also reviews measures for other CMS reporting programs.

[1] http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx

CMCS is encouraged by state reporting on the core measures. For the Child Core Set, fifty states and the District of Columbia voluntarily reported, for federal fiscal year (FFY) 2014, a median of 16 measures. For the Adult Core Set, 34 states reported a median of 17 measures in FFY 2014. Additional information on state reporting and performance on each core set can be found in the forthcoming respective *2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP* and *the 2015 Annual Report on the Quality of Care for Adults Enrolled in Medicaid* . CMCS looks forward to working with states on the core measures reporting for FFY 2015.

2016 Child Core Set

Since the release of the initial Child Core Set in 2011, CMCS has collaborated with state Medicaid and CHIP agencies to voluntarily collect, report, and use the measures to drive quality improvements. Section 1139A of the Social Security Act, as amended by Section 401(a) of the Children's Health Insurance Reauthorization Act (CHIPRA) of 2009, provides that, beginning annually in January 2013, the Secretary shall publish recommended changes to the core measures.[2]

For the 2016 Child Core Set update, CMCS will add two measures:

- Use of Multiple Concurrent Antipsychotics in Children and Adolescents[3]
- Audio logical Evaluation no later than 3 months of age[4]

The addition of these two measures allows CMCS to expand the measurement of quality of care for two populations – children prescribed psychotropic drugs and children at-risk of hearing problems. CMCS also is engaged in a pilot of a reporting process for the child version of the hospital Consumer Assessment of Healthcare Providers and Systems survey (Child HCAHPS)[5] in order to determine whether or not to include HCAHPS in a future Child Core Set. This measure was recommended by the 2014 MAP to help address gaps noted in the measure set in three areas: inpatient care; patient experience; and care coordination. Additional information about the 2015 Child Core Set MAP review process and their recommendations to CMCS can be found at: http://medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/chipra-initial-core-set-of-childrens-health-care-quality-measures.html.

2016 Adult Core Set

In January 2012, CMCS released its initial Adult Core Set. Section 1139B of the Social Security Act, as amended by Section 2701 of the Affordable Care Act, notes that the Secretary shall issue updates to the Adult Core Set beginning in January 2014 and annually thereafter.[6, 7]

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[2] The first update was issued via a State Health Official Letter "2013 Children's Core Set of Health Care Quality Measures," SHO #13-002. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf . The 2014 update was issued via a CMCS Informational Bulletin "2014 Updates to the Child and Adult Core Health Care Quality Measurement Sets." http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf as was the "2015 Updates to the Child and Adult Health Care Quality Measurements Sets." http://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-30-2014.pdf

[3] Measure steward: AHRQ-CMS CHIPRA National Collaborative for Innovation in Quality Measurement (NCINQ), Not NQF Endorsed

[4] Measure steward: Centers for Disease Control and Prevention, NQF #1360

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

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

For the 2016 Adult Core Set update, CMCS will add two measures:

- Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage[8]
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[9]

The addition of these two measures allows CMCS and states to expand the measurement of quality of care in Medicaid for two population groups – adults with substance use disorders and/or mental health disorders. Additional information about the 2015 Adult Core Set MAP review process and their recommendations to CMCS can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html

Next Steps

The 2016 updates to the Core Sets will take effect in the FFY 2016 reporting cycle, which will begin no later than December 2016. To support states in making these changes, CMCS will release updated technical specifications for both Core Sets in spring 2016 and make them available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html. States with questions or that need further assistance with reporting and quality improvement regarding the Child and Adult Core Sets can submit questions or requests to: MACQualityTA@cms.hhs.gov.

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

[7] The second update was issued via a CMCS Informational Bulletin "2015 Updates to the Child and Adult Core Health Care Quality Measurement Sets."http://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-30-2014.pdf

[8] Measure steward: Pharmacy Quality Alliance, Not NQF Endorsed

[9] Measure steward: NCQA, NQF #1932

2016 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

NQF #	Measure Steward	Measure Name
Preventive Care		
0032	NCQA	Cervical Cancer Screening (CCS)
0033	NCQA	Chlamydia Screening in Women (CHL)
0039	NCQA	Flu Vaccinations for Adults Age 18 and Older (FVA)
0418	CMS	Screening for Clinical Depression and Follow-Up Plan (CDF)
2372	NCQA	Breast Cancer Screening (BCS)
NA	NCQA	Adult Body Mass Index Assessment (ABA)
Maternal and Perinatal Health		
0469	TJC	PC-01: Elective Delivery (PC01)
0476	TJC	PC-03: Antenatal Steroids (PC03)
1517	NCQA	Prenatal & Postpartum Care: Postpartum Care Rate (PPC)
Behavioral Health and Substance Use		
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)
0105	NCQA	Antidepressant Medication Management (AMM)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*
NA	NCQA	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA)
NA	PQA	Use of Opioids at High Dosage (OHD)*
Care of Acute and Chronic Conditions		
0018	NCQA	Controlling High Blood Pressure (CBP)
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01)
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08)
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05)
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15)
1768	NCQA	Plan All-Cause Readmissions (PCR)
2082	HRSA	HIV Viral Load Suppression (HVL)
2371	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM)
Care Coordination		
0648	AMA-PCPI	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR)
Experience of Care		
0006	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, Version 5.0 (Medicaid) (CPA)

* This measure was added to the 2016 Medicaid Adult Core Set.

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

The Department of Health and Human Services

2015 Annual Report on the Quality of Care for Adults in Medicaid

Health and Human Services Secretary

Sylvia Mathews Burwell

February 2016

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CONTENTS

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TABLES

FIGURES

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EXECUTIVE SUMMARY

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

In federal fiscal year (FFY) 2014, Medicaid covered a total of 44.3 million adults, including 27.1 million non-elderly adults, 6.3 million adults age 65 and over, and 10.9 million individuals who are blind/disabled.[1] The Centers for Medicare & Medicaid Services (CMS), the HHS agency responsible for ensuring effective health care coverage for Medicaid enrollees, plays a key role in promoting quality health care for adults enrolled in Medicaid. As part of this role, CMS works collaboratively with states to support and encourage reporting and strengthen systems for standardizing reporting on access and quality measures.

This is CMS's second annual report on the quality of care for adults in Medicaid, and the first year that CMS is publicly reporting findings on the core set of health care quality measures for adults enrolled in Medicaid (referred to as the Adult Core Set).[2] This 2015 report presents findings on voluntary state reporting of the Adult Core Set measures for FFY 2014, and summarizes information on managed care quality measurement and improvement reported in the external quality review (EQR) technical reports submitted to CMS by states during the 2014–2015 reporting cycle. Adult Core Set data reported for FFY 2014 generally cover care delivered in calendar year (CY) 2013.

Health insurance coverage—public or private—is critically important for reducing financial barriers in access to quality care. There is considerable evidence that adults covered by Medicaid generally have better access to care than uninsured adults. The landmark Oregon Health Insurance Experiment, a randomized controlled trial that compared the care of Medicaid enrollees selected to be offered coverage with those on a waiting list who were not selected, found Medicaid enrollees had better access to primary care, preventive services, and self-reported physical and mental health.[3] A more recent analysis of data from the 2013 National Health Interview Survey found that non-elderly adults covered by Medicaid were significantly

[1] "2014 CMS Statistics," Table I.16. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf. The blind/disabled total includes some children.

[2] The 2014 Secretary's Report is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-adult-sec-rept.pdf.

[3] Finkelstein A. et al. "The Oregon Health Insurance Experiment: Evidence from the First Year." The Quarterly Journal of Economics, August 2012, vol. 127, no. 3, pp. 1057–106.

more likely than the uninsured to have a usual source of medical care, and to have had a general doctor visit, and a specialty care visit in the past 12 months.[4]

Data Limitations

The legislation that created the adult health care quality measurement program established it as a voluntary reporting program, at the discretion of state Medicaid agencies to participate. In FFY 2014, 34 states[5] voluntarily reported on one or more of the Adult Core Set measures. As such, it is not possible to make national observations of the quality of care provided to adult Medicaid beneficiaries based on data from these 34 states, or based on the smaller number of states that reported on the 10 frequently reported measures for which CMS conducted detailed analysis.[6] This report also does not compare the quality of care for adults covered by Medicaid with that of adults covered through other kinds of health coverage.

This report covers data for the Core Set FFY 2014 reporting period. In most cases, states submitted data for utilization that occurred in calendar year (CY) 2013. In cases in which CY 2013 data were not available, states reported rates for an earlier period.[7] These data therefore do not inform observations about the impact of coverage changes, including the expansion of Medicaid to low-income adults that took effect in 2014. Over the past year, CMS has worked with states to improve the quality and completeness of the data, but some variation remains.

Quality Measurement Using the Adult Core Set

This is the second year of state reporting and the first year that CMS is publicly reporting findings on the Adult Core Set measures. Over the past year, CMS and states achieved significant progress toward CMS's major adult quality reporting goals, including increasing the number of states reporting on the Adult Core Set measures and increasing the use of measures in quality improvement projects.

The number of states voluntarily reporting Adult Core Set measures increased from 30 states for FFY 2013 to 34 states for FFY 2014. While the median number of measures is unchanged at 16.5 measures reported in both years, 31 states reported data on at least half of the 26 Adult Core Set measures for FFY 2014, with two states, Georgia and New York, reporting almost all of the measures (25 and 24, respectively).

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[4] Paradise, J. "Medicaid Moving Forward." Kaiser Family Foundation, March 2015. Available at http://kff.org/health-reform/issue-brief/medicaid-moving-forward/.

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

[6] Measure-specific tables for these 10 measures are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Adult-Core-Set-Measures-FFY-2014.zip. See also Table 2 of the report.

[7] Of the 10 frequently reported Adult Core Set measures for FFY 2014, each measure was reported by at least one state using a measurement period that differed from the measure technical specifications.

Thirteen measures were frequently reported for FFY 2014—defined as measures reported by at least 25 states—with the most frequently reported measures focused on diabetes care management, postpartum care visits, and women's preventive health care. CMS conducted detailed analysis of state performance on 10 of these frequently reported measures,[8] with the results (including percentiles, means, medians, trends, and geographic variation) presented in four domain-specific reports: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, and (4) behavioral health care.[9]

State Performance on the Adult Core Set

Analysis of performance on the 10 Adult Core Set measures reported by 25 or more states for FFY 2014 provides a snapshot of the quality of care obtained by adults across a continuum of needs. Relative to other measures analyzed in this report, median state performance was fairly high on the three measures of care for acute and chronic conditions (HbA1c test, LDL-C screening test, and monitoring of patients on persistent medications). In addition, performance on the maternity care measure (timeliness of postpartum visit) and the four measures of primary and preventive care (body mass index [BMI] documented in the medical records, and screenings for breast cancer, cervical cancer, and chlamydia), had median rates of 50 percent or higher. Rates of performance on behavioral health measures were lower.

Managed Care External Quality Review Findings

Federal regulations require states to conduct an annual external quality review (EQR) for each contracted managed care organization (MCO) and prepaid inpatient health plan (PIHP). Additionally, the state requires each managed care plan to have an ongoing program of performance improvement projects (PIPs) to improve quality in clinical and nonclinical areas. The results of the EQR and PIPs are summarized in an annual EQR technical report that is available to the public and is submitted to CMS.

Of the 41 states[10] that currently contract with managed care plans, 38 submitted EQR technical reports to CMS for the 2014–2015 reporting cycle.[11] The most frequently reported adult performance measures included in these EQR reports are the same as or similar to those most frequently reported in the Adult Core Set, including measures evaluating adult Medicaid enrollees' behavioral health, diabetes care, and primary care access.

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[8] Three additional measures were reported by at least 25 states, but were not publicly reported for FFY 2014 due to lack of comparable data across states: PQI 01: Diabetes Short-Term Complications Admission Rate; PQI 08: Congestive Heart Failure (CHF) Admission Rate; and PQI 15: Asthma in Younger Adults Admission Rate.

[9] The domain-specific reports are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip. A fifth domain-specific report focuses on children's use of dental and oral health services in Medicaid and CHIP.

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

[11] The 2014–2015 reporting cycle includes reports that were submitted between May 1, 2014 and April 30, 2015. Of the three states that did not submit EQR technical reports in time for the 2014–2015 reporting cycle, two are on target to submit reports by the end of the year, and CMS is monitoring the status of reporting by the third.

Through their managed care entities, states are engaged in various types of improvement projects for adults. For the 2014–2015 reporting cycle, behavioral health and diabetes care were the most common PIP topics among states. While PIP topics, target populations, and interventions and activities were often specific to each managed care entity in a state, 21 states mandated improvement projects on at least one priority health topic. For example, eight states mandated PIPs related to behavioral health.[12] CMS conducted detailed abstractions of reporting on PIPs in four topic areas: (1) diabetes care, (2) hospital readmissions, (3) ED visits, and (4) substance use disorders (SUDs). Analysis of the PIPs indicates that states are using a diverse set of interventions to improve quality of care.

Summary and Conclusion

This report shows the continued progress made by HHS and states in building a national, cross-state voluntary quality measurement and reporting program for adults enrolled in Medicaid. The evolving quality measurement field offers data on performance as a new tool for states to use in driving improvements in care.[13] CMS awarded Adult Medicaid Quality Grants in 2012 to 26 states to develop their capacity to report on the core measures and use that data in quality improvement projects. State efforts focused on topic areas including behavioral health, substance use disorders, and diabetes. In addition, through managed care entities, states continue to advance improvement projects specific to adults in many of these same topic areas, as well as others such as hospital readmissions and cancer screening. In addition, quality improvement initiatives underway in the states and at CMS are aimed at improving health care provided to adults enrolled in Medicaid. In 2014, CMS launched a Maternal and Infant Health Initiative to drive improvements in the care provided during the postpartum period to improve the health outcomes of Medicaid and CHIP enrollees. CMS's Medicaid Innovation Accelerator Program provides program support to states to strengthen care delivery related to substance use disorders, physical/behavioral health integration, community integration using long term services and supports, and Medicaid beneficiaries with complex needs and high costs.

[12] The eight states were Arizona, Florida, Massachusetts, Minnesota, New Hampshire, Oregon, Pennsylvania, and Virginia.

[13] Berwick, D.M., B. James, and M.J. Coye. "Connections Between Quality Measurement and Improvement." Medical Care, vol. 41, no. 1 (Supplement), January 2003, pp. I30–38.

I. INTRODUCTION

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), established the National Quality Strategy for Quality Improvement in Health Care, which serves as the national blueprint to improve the health care delivery system and health outcomes by pursuing three goals: better care, healthy people/healthy communities, and affordable care.[14] These three goals are reflected in the activities undertaken by the Centers for Medicare & Medicaid Services (CMS) and other agencies of the U.S. Department of Health and Human Services (HHS) to improve care for adults enrolled in Medicaid.

Medicaid provided health care coverage to nearly 65 million Americans in federal fiscal year (FFY) 2014, including eligible low-income adults, children, pregnant women, older adults, and people with disabilities. In FFY 2014, Medicaid served 27.1 million non-elderly adults, 6.3 million adults age 65 and over, and 10.9 million individuals who are blind/disabled.[15] Medicaid also provides supplemental coverage for Medicare enrollees (often called dually eligible beneficiaries).

By 2016, an estimated 75 percent of Medicaid enrollees will obtain their care through managed care plans, although the rate of managed care enrollment for adults in Medicaid varies widely across state Medicaid programs.[16] Because of these varying arrangements, a diverse set of quality measurement and improvement efforts are underway across payment and service delivery settings.

The Affordable Care Act required the Secretary of HHS to establish an adult health care quality measurement program to obtain standardized data on the quality of health care across state Medicaid programs. As required by Section 1139B of the Social Security Act, as added by Section 2701 of the Affordable Care Act, this report summarizes FFY 2014 state reporting and performance on the core set of health care quality measures for adults enrolled in Medicaid (referred to as the Adult Core Set) and information collected through external quality reviews (EQRs) of managed care entities.[17,18] This is CMS's second annual report on the quality of care for adults in Medicaid, and the first year that CMS is publicly reporting findings on the Adult

[14] Available at http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2014annlrpt.pdf.

[15] "2014 CMS Statistics," Table I.16. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf. The blind/disabled total includes some children.

[16] Avalere Analysis: Medicaid Managed Care Expected to Grow by 13.5 Million (2015) http://avalere.com/expertise/managed-care/insights/avalere-analysis-medicaid-managed-care-enrollment-set-to-grow-by-13.5-milli.

[17] For a list of the 2014 Adult Core Set measures, see Supplemental Table AD-1 at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/overview-of-the-adult-core-set-measures-ffy-2014.zip.

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

Core Set.[19] The 2015 report presents findings on the Adult Core Set measures and summarizes information on managed care quality measurement and improvement reported in the EQR technical reports submitted to CMS by states. This report covers data for the Core Set FFY 2014 reporting period, which generally covers utilization occurring in calendar year (CY) 2013. In some cases, states reported rates for an earlier period if data were not available for CY 2013. As Medicaid expansion became effective on January 1, 2014 for those who signed up, the report does not include specific information or draw conclusions about the effects of the Medicaid expansion on the quality of care for adults enrolled in Medicaid.

[19] The 2014 Secretary's Report is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2014-adult-sec-rept.pdf.

II. STATE-SPECIFIC FINDINGS ON QUALITY AND ACCESS IN MEDICAID

A. Data Limitations

The legislation that created the adult health care quality measurement program established it as a voluntary reporting program, at the discretion of state Medicaid agencies to participate. In FFY 2014, 34 states voluntarily reported on one or more of the Adult Core Set measures. As such, it is not possible to make national observations of the quality of care provided to adult Medicaid beneficiaries based on data from these 34 states, or based on the smaller number of states that reported on the 10 frequently reported measures for which CMS conducted detailed analysis. This report also does not compare the quality of care for adults covered by Medicaid with that of adults covered through other kinds of health coverage.

This report covers data for the Core Set FFY 2014 reporting period. In most cases, states submitted data for utilization that occurred in calendar year (CY) 2013. In cases in which CY 2013 data were not available, states reported rates for an earlier period. Of the 10 frequently reported Adult Core Set measures for FFY 2014, for example, each measure was reported by at least one state using a measurement period that differed from the measure technical specifications. These data therefore do not inform observations about the impact of coverage changes, including the expansion of Medicaid to low-income adults that took effect in 2014.

States may not always adhere to the measure technical specifications when reporting, making it difficult to compare results from state to state. For example, although the technical specifications for several measures ask states to stratify by two age groups (ages 18 to 64 and age 65 and older), results presented in this report focus on data for enrollees ages 18 to 64. For FFY 2014, CMS chose not to publicly report data separately for Medicaid enrollees age 65 and older, as states varied widely in their use of Medicare data, and without Medicare data, the portrait of care for enrollees age 65 and older would be incomplete. Additionally, the extent to which reported data have been validated is unknown in all states, though CMS is seeking to more consistently obtain this information from states with future reporting.

To improve the quality and completeness of Core Set data, CMS implemented a systematic real-time data review and outreach process for FFY 2014 Core Set data. After reviewing the data, CMS contacted each state to follow up on any concerns about the accuracy or completeness of reported data (such as missing data, transposed values, and inconsistencies in data reported across measures or over time) and also to clarify any aspects of the state's reported populations or methodology that were unclear. As part of this process, CMS also offered states additional technical support with reporting Core Set measures through email and in telephone calls. As a result of this outreach, some states corrected and refined their Core Set data. The corrected data were used to publicly report the data seen in this report. In addition, CMS gained a better understanding of factors that may affect changes in rates reported across years.

With any new reporting program, it may take several years of reporting on the measures before data quality issues like the ones highlighted are resolved. CMS continues to work with states to help improve the accuracy and completeness of the data reported.

B. Quality Measurement Using the Adult Core Set

In FFY 2013 and FFY 2014, states have voluntarily collected and reported data on the Adult Core Set measures. While reporting of a subset of the Adult Core Set measures was required for Adult Medicaid Quality (AMQ) grantee states for FFY 2013 (though states could choose which measures to report), reporting for FFY 2014 was voluntary for all states.[20] Through participation in AMQ quality improvement projects (QIPs) and managed care performance improvement projects (PIPs), states have also continued to engage in initiatives designed to improve the quality of care for adults enrolled in Medicaid.

CMS viewed the first year of reporting of the Adult Core Set as an opportunity to learn and refine the Core Set measures. CMS identified four major goals for the second year of state reporting:

- Increase the number of states reporting on the Adult Core Set measures;
- Increase the number of measures reported by each state;
- Improve the completeness of the data reported; and
- Use the measures as part of state quality improvement initiatives, including for managed care external quality review (EQR) PIPs.

During the past year, CMS and states achieved significant progress toward these goals. Thirty-four states reported one or more of the Adult Core Set measures for the FFY 2014 reporting year, compared to 30 states for FFY 2013 (Table 1 and Figure 1). While the median number of reported measures is unchanged at 16.5 measures reported in both years, altogether, 31 states reported data on at least half, or 13, of the Adult Core Set measures for FFY 2014, up from 28 states for FFY 2013. The states reporting for both years included the 26 AMQ grantees and 4 non-grantee states (Delaware, Illinois, Tennessee, and Virginia). Additionally, four non-grantee states reported at least one Adult Core Set measure for the first time for FFY 2014 (the District of Columbia, Hawaii, Kentucky, and Mississippi). Detailed analysis of state-specific findings is included in four domain-specific reports that provide a snapshot of state performance on 10 Adult Core Set measures reported by at least 25 states.[21]

In January 2012, CMS published the Initial Adult Core Set for voluntary reporting by states.[22] The Affordable Care Act further required that improvements to the core set be issued beginning

[20] Additional information about the Adult Medicaid Quality Grant Program is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-medicaid-quality-grants.html.

[21] Detailed results on state performance on the Adult Core Set measures are presented in four domain-specific reports: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, and (4) behavioral health care. A fifth report summarizes children's use of dental and oral health services in Medicaid and CHIP. The domain-specific reports are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

[22] The Affordable Care Act (Section 1139B) required HHS to identify and publish a core set of health care quality measures for adult Medicaid enrollees for voluntary use by state Medicaid programs. In January 2012, HHS published, an initial core set of 26 measures.

January 2014, and annually thereafter. Part of the process of collecting, reporting, and using the Adult Core Set measures is to establish a way to periodically identify new measures to potentially include in future Adult Core Sets. This process serves several purposes: (1) build upon the original measure set by addressing gap areas; (2) improve upon existing Adult Core Set measures; and (3) better align with national quality measurement activities. The intended result is an Adult Core Set that is more robust and better able to support states' and CMS's quality measurement needs.[23] CMS worked with the National Quality Forum's (NQF's) Measure Applications Partnership (MAP) to conduct an expedited review of the measures in September 2013. After reviewing MAP recommendations and potential updates through CMS's internal measurement review process, CMS issued the 26-measure 2014 Adult Core Set, which removed one measure, Annual HIV/AIDS Medical Visit, and replaced it with the HIV Viral Load Suppression measure.[24] In December 2013, CMS issued an Informational Bulletin detailing updates to the 2014 Adult Core Set.[25]

As with the measures themselves, the data systems and sources used to collect information and monitor progress are also subject to periodic adjustments. CMS has continued making progress toward a modernized and streamlined Medicaid and CHIP data infrastructure known as the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. In the future, information collected as part of MACBIS will serve as the primary data source for the Center for Medicaid and CHIP Services' (CMCS's) quality reporting and performance measurement capacities.

For the 2015 Secretary's Report, CMS conducted the following activities to assess the status of quality measurement, reporting, and improvement efforts by states:

- Reviewed and analyzed findings on the Adult Core Set measures reported to CMS by states for FFY 2014, including analyses of 10 measures reported by at least 25 states;
- Conducted outreach by email and telephone to selected states about the completeness and accuracy of their Adult Core Set data;
- Summarized information on the quality measures and PIPs reported in the EQR technical reports from states that contract with managed care plans to deliver services to Medicaid enrollees (see Chapter III); and
- Prepared detailed analyses of state performance on Adult Core Set measures in four domains: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, and (4) behavioral health care.[26]

[23] Background on the Initial Core Set can be found in a January 2012 Informational Bulletin, available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-1-4-2012.pdf.

[24] For a list of the 2014 Adult Core Set measures, see Supplemental Table AD-1 at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/overview-of-the-adult-core-set-measures-ffy-2014.zip.

[25] Updates to the 2014 Adult Core Set are described in a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin, available at http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf.

[26] The domain-specific reports are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

C. Changes in State Reporting of the Adult Core Set for FFY 2014

The median number of measures reported by the 34 states reporting for FFY 2014 remains unchanged from FFY 2013 at 16.5 measures. Altogether, 31 states reported data on at least half, or 13, of the Adult Core Set measures for FFY 2014 (Figure 1), up from 28 states for FFY 2013. Seven states reported on 21 or more Adult Core Set measures for FFY 2014, including one state, Georgia, which reported on 25 measures. This demonstrates improvement over the past year, when five states reported on 21 or more measures for FFY 2013. Fifteen states reported more measures for FFY 2014 than FFY 2013. Seven states reported the same number of measures, and 12 states reported fewer measures for FFY 2014 than FFY 2013.

Altogether, 13 Adult Core Set measures were reported by at least 25 states for FFY 2014, 10 of which are being publicly reported (Figure 2).[27] The five measures reported most frequently by states are part of the Healthcare Effectiveness Data and Information Set (HEDIS®), and are often included in Medicaid managed care contracts for monitoring the quality of care provided to Medicaid enrollees receiving care through managed care entities.[28] In addition, these measures are calculated primarily using Medicaid administrative data and do not require medical record review. In FFY 2014, the five most frequently reported measures were:

- Comprehensive Diabetes Care: Hemoglobin A1c Testing: 34 states reporting
- Comprehensive Diabetes Care: LDL-C Screening: 34 states reporting
- Postpartum Care Rate: 34 states reporting
- Cervical Cancer Screening: 33 states reporting
- Chlamydia Screening in Women: 32 states reporting

The majority of the Adult Core Set measures (20 measures) saw an increase in the number of states reporting data for FFY 2014 (Figure 3). The measures with the largest increase from FFY 2013 to FFY 2014 in the number of states reporting were:

- Adult Body Mass Index (BMI) Assessment: increased from 16 to 26 states reporting
- Chlamydia Screening in Women: increased from 26 to 32 states reporting
- Antidepressant Medication Management: increased from 25 to 31 states reporting
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: increased from 18 to 24 states reporting

[27] For a measure to be publicly reported, data must be provided to CMS by at least 25 states and meet internal standards for quality. Three measures (PQI-01, PQI-08, and PQI-15) were reported by at least 25 states, but are not publicly reported this year due to data quality issues that CMS is actively working to address in collaboration with states.

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

The least frequently reported measures in the 2014 Adult Core Set require states to conduct medical record reviews to collect the necessary data, which is a resource-intensive process for states. Reasons for not reporting vary by state, but the medical record review requirement, data availability, and data access are among the most frequently cited reasons for not reporting. Through the Quality Measures Technical Assistance and Analytic Support (TA/AS) Program,[29] CMS will continue to work with states to support state capacity for reporting.

D. Summary of Key Findings

The increase in the number of states reporting Adult Core Set measures—from 30 states for FFY 2013 to 34 states for FFY 2014—enabled CMS to conduct deeper analysis on the most frequently reported measures this year. Although the technical specifications for several measures ask states to stratify by two age groups (ages 18 to 64 and age 65 and older), results presented in this report focus on data for enrollees ages 18 to 64.[30] This section summarizes CMS's analysis of state performance on 10 measures across four domains: (1) primary care access and preventive care, (2) maternal and perinatal health, (3) care of acute and chronic conditions, and (4) behavioral health.[31]

1. Primary Care Access and Preventive Care

Four measures of primary care access and preventive care—Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, and Adult Body Mass Index (BMI) Assessment—were available for analysis for FFY 2014.

The frequency of breast and cervical cancer screenings is an indicator of the preventive care services provided to women enrolled in Medicaid. For FFY 2014, the median rates were 53 percent for breast cancer screening (31 states reporting), and 58 percent for cervical cancer screening (33 states reporting) (Table 2). Chlamydia screening also plays a critical role in promoting women's health. Left untreated, chlamydia can affect a woman's ability to have children. The median rate was 59 percent of sexually active women ages 21 to 24 who received the recommended chlamydia screening (32 states reporting).

Monitoring of BMI helps providers identify adults at risk for becoming overweight or obese. The Adult BMI Assessment measure indicates the percentage of adults with a primary care visit

[29] The TA/AS Program is led by Mathematica Policy Research in collaboration with National Committee for Quality Assurance (NCQA) and Center for Health Care Strategies (CHCS), and supports reporting of CMCS Medicaid/CHIP quality measures, including the Adult, Child, and Health Homes Core Sets, and Maternal and Infant Health Initiative measures. More information about the TA/AS Program is available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/tafactsheet.pdf.

[30] For FFY 2014, CMS chose not to publicly report data separately for Medicaid enrollees age 65 and older. States varied widely in their use of Medicare data, and without Medicare data, the portrait of care for enrollees age 65 and older would be incomplete.

[31] Additional information on state performance, including percentiles and geographic variation, is available in domain-specific reports, along with companion measures from the Child Core Set. The domain-specific reports are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

whose BMI value was documented in the medical record. About two-thirds of adults with a primary care visit in the past year had their BMI value documented in the medical record (the median was 69 percent among 26 states reporting for FFY 2014).

For more information on the Primary Care Access and Preventive Care measures, see the Primary Care Access and Preventative Care domain-specific report at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

2. Maternal and Perinatal Health

In 2010, Medicaid financed nearly half of all births in the United States, ranging from a low of 24 percent of all births in Hawaii to a high of 69 percent of births in Louisiana.[32] Postpartum visits provide an opportunity to assess women's physical recovery from pregnancy and childbirth, and to address chronic health conditions (such as diabetes and hypertension), mental health status (including postpartum depression), and family planning (including contraception and inter-conception counseling). CMS's Maternal and Infant Health Initiative aims to increase the postpartum care rate among women enrolled in Medicaid.[33]

The Postpartum Care Rate measure assesses how often Medicaid enrollees received timely postpartum care (between 21 and 56 days after delivery). Among the 34 states reporting for FFY 2014, a median of 58 percent of women covered by Medicaid/CHIP had a postpartum visit between 21 and 56 days after delivery (Table 2).

For more information on the Maternal and Perinatal Health measures, as well as the CMS initiatives underway to improve perinatal care, see the Perinatal Care domain-specific report at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

3. Care of Acute and Chronic Conditions

Visits for routine screening and monitoring play an important role in managing the health care needs of people with acute and chronic conditions, potentially avoiding or slowing disease progression, and reducing costly hospital admissions and ED visits. Three Adult Core Set measures of the Care of Acute and Chronic Conditions—Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Test, Comprehensive Diabetes Care: LDL-C Test, and Annual Monitoring for Patients on Persistent Medications—were available for analysis for FFY 2014. Two of these measures assess whether Medicaid enrollees had routine monitoring for diabetes care (type 1 or type 2), while the third assesses monitoring for medication treatments including angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), digoxin, or diuretics.

[32] Markus, A.R., E. Andres, K.D. West, N. Garro, and C. Pellegrini. "Medicaid Covered Births, 2008 through 2010, in the Context of the Implementation of Health Reform." Women's Health Issues, vol. 23, no. 5, pp. e273–e280.

[33] More information about CMS's Maternal and Infant Health Initiative is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/maternal-and-infant-health-care-quality.html. The Initiative aims to increase by 10 percentage points the rate of postpartum visits among women in Medicaid and CHIP in at least 20 states over a 3-year period.

Overall, performance by the states reporting on the three measures was relatively high. A median of 80 percent of Medicaid enrollees with diabetes had an HbA1c test during the year and a median of 68 percent of enrollees had an LDL-C screening test during the year among the 34 states reporting the two measures (Table 2). In addition, the vast majority of adult Medicaid enrollees who received ambulatory medication therapy for a select therapeutic agent for at least 180 treatment days had routine monitoring for the medication during the year. Among the 27 states reporting the Annual Monitoring for Patients on Persistent Medications measure, the state median was 85 percent.

For more information on the Care of Acute and Chronic Conditions measures, see the Care of Acute and Chronic Conditions domain-specific report at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

4. Behavioral Health Care

As the single largest payer for mental health services in the United States, Medicaid plays an important role in providing behavioral health care to adults, and monitoring the effectiveness of that care. Two measures of behavioral health care—Follow-Up After Hospitalization for Mental Illness and Antidepressant Medication Management—were available for analysis for FFY 2014.

Follow-up care after hospitalization for mental illness helps improve health outcomes and prevent readmissions in the days following discharge from inpatient mental health treatment. For FFY 2014, 30 states reported a median rate of 37 percent for follow-up visits within seven days of discharge and 57 percent for follow-up visits within 30 days of discharge (Table 2).

The effective use of antidepressants is an important standard of care for patients receiving treatment for depression. When individuals are first diagnosed with major depression, medication may be prescribed either alone or in combination with psychotherapy. An initial course of medication treatment is recommended for 12 weeks to choose an effective regimen and observe a clinical response. Continued treatment for six months is recommended to prevent relapse and to maintain functioning. Among the 31 states reporting the Antidepressant Medication Management measure for FFY 2014, the median rates were 47 percent of Medicaid enrollees who were treated with antidepressant medication for 12 weeks, and 31 percent who were treated with medication for six months.

These results suggest that states have substantial room for improvement on the two behavioral health care measures, and suggest there is a need for enhanced integration of physical and behavioral health care and more coordination across multiple settings of care.

For more information on the Behavioral Health Care measures, see the Behavioral Health Care domain-specific report at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

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III. MONITORING AND IMPROVING CARE FOR ADULTS ENROLLED IN MANAGED CARE

In 2011, 62 percent of adults ages 21 to 64 enrolled in Medicaid obtained their health care through managed care plans. The rate of managed care enrollment for adults in Medicaid varied widely across state Medicaid programs, ranging from less than 10 percent of enrollees in 18 states to more than 90 percent in Delaware, Hawaii, and Tennessee.[34] Regardless of the enrollment rate, states using a managed care delivery system must comply with certain federal requirements, including standards to assess and monitor the quality of care provided by contracted managed care plans. This chapter summarizes state activities related to monitoring and improving care for adults in managed care.[35]

A. Overview

The Balanced Budget Act of 1997 created system-wide quality standards for states that elect to use managed care for the delivery of health care in Medicaid.[36] Federal regulations implemented in 2003 require states to perform an annual external quality review (EQR) for each contracted managed care organization (MCO), prepaid inpatient health plan (PIHP), and health insuring organization (HIO).[37] These annual EQRs analyze and evaluate information on the quality, timeliness, and access to the health care services that an MCO or PIHP, and their contractors, furnish to Medicaid beneficiaries. Section 1139B(d) of the Social Security Act, as amended by section 2701 of the Affordable Care Act, requires the HHS Secretary to include in this annual report information that states collect through EQRs.[38]

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

[34] Mathematica analysis of 2011 Medicaid Analytic eXtract data from 45 states. Because MAX 2011 data are unavailable for Arizona, Colorado, the District of Columbia, Hawaii, Idaho, and Louisiana, MAX 2010 data were used. Includes full-benefit and non-full-benefit enrollees (e.g., enrollees for family planning, breast cancer, and Medicare cost-sharing only).

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

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

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

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

EQR-related activities: (1) validation[39] of performance measures; [40] (2) validation of performance improvement projects (PIPs);[41] and (3) a review, at least every three years, to determine the managed care plan's compliance with state standards for access to care, structure and operations, and quality measurement and improvement.[42] The state also may choose to perform additional EQR-related activities.[43]

The state must contract with a qualified EQRO to produce an annual technical report that uses information from the EQR-related activities to assess the quality, timeliness, and access to care provided by each MCO and PIHP. Per regulation, the EQR technical report is a public document, available upon request to all interested parties.[44]

B. External Quality Review Technical Reports Submitted to CMS, 2014–2015 Reporting Cycle

Of the 41 states[45] that contracted with MCOs or PIHPs during the 2014–2015 reporting cycle,[46] 38 states submitted EQR technical reports to CMS.[47] These states contracted with 15 different EQROs to conduct the annual EQR, and five EQROs conducted reviews for multiple states during the 2014–2015 reporting cycle.[48] The majority of EQR technical reports focused on

[39] 42 CFR 438.320 defines validation as the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

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

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

[42] 42 CFR §438.358(b)(3).

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

[44] See 42 C.F.R. § 438.364.

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

[46] The 2014–2015 reporting cycle includes reports that were submitted between May 1, 2014 and April 30, 2015.

[47] Of the 41 states that contracted with MCOs or PIHPs, three (Indiana, Puerto Rico, and Texas) did not submit an EQR technical report before April 30, 2015 for inclusion in this analysis, and one (Delaware) submitted readiness reviews only. North Dakota's managed care program was limited to the Children's Health Insurance Program (CHIP) population during the 2014–2015 reporting cycle; therefore, North Dakota's EQR technical report is not included in this analysis. Alabama, Alaska, Arkansas, Connecticut, Guam, Idaho, Maine, Montana, Oklahoma, South Dakota, the Virgin Islands, and Wyoming do not have MCOs or PIHPs that enroll adults covered by Medicaid. While Vermont is required to conduct an EQR under the terms of its Section 1115 demonstration, its managed care entity is neither an MCO nor a PHIP and therefore is excluded from this analysis.

[48] For a list of EQROs with current state Medicaid contracts in 2014, see EQR Table AD-1 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2014-2015.zip.

physical health services, but some included information on other types of managed care services, such as long-term services and supports (LTSS) or behavioral health.

The 2014–2015 EQR technical reports provide insight into the strategies and efforts that states use to improve the quality of care for adults in Medicaid. This report profiles quality measurement and improvement efforts underway related to adults enrolled in Medicaid managed care entities. The EQR technical reports indicate that states and managed care entities engage in a variety of quality measurement and improvement efforts. Generally, the scope and focus of state initiatives are based on several factors, including the populations served by managed care, stakeholder and beneficiary feedback, and clinical areas in need of improvement.

The structure, level of detail, and focus on quality, access, and timeliness of care varied considerably depending on the EQR technical report. For example, some EQR technical reports did not explicitly discuss quality, access, and timeliness at all, while others provided substantial detail related to the performance measure and PIP validation process, PIP interventions, and performance outcomes. This lack of uniformity across EQR technical reports is due to differences in state interpretation of regulatory language. While regulations require states to validate performance measures and PIPs annually, they do not specifically require the inclusion of details on outcomes or interventions in the EQR technical reports.

C. Performance Measures, 2014–2015 Reporting Cycle

In the 2014–2015 reporting cycle, the most frequently reported performance measures for adults focused on behavioral health (reported by 29 states),[49] diabetes care (27 states), cancer screening (25 states), asthma/Chronic Obstructive Pulmonary Disease (COPD) (24 states), access to primary care (24 states), and cardiac care (22 states).[50] The reported performance measures showed considerable overlap with both the CMS Adult Core Set and the HEDIS 2014 measures, though the use of these measure sets is not required by CMS. Additionally:

- Of the 37 states that submitted EQR technical reports for the 2014–2015 reporting cycle for managed care plans that cover adults, 35 identified the topic or focus of performance measures reported by MCOs and PIHPs, and 34 identified the performance measures validated by the EQRO.[51]

[49] Behavioral health is defined broadly to include tobacco cessation and treatment of mental health and substance use disorders (SUDs) including alcohol and other drugs.

[50] See EQR Figure AD-1 for information about the number of states reporting performance measures in each topic area. More detailed information related to state reported performance measures for adults can be found on EQR Table AD-3 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2014-2015.zip.

[51] This analysis focuses on the 37 states that submitted EQR technical reports for the 2014–2015 reporting cycle for managed care plans that cover adults. North Dakota's managed care program was limited to the Children's Health Insurance Program (CHIP) population during the 2014–2015 reporting cycle; therefore, North Dakota's EQR technical report is not included in this analysis.

- 31 states included the performance rates achieved by each MCO or PIHP.[52] Of these:
  - 27 states compared MCO and PIHP performance to national HEDIS Medicaid rates.
  - 24 states compared performance in the 2014–2015 reporting cycle to performance in previous years.
  - 23 states compared individual MCO and PIHP performance rates to statewide managed care performance rates.
  - 17 states included comparisons to state target rates.
  - 14 states reported performance rates for specific subpopulations within the state. For example, Arizona, Florida, and New York included performance rates by geographic region, while Georgia reported results by delivery system (managed care versus fee-for-service).

The most commonly reported performance measures for this reporting cycle are consistent with those reported in the previous reporting cycle (Figure 4). Among the 33 states that reported performance measures in both reporting cycles, the most notable changes were the increases in the number of states reporting cancer screening measures (an increase of 9 states), primary care access measures (increase of 7 states), and behavioral health measures (increase of 6 states).

D. Performance Improvement Projects, 2014–2015 Reporting Cycle

Of the 37 states that submitted EQR technical reports for the 2014–2015 reporting cycle for managed care plans that cover adults, 34 included at least one PIP that targeted adults, and all of those states provided information on the results of the review process in the EQR report, as required by regulation (Table 3). States often deferred to the MCO or PIHP to propose and implement topics and interventions; however, 21 states mandated at least one specific PIP topic or required participation in a collaborative project focused on adults.[53] For example, eight states (Arizona, Florida, Massachusetts, Minnesota, New Hampshire, Oregon, Pennsylvania, and Virginia) mandated that managed care entities in the state conduct PIPs related to behavioral health. Other state-mandated PIP topics included: asthma/COPD, care transitions, colorectal cancer screening, diabetes care, ED visits, and hospital readmissions.

The topical focus and number of PIPs varied considerably among the 34 states that included at least one PIP that targeted adults (Table 3).

[52] See EQR Table AD-4 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2014-2015.zip.

[53] States that mandated PIP topics for MCOs or PIHPs include: Arizona, California, Florida, Georgia, Hawaii, Illinois, Kansas, Louisiana, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, Virginia, Washington, and West Virginia.

- Most states conducted 20 or fewer PIPs targeting adults, while eight states had more than 20 PIPs. Florida, Minnesota, and Oregon conducted the largest number of PIPs: 87, 51, and 49 PIPs, respectively. In many states, particularly in those that mandated PIPs on specific topics, the PIPs in the state focused on a small number of priority health topics. For example, in Arizona almost all of the PIPs in the state focused on reducing preventable hospital readmissions. States that required each of their managed care entities to conduct multiple PIPs and allowed them to choose at least one topic, reported a wider variety of topics. Minnesota required health plans to conduct PIPs focused on behavioral health, cancer screening, and diabetes care. In addition, plans in the state also conducted PIPs focused on COPD, care transitions, reducing ED visits, and reducing hospital readmissions, resulting in a wide range of improvement projects in the state.
- Behavioral health and diabetes were the most common PIP topics for the 2014–2015 reporting cycle (20 states reported PIPs related to each of these topics).
- Other common PIP topics included hospital readmissions (15 states and 91 PIPs), ED visits (12 states and 34 PIPs), and cancer screening (11 states and 35 PIPs).

Among the 32 states that submitted EQR technical reports during both the 2013–2014 and 2014–2015 reporting cycles, the total number of states conducting PIPs focused on asthma/COPD, behavioral health, cancer screening, cardiac care, diabetes, hospital readmissions, and weight/BMI increased from the previous reporting cycle (Figure 5). The increased focus on quality improvement efforts in these topic areas may reflect changing health care needs or priorities within the states.

Discussions of EQRO findings on the performance, progress, and limitations of each PIP differed greatly across reports, with descriptions of PIPs occasionally lacking key details. This lack of detailed intervention and outcomes information within the EQR technical reports has limited CMS's ability to conduct a comprehensive assessment on the efficacy of state quality improvement efforts for children and pregnant women enrolled in managed care. However, the level of detail presented in the EQR technical reports has become more comprehensive over the past few years, following intensive CMS outreach and technical assistance efforts.

E. Review of Performance Improvement Projects

The following section presents findings from detailed abstractions of EQRO reporting on PIPs in four health topic areas: (1) diabetes care, (2) hospital readmissions, (3) ED visits, and (4) treatment of substance use disorders.[54] An example of a state improvement project is highlighted for each topic area. Criteria for selecting states to highlight included geographic diversity across reporting years and across PIP topics, the EQR validation rating,[55] and the

[54] Additional information on "Findings from EQR Technical Reports, 2014–2015" is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2014-2015.zip.

[55] Use of the term "validation" differed across EQR reports. The state examples all based the validation rating on the EQR Protocol 3: Validating Performance Improvement Projects (PIPS): A Mandatory Protocol for External

amount of information related to interventions and outcomes included in the EQR technical reports.

1. Diabetes Care

Twenty states reported a combined total of 101 PIPs on adult diabetes during this reporting cycle (Table 3). In seven states (Georgia, Hawaii, Kansas, Minnesota, Nevada, Ohio, and Oregon), diabetes PIPs were mandated for all health plans. While the PIP interventions varied across states and health plans, common improvement aims included: controlling HbA1c (a measure of blood sugar), managing LDL-C (a measure of cholesterol), managing blood pressure, increasing the percentage of members who had a diabetic retinal eye exam, and improving medication management.

All seven MCOs in Hawaii operated PIPs aimed at improving care for members with diabetes. In the 2014–2015 reporting cycle, the PIPs were in different stages of implementation; two MCOs reported baseline data, three MCOs had progressed to the first year of results, one MCO was in the third year of results, and one MCO was in the fourth year of results. The study indicators that the MCOs used to assess performance differed slightly across plans, and included the percentage of members with diabetes (type 1 and type 2) who had: (1) an eye screening for diabetic retinal disease, (2) a blood pressure reading with the most recent reading being <140/90mmHg, (3) an HbA1c test with the most recent results being <8 percent, and (4) an LDL-C test with the most recent results being <100mg/dL. Baseline performance on these indicators ranged considerably by indicator and by MCO. For example, baseline rates on the LDL-C screening indicator ranged from 24 percent of members in one MCO to 79 percent of members in two MCOs. Each MCO set its own goals for each study indicator, most commonly targeted to the HEDIS 50th and 75th percentiles for the year.

Based on positive results from PIP interventions in previous years, most of the MCOs continued member and provider outreach and education activities that they had implemented prior to the 2014–2015 reporting cycle. For example, most MCOs continued to provide materials on diabetes care to members to increase their awareness of disease management programs. The MCOs also continued to focus on provider activities such as pay-for-performance programs and distribution of HEDIS toolkits. During this reporting cycle, the MCOs also implemented new member-outreach interventions including targeted outreach to members with gaps in care, using service coordinators to improve member compliance with disease management guidance (such as refilling and picking up medications and completing recommended appointments with physicians), providing free eye exams from a van that traveled to areas with need for additional services, and enrolling members in patient-centered medical homes. New interventions targeted

(continued)

Quality Review (EQR), Version 2.0, September 2012. The protocol details the following 10 activities: (1) select the study topic; (2) define the study question(s); (3) select the study indicators; (4) use a representative and generalizable study population; (5) use sound sampling techniques (if sampling was used); (6) reliably collect data; (7) analyze and interpret study results; (8) implement intervention and improvement strategies; (9) assess for real improvement; and (10) assess for sustained improvement. Each EQRO calculated the percentage score of evaluation elements met by each MCO to determine a status of met, partially met, or not met.

at providers included efforts to improve disease management collaboration across different types of providers and targeted resources for providers to identify patients who had gaps in care.

All seven MCOs met EQRO validation criteria for the 2014–2015 reporting cycle. Overall, greater performance improvements were achieved by the PIPs in their third and fourth years than by the PIPs reporting their first year of results. The MCO reporting its fourth year of results had relatively high performance on all three of its study indicators at baseline and reported improvements on all three indicators in this reporting cycle, with two increases being statistically significant. The MCO reported statistically significant increases on the HbA1c indicator (from 83 percent at baseline to 88 percent in this reporting cycle) and the retinal eye exam indicator (from 43 percent to 64 percent), and an increase that was not statistically significant on the LDL-C screening indicator (from 79 percent to 83 percent). Although results were more mixed in the MCOs reporting their first year of results, there were some improvements among these PIPs as well. For example, one MCO reported a statistically significant increase in the LDL-C indicator, from 56 percent at baseline to 66 percent in the first year of results, exceeding the MCO's goal.

2. Hospital Readmissions

Fifteen states reported a combined total of 91 PIPs aimed at reducing preventable hospital readmissions during this reporting cycle (Table 3). Seven states (Arizona, California, Hawaii, Illinois, Massachusetts, Pennsylvania, and Washington) mandated PIPs targeting hospital readmissions for all health plans. Interventions often focused on implementing discharge planning and transitional care activities, such as appointment reminder calls and mailings after discharge, to ensure members' post-discharge needs were met.

Pennsylvania required all eight of its MCOs to implement a PIP aimed at decreasing the percentage of inpatient acute care discharges with subsequent readmission to inpatient acute care within 30 days of discharge.[56] In their PIP documentation, the MCOs stated that hospital readmissions are costly, potentially harmful to the patient, and often avoidable. In developing their PIPs, the MCOs reviewed the factors associated with readmissions, such as poor discharge procedures, poor coordination of services, incomplete discharge care, and inadequate follow-up care. To address these issues, the MCOs implemented member, provider, and system-level interventions. Examples of member-level activities include: (1) calling members with special needs who would benefit from a case management evaluation and (2) performing case management outreach and follow-up with discharged members for coordination of care. Examples of provider-level activities include: (1) contacting primary care providers to notify them of a member's hospitalization, (2) conducting outreach to providers to discuss case management for members with frequent inpatient events, and (3) delivering Evidence-Based Quality Guideline Toolkits to high-volume practices. Examples of system-level activities include: (1) enhancing case management by meeting beneficiaries in their communities, (2) conducting daily reviews of admission reports and member discharge plans, (3) increasing

[56] Pennsylvania also required its five behavioral health plans to implement PIPs that aimed to reduce the percentage of members who were discharged from acute inpatient psychiatric facilities to an ambulatory setting who were readmitted within 30 days without a substance use disorder diagnosis. These PIPs were in the implementation stages in the 2014–2015 reporting cycle and results were not yet available.

collaboration with behavioral health MCOs, (4) adding embedded nurses and case managers in targeted hospitals, and (5) supporting the Medicaid Asthma Condition Management Program.

The MCOs assessed their performance on each of the study indicators at six-month intervals, including analyzing results by subpopulation of enrollees (based on demographic factors such as race, ethnicity, and age as well as differences across hospitals) to determine progress and identify areas for targeted interventions. For example, after assessing interim results, one MCO eliminated the requirement for home health care authorization for the member's first six visits to address the burden of obtaining authorization by providers and discharge planners. In the second results measurement period, six of Pennsylvania's eight MCOs succeeded in decreasing their rate of inpatient acute care readmissions from their baseline rates. Readmission rates at baseline differed considerably across plans and limited direct comparison of PIP results. For example, 30-day readmissions rates at baseline ranged from a low of 4.4 percent to 31.3 percent across MCO. In the remeasurement period, the MCOs reported decreasing their admission rates between 1.3 and 9.4 percentage points. The MCO with the highest rate at baseline had the greatest rate reduction, reporting a post-intervention rate of 21.9 (a reduction of 9.4 percentage points). The MCO with the lowest rate at baseline reported a smaller decline of 1.4 percentage points, but achieved a readmission rate of 3.0 percent, maintaining the lowest rate in the state. The two MCOs that reported increased readmission rates both reported increases of less than one percentage point over their baseline rate. The EQRO noted that interventions that drive systems changes, pay structure changes, and case management targeting groups most in need will help drive improvements and encouraged the MCOs to continue to move toward these types of interventions to make additional progress, rather than focusing on broader educational interventions.

3. Emergency Department Visits

Twelve states reported a combined total of 34 PIPs focused on reducing inappropriate ED use during this reporting cycle (Table 3). The mostly frequently reported improvement aims in this area were reducing the rate of avoidable ED utilization and increasing the rate of ED visits that do not result in an inpatient stay. PIP interventions most commonly focused on outreach and education to providers and members to encourage greater use of primary and preventive care services.

Beginning in the 2013–2014 reporting cycle, Louisiana required all four of its MCOs to conduct PIPs aimed at decreasing ED utilization. All MCOs used the HEDIS Ambulatory Care: ED Visits measure as the target indicator but they developed their own performance goals for the 2014–2015 reporting cycle. For example, three MCOs aimed to reduce their ED visit rate to meet or exceed the Medicaid HEDIS 50th percentile. Another MCO aimed to reduce ED visits for diabetes, asthma, and cardiac disease by 3 percent. One MCO also tracked the percentage of ED visits that were made by "frequent fliers," or individuals with high rates of ED use. To reduce ED visit rates, the MCOs implemented a variety of interventions aimed at both members and providers. Interventions targeted to members included: targeted mailing of educational materials, outreach to encourage use of primary care medical homes, telephonic outreach to members, and home visits conducted by the Community Education Department.

Provider interventions across the four MCOs included providing ED utilization data to providers, compensating providers for after-hours services, distributing provider report cards, and educating interns and residents about appropriate use of the ED. Three of the four MCOs also implemented system-level interventions, including implementing an ER Coach pilot project, establishing a 24/7 nurse hotline, promoting primary care medical home accreditation, expanding contracts with urgent care centers, and assigning care managers to high-volume EDs.

Louisiana's EQR technical report included different levels of detail about the baseline and post-intervention rates for each MCO, precluding overall assessments of PIP performance in the state. Baseline and results data were available for two MCOs and both of these MCOs achieved reductions in ED visit use. One MCO achieved its goal of exceeding the HEDIS 50th percentile of 63.15 visits per 1,000 member months (with the rate decreasing from 64.1 at baseline to 58.7 at remeasurement). In the other MCO with sufficient data, the decline was slight (from a rate of 74.9 at baseline to 74.0 at remeasurement). To achieve greater reductions in ED visit rates the EQRO recommended that the MCOs add or enhance targeted interventions to individuals with certain chronic conditions (such as asthma and sickle cell) as well as individuals who continue to be high ED utilizers.

4. Substance Use Disorders

Within the broader category of behavioral health, nine states (Arizona, California, Hawaii, Kansas, Massachusetts, Oregon, Tennessee, Utah, and Wisconsin) reported one or more PIPs specifically focused on substance use disorders, for a combined total of 38 PIPs on SUDs. Substance use disorder PIPs include those that focus on treatments to reduce the use of alcohol, tobacco, and other drugs.

Since 2011, Massachusetts has required all five of its MCOs to participate in a PIP to determine whether the receipt of aftercare services following discharge from an acute inpatient treatment services facility for substance use results in a lower percentage of members readmitted to an inpatient facility. The state cited research indicating that patients who participate in aftercare following detoxification have better outcomes regarding drug abstinence and detoxification readmission. In addition to plan-specific interventions, all five MCOs implemented the Community Support Program Specialty Model of Care, which connects members who are being discharged from detoxification programs with a community-based team of providers. These services are designed to respond to the needs of members whose pattern of service utilization indicates a high risk of readmission to 24-hour treatment facilities, and they are structured to support individuals who are not able to independently navigate access and sustain involvement with needed services.

The MCOs used different performance measures to assess their progress on the PIP. As a result, the results are not directly comparable across MCOs, though they appear to indicate mixed success in reducing readmission rates. However, the EQRO noted that in all PIPs the readmission rates for members who received aftercare were lower than the rates for members who did not receive these services.

- Three MCOs compared readmission within 30 days for members ages 13 to 64 who received aftercare services to rates for members who did not receive aftercare services. Two of these MCOs reduced readmission rates from baseline for members who received aftercare services. One reduced its rate by 2.1 percentage points (to a rate of 14.5 percent); the second reduced its rate by 5.5 percentage points (to a rate of 10.8 percent). The third MCO reported an increase in readmissions of less than 1 percentage point (to a remeasurement rate of 16.3) among members who received aftercare. The MCO that reported increased readmissions redesigned its aftercare program following its initial results. The purpose of the redesign was to increase member engagement and included both telephonic and community-based services to members based on their identified needs and preference.
- The fourth MCO also compared readmission rates for members with and without aftercare; however, the MCO focused on the 90-day readmission rate among members ages 19 to 64. This MCO reported an increased readmission rate, from 26.3 percent at baseline to 30.7 percent at remeasurement. The EQR report indicated that the MCO continued to refine its interventions to support its effort to reduce readmission rates.
- The remaining MCO assessed 30-day readmission rates for all members and did not distinguish between those who received aftercare and those who did not. The MCO reported an increased readmission rate (from 22 to 29 percent). Following this decline in performance, the MCO enhanced efforts to coordinate care among providers following inpatient discharges and increased its outreach to low-performing providers. The EQRO suggested that the MCO add interventions that were more focused on members.

IV. SUMMARY AND CONCLUSION

This report shows the progress made by HHS and states in building a national, cross-state quality measurement and reporting program for adults enrolled in Medicaid. This report covers data for the Adult Core Set FFY 2014 reporting period, which generally covers utilization occurring in calendar year (CY) 2013. In cases in which CY 2013 data was not available, states reported rates for an earlier period.[57] As Medicaid expansion became effective on January 1, 2014 for those who signed up, the report does not include specific information or draw conclusions about the effects of the Medicaid expansion on the quality of care for adults enrolled in Medicaid. During the second year of reporting on the Adult Core Set, the number of states voluntarily reporting measures increased from 30 states for FFY 2013 to 34 states for FFY 2014. States reported a median of 16.5 measures for FFY 2014.

Analysis of performance on the 10 Adult Core Set measures reported by 25 or more states for FFY 2014 provides a snapshot of the quality of care obtained by adults across a continuum of needs. States had relatively high performance on the three measures of care for acute and chronic conditions (HbA1c test, LDL-C screening test, and monitoring of patients on persistent medications); the median rates ranged from 68 to 85 percent. Performance on three measures of preventive care and one on maternity care was mixed, with median rates of slightly more than half of women receiving recommended screenings (for breast cancer, cervical cancer, and chlamydia), two-thirds of adults had their BMI documented in the medical records, and three-fifths of women who gave birth had a postpartum visit during the recommended time period (21 to 56 days after delivery). Findings on the two behavioral health measures (follow-up after hospitalization for mental illness and antidepressant medication management) highlight the need for improvement in the care of enrollees with mental health problems (on three of the four rates that comprise these two measures, medians were below 50 percent across the states reporting the measures). The review of improvement projects summarized in the EQR technical reports identified state-initiated efforts underway to assess and improve the quality of care for adults in Medicaid managed care. During the 2014–2015 reporting cycle, the most common improvement topic area was behavioral health (including substance use disorders), a focus that is consistent with findings on state performance on the Adult Core Set measures, which highlighted the need for improvements in the quality of care for adults with behavioral health diagnoses.

Health insurance coverage—public or private—is critically important for reducing financial barriers in access to quality care. While there is considerable evidence that adults covered by Medicaid generally have better access to care than uninsured adults, there is more limited research and mixed results when comparing access and quality of care among low-income adults with health coverage. The landmark Oregon Health Insurance Experiment found Medicaid enrollees had better access to primary care, preventive services, and self-reported physical and mental health relative to the control group.[58] A more recent analysis found that non-elderly

[57] Of the 10 frequently reported Adult Core Set measures for FFY 2014, each measure was reported by at least one state using a measurement period that differed from the measure technical specifications.

[58] Finkelstein A. et al. "The Oregon Health Insurance Experiment: Evidence from the First Year." The Quarterly Journal of Economics, August 2012, vol. 127, no. 3, pp. 1057–106.

adults covered by Medicaid were significantly more likely than the uninsured to have a usual source of medical care, and to have had a general doctor visit, and a specialty care visit in the past 12 months.[59] The limited research comparing access and quality of care among low-income adults with health coverage shows more mixed results. For example, data from two nationally representative surveys provide evidence that individuals covered by Medicaid have rates of access that are comparable to those of individuals with job-based coverage. One study, analyzing data from the 2013 National Health Interview Survey, found that when controlling for differences in demographics, health status, and socioeconomic factors, the percentage of nonelderly adults with a doctor visit or specialty care visit in the past year were not significantly different between Medicaid and job-based coverage, though the percentage of nonelderly adults with a usual source of care was slightly higher for those with job-based versus Medicaid coverage.[60] Similar findings were reported in an analysis of low-income adults using data from the 2003–2009 Medical Expenditure Panel Survey.[61] In contrast, an assessment that compared low-income adults covered by Medicaid to privately-insured adults (irrespective of their income) found that privately-insured adults had better access than adults covered by Medicaid on five (63 percent) of eight measures, but privately-insured adults fared about the same as adults covered by Medicaid on eight (50 percent) of 16 quality measures examined. Clearly more research is needed in this area, and CMS and states will continue to work together to measure performance and use the data collected to drive improvements in the quality of health care.

There are several CMS initiatives currently underway to better understand what we know about, and how to improve, access and quality of care for adults enrolled in Medicaid. Many of these initiatives are focused in areas that align with the Adult Core Set domains. In 2012, for example, CMS awarded Adult Medicaid Quality Grants to 26 states to develop their staff capacity to report on the Adult Core Set measures and use that data in quality improvement projects linked to the Core Set measures.[62] These efforts focused on a range of topic areas, including behavioral health, substance use disorders, maternity care, and diabetes. Many of these projects are underway now. Additionally, CMS's Medicaid Innovation Accelerator Program (IAP) is providing states with targeted program support, tools, and technical resources related to: (1) substance use disorders; (2) Medicaid beneficiaries with complex needs and high costs; (3) community integration using long-term services and supports; (4) and physical/mental health integration.[63] In July 2014, CMS also launched a Maternal and Infant Health Initiative to drive improvements in the care

[59] Paradise, J. "Medicaid Moving Forward." Kaiser Family Foundation, March 2015. Available at http://kff.org/health-reform/issue-brief/medicaid-moving-forward/.

[60] Paradise, J. "Medicaid Moving Forward." Kaiser Family Foundation, March 2015. Available at http://kff.org/health-reform/issue-brief/medicaid-moving-forward/.

[61] Coughlin, T. et al. "What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection Under Medicaid for Low-Income Adults." Kaiser Family Foundation, May 2013. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf; Kaiser Commission on Medicaid and the Uninsured. Health Coverage for Low-Income Americans, An Evidence-Based Approach to Public Policy, Figure 3 Jan 2007. Kaiser Family Foundation.

[62] More information about the Adult Medicaid Quality grants is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-medicaid-quality-grants.html.

[63] Information about the IAP is available at http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/innovation-accelerator-program.html.

provided during the postpartum period to improve the health outcomes of Medicaid and CHIP enrollees.[64] The Initiative is part of a comprehensive effort to develop and implement evidence-based policies and programs in Medicaid and CHIP. Core Set findings showing relatively modest use of preventive services when compared to other measures in this report show the need for materials such as the recently-released CMS *Living Well* toolkit to support Medicaid agencies in improving use of preventive services.[65]

The quality measurement and improvement initiatives underway in the states and at CMS are gaining momentum to accelerate improvements in the quality of health care provided to adults enrolled in Medicaid. As the momentum to pay for value rather than volume of services grows, state-specific performance data will be critical in guiding efforts to transform the systems of care that provide services to Medicaid enrollees.

[64] Information about the Maternal and Infant Health Initiative is available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-18-2014.pdf. The goals of the initiative are to: (1) increase by 10 percentage points the rate of postpartum visits among pregnant women in Medicaid and CHIP in at least 20 states over a 3-year period, and (2) increase by 15 percentage points the use of effective methods of contraception in Medicaid and CHIP in at least 20 states over a 3-year period.

[65] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-tools/living-well/living-well.html.

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TABLES

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Table 1. Overview of State Reporting of the Medicaid Adult Core Set Measures, FFY 2014

	Number of Measures Reported	Flu vaccinations for Adults Ages 18 to 64	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening in Women	Adult Body Mass Index Assessment	Screening for Clinical Depression and Follow-up Plan	Postpartum Care Rate	PC-01: Elective Delivery	PC-03: Antenatal Steroids	Antidepressant Medication Management	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Adherence to Antipsychotics for Individuals with Schizophrenia	Follow-Up After Hospitalization for Mental Illness	Medical Assistance With Smoking and Tobacco Use	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Comprehensive Diabetes Care: LDL-C Screening	PQI 01: Diabetes Short-Term Complications Admission Rate	PQI 05: COPD and Asthma in Older Adults Admission Rate	PQI 08: Heart Failure Admission Rate	PQI 15: Asthma in Younger Adults Admission Rate	Plan All-Cause Readmissions	Annual Monitoring for Patients on Persistent Medication	Controlling High Blood Pressure	HIV Viral Load Suppression	Care Transition – Transition Record Transmitted to Health Care Professional	CAHPS Health Plan Survey 5.0H – Adult Questionnaire
U.S. Total	16.5 (Median)	15	31	33	32	26	5	34	12	3	31	24	21	30	16	34	34	25	24	25	25	21	27	19	3	4	18
Alabama	18	X	X	X	X	X	X	X	X	--	X	--	X	X	--	X	X	X	X	X	X	X	--	--	--	--	--
Arkansas	17	--	X	X	X	--	--	X	X	--	X	--	X	X	--	X	X	X	X	X	X	X	X	--	--	X	--
California	15	--	X	X	X	--	--	X	--	--	X	X	X	--	--	X	X	X	X	X	X	X	X	--	--	--	--
Colorado	21	X	X	X	X	X	--	X	X	--	X	X	X	--	X	X	X	X	X	X	X	X	X	X	--	--	X
Connecticut	17	--	X	X	X	X	--	X	--	--	X	X	X	X	--	X	X	X	X	--	X	X	X	X	--	--	--
Delaware	21	X	X	X	X	X	--	X	X	X	X	X	X	X	X	X	X	--	--	X	X	--	X	X	X	--	X
Dist. of Col.	14	X	--	X	X	X	--	X	--	--	X	X	--	X	X	X	X	--	--	--	--	--	X	X	--	--	X
Georgia	25	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	X
Hawaii	14	--	X	X	X	X	--	X	--	--	X	X	--	X	--	X	X	--	--	--	--	X	X	X	--	--	X
Illinois	13	--	X	X	X	X	--	X	--	--	X	--	--	X	--	X	X	X	X	X	X	--	--	--	--	--	--
Indiana	18	--	X	X	X	X	X	X	--	--	X	X	X	X	--	X	X	X	X	X	X	X	X	--	--	--	--
Iowa	19	X	X	X	X	--	--	X	--	--	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	--	X
Kentucky	15	X	X	X	X	X	--	X	--	--	X	X	--	X	X	X	X	--	--	--	--	--	X	X	--	--	X
Louisiana	21	X	X	X	X	--	--	X	X	--	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	--	X
Massachusetts	15	--	X	X	X	X	--	X	X	--	X	X	--	X	--	X	X	--	--	--	--	X	X	X	--	X	--
Michigan	14	--	X	X	X	X	--	X	X	--	X	--	--	--	--	X	X	X	X	X	X	--	X	--	--	--	--
Minnesota	18	X	X	X	X	X	--	X	--	--	X	X	--	X	X	X	X	X	X	X	X	--	--	X	--	--	X
Mississippi	13	--	X	X	X	X	--	X	--	--	X	X	--	X	--	X	X	--	--	--	--	--	X	X	--	--	X
Missouri	12	--	X	X	X	X	--	X	--	--	X	--	X	X	--	X	X	--	--	--	--	X	X	--	--	--	--
Montana	16	--	X	X	X	--	--	X	--	--	X	X	X	X	--	X	X	X	X	X	X	X	X	--	--	--	--
New Hampshire	16	X	X	X	--	--	--	X	X	--	X	--	--	X	X	X	X	X	X	X	X	--	X	--	--	--	X
New Mexico	15	--	X	X	X	X	--	X	--	--	X	--	X	--	--	X	X	X	X	X	X	X	X	--	--	--	--
New York	24	X	X	X	X	X	--	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X
Ohio	12	--	--	X	X	--	--	X	--	--	X	X	X	X	--	X	X	X	--	X	--	X	--	--	--	--	--
Oklahoma	15	X	X	X	X	X	--	X	--	--	--	--	--	X	X	X	X	X	X	X	X	--	--	--	--	--	X
Oregon	19	X	--	X	X	X	X	X	X	--	--	X	--	X	X	X	X	X	X	X	X	X	--	X	--	--	X
Pennsylvania	21	X	X	X	X	X	--	X	--	--	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	X
Rhode Island	18	--	X	X	X	X	X	X	X	--	X	X	X	X	X	X	X	--	--	--	--	X	X	X	--	X	--
Tennessee	19	--	X	X	X	X	--	X	--	--	X	X	X	X	X	X	X	X	X	X	X	--	X	X	--	--	X
Texas	16	--	X	X	X	X	--	X	--	--	X	X	--	X	--	X	X	X	X	X	X	--	X	X	--	--	--

Table 1 (continued)

	Number of Measures Reported	Flu vaccinations for Adults Ages 18 to 64	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening in Women	Adult Body Mass Index Assessment	Screening for Clinical Depression and Follow-up Plan	Postpartum Care Rate	PC-01: Elective Delivery	PC-03: Antenatal Steroids	Antidepressant Medication Management	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Adherence to Antipsychotics for Individuals with Schizophrenia	Follow-Up After Hospitalization for Mental Illness	Medical Assistance With Smoking and Tobacco Use	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Comprehensive Diabetes Care: LDL-C Screening	PQI 01: Diabetes Short-Term Complications Admission Rate	PQI 05: COPD and Asthma in Older Adults Admission Rate	PQI 08: Heart Failure Admission Rate	PQI 15: Asthma in Younger Adults Admission Rate	Plan All-Cause Readmissions	Annual Monitoring for Patients on Persistent Medication	Controlling High Blood Pressure	HIV Viral Load Suppression	Care Transition – Transition Record Transmitted to Health Care Professional	CAHPS Health Plan Survey 5.0H – Adult Questionnaire
Vermont	21	X	X	X	X	X	--	X	--	--	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	X
Virginia	8	--	X	--	--	--	--	X	--	--	X	--	--	X	--	X	X	--	--	--	--	--	--	--	X	--	--	X
Washington	17	--	X	X	X	X	--	X	--	--	X	X	X	X	--	X	X	X	X	X	X	X	X	X	--	--	--	--
West Virginia	15	--	X	X	X	X	--	X	--	--	--	--	X	X	--	X	X	X	X	X	X	X	--	X	X	--	--	--

Source: Mathematica analysis of FFY 2014 CARTS reports, as of May 8, 2015.

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

X = measure was reported by the state; -- = measure was not reported by the state.

CARTS = CHIP Annual Reporting Template System; CAHPS = Consumer Assessment of Healthcare Providers and Systems; COPD = Chronic Obstructive Pulmonary Disease; HIV = Human Immunodeficiency Virus.

Table 2. Performance Rates on Frequently Reported Medicaid Adult Core Set Measures, FFY 2014

Measure	Measure Description	Number of States Reporting Using Core Set Specifications	Mean	Median	25th Percentile	75th Percentile
Primary Care Access and Preventive Care						
Breast Cancer Screening	Percentage of Woman Receiving Mammogram	31	51.5	52.5	46.2	59.2
Cervical Cancer Screening	Percentage Screened for Cervical Cancer	33	57.5	57.7	50.9	66.2
Chlamydia Screening	Percentage of Sexually Active Women Screened for Chlamydia	32	59.7	59.3	53.5	65.0
Body Mass Index (BMI) Assessment	Percentage with a BMI Value Documented	26	52.6	69.3	7.7	81.2
Maternal and Perinatal Health						
Postpartum Care Rate	Percentage of deliveries of live births that had a postpartum visit on or between 21 and 56 days after delivery.	34	54.4	58.2	42.5	63.9
Care of Acute and Chronic Conditions						
Comprehensive Diabetes Care	Percentage with diabetes (type 1 or type 2) who had a hemoglobin A1c (HbA1c) test	34	78.2	79.5	74.6	82.4
Comprehensive Diabetes Care	Percentage with diabetes (type 1 or type 2) who had a LDL-C screening test	34	68.4	67.6	64.2	75.6
Annual Monitoring for Patients on Persistent Medications	Percentage who received at least 180 treatment days of ambulatory medication therapy and annual monitoring	27	84.0	84.9	82.0	87.1
Behavioral Health						
Antidepressant Medication Management	Percentage Treated with Antidepressant Medication for 12 weeks	31	47.6	47.2	41.0	53.6
Antidepressant Medication Management	Percentage Treated with Antidepressant Medication for 6 months	31	31.4	31.2	24.9	36.7
Follow-Up After Hospitalization for Mental Illness	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit within 7 Days	30	39.0	37.0	25.5	54.7
Follow-Up After Hospitalization for Mental Illness	Percentage of Hospitalizations for Mental Illness with a Follow-Up Visit within 30 Days	30	56.7	57.3	45.0	71.9

Source: Mathematica analysis of FFY 2014 Adult CARTS reports as of May 8, 2015.

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

This table includes frequently reported Adult Core Set measures, defined as measures reported by at least 25 states using Adult Core Set specifications. This table includes data for states that used Adult Core Set specifications to report the measures and excludes states that used other specifications and states that did not report the measures for FFY 2014. Additionally, rates were excluded if a state reported a denominator less than 30. Means are calculated as the unweighted average of all state rates. PQI 01, 08 and 15 were all reported by at least 25 states, but will not be publicly reported this year due to data quality issues that CMS is actively working to address in collaboration with states. Measure-specific tables are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Adult-Core-Set-Measures-FFY-2014.zip.

BMI = body mass index; CARTS = CHIP Annual Reporting Template System; CMS = Centers for Medicare & Medicaid Services.

Table 3. Performance Improvement Projects (PIPs) Targeting Adults Included in External Quality Review (EQR) Technical Reports, by Topic Area, 2014–2015 Reporting Cycle

State	Years of Data	PIPs Validated[a]	PIP Population[b]	Number of PIPs	Asthma/ COPD	Behav. Health[c,d]	Cancer Screening	Cardiac Care	Care Transitions	Diabetes Care	ED Visits	Hospital Readmissions	Weight/ BMI	Other[e]
Total PIPs				565	22	154	35	17	22	101	34	91	10	115
Total States				34	11	20	11	7	7	20	12	15	7	17
Arizona	Varies by PIP	All	U	14	--	1*	--	--	--	--	--	13*	--	--
California	2013	All	A	41	--	1	2	2	--	9	--	23*	--	4
			A/C	1	1	--	--	--	--	--	--	--	--	--
			U	2	--	--	--	--	--	--	1	--	--	1
Colorado	FY2013–2014	All	A	3	--	1	--	--	--	--	--	--	1	1
			U	3	--	3	--	--	--	--	--	1	--	--
Florida	Varies by PIP	Some	A	27	--	1	1	--	1	8	--	1	--	15
			A/C	17	2	13*	--	--	--	--	--	2	--	--
			U	43	--	6	--	--	1	1	2	2	1	31
Georgia	2013	All	A	3	--	--	--	--	--	3*	--	--	--	--
			U	6	--	--	--	--	--	--	--	--	--	6*
Hawaii	Varies by PIP	All[f]	A	14	--	2	--	--	--	7*	--	5*	--	--
			A/C	2	--	--	--	--	--	--	--	--	2	--
Illinois	2012–2013	All[f]	U	4	--	--	--	--	2	--	--	2*	--	--
Iowa	2013	All	A	1	--	--	--	--	--	1	--	--	--	--
			A/C	1	1	--	--	--	--	--	--	--	--	--
Kansas	Varies by PIP	All[f]	A	3	--	--	--	--	--	3*	--	--	--	--
			A/C	2	--	2	--	--	--	--	--	--	--	--
Kentucky	2013	All	A	4	1	2	--	--	--	--	1	--	--	--
			A/C	6	1	2	--	--	--	--	3	--	--	--
			U	1	--	--	--	--	--	--	--	1	--	--
Louisiana	2013–2014	All[f]	A	4	--	--	4	--	--	--	--	--	--	--
			A/C	4	--	--	--	--	--	--	4*	--	--	--
Maryland	2013	All	A	6	--	--	--	6*	--	--	--	--	--	--
Massachusetts	Varies by PIP	All[f]	A	14	--	2*	--	1	--	3	--	7*	--	3
			U	5	--	5*	--	--	--	--	--	5*	--	--
Michigan	2013–2014	All	A	5	--	--	--	--	--	3	--	--	1	1
Minnesota	Varies by PIP	All	A	29	3	1	9*	--	5	9*	1	--	--	1
			A/C	3	--	--	--	--	--	--	--	--	--	--
			U	19	2	9*	--	--	2	--	1	1	--	6

Table 3 (continued)

State	Years of Data	PIPs Validated[a]	PIP Population[b]	Number of PIPs	Asthma/ COPD	Behav. Health[c,d]	Cancer Screening	Cardiac Care	Care Transitions	Diabetes Care	ED Visits	Hospital Readmissions	Weight/ BMI	Other[e]
Mississippi	2013	All	A	5	--	--	--	3	--	2	--	--	--	--
			A/C	4	2	--	--	--	--	--	--	--	2	--
Missouri	2013	All[f]	A/C	1	--	1	--	--	--	--	--	--	--	--
			U	1	1	--	--	--	--	--	--	1	--	--
Nebraska	Varies by PIP	All	A	2	--	--	1	--	--	--	--	1	--	--
			A/C	4	--	1	--	--	--	--	3	--	--	--
			U	1	--	1	--	--	--	--	--	--	--	--
Nevada	2013–2014	All	A	1	--	--	--	--	--	1*	--	--	--	--
			A/C	2	--	--	--	--	--	--	2*	--	--	--
New Hampshire	2013–2014	All	A	5	--	2	--	--	--	3	--	--	--	--
			A/C	3	--	2*	--	--	--	--	--	--	--	1
			U	3	--	--	--	--	--	--	--	1	--	2*
New Jersey	2013	All	A	4	--	--	--	1	--	1	--	--	--	2
			U	1	--	--	--	--	--	--	--	--	1	--
New Mexico	2012–2013	All[f]	A	11	--	--	4	--	2*	5	--	--	--	--
			A/C	1	1	--	--	--	--	--	--	--	--	--
North Carolina	Varies by PIP	Some	A/C	1	--	--	--	--	--	--	--	--	--	1
			U	12	--	6	--	--	--	--	1	--	--	5
Ohio	2013	All[f]	A	7	--	--	--	--	--	7*	--	--	--	--
Oregon	Varies by PIP	Some	A	36	1	16*	1	1	--	16*	--	--	--	1
			U	13	--	6	--	--	--	--	1	4	--	5
Pennsylvania	Varies by PIP	Some	A	2	--	--	--	--	--	--	1*	--	--	1*
			A/C	5	--	5*	--	--	--	--	--	--	--	--
			U	20	--	11*	--	--	--	--	8*	12*	--	--
Rhode Island	2013	All	A	2	--	1	1	--	--	--	--	--	--	--
			A/C	4	--	--	--	--	--	--	--	--	--	4*
South Carolina	2013	All[f]	U	2	--	--	--	--	--	--	--	--	--	2
Tennessee	2013–2014	All	A	10	--	5	--	--	2	3	--	--	--	--
			A/C	3	--	3	--	--	--	--	--	--	--	--
			U	14	--	--	--	--	--	--	--	--	--	14
Utah	2012	All	A	3	--	1	1	--	--	1	--	--	--	--
			A/C	1	--	1	--	--	--	--	--	--	--	--
			U	9	--	9	--	--	--	--	--	--	--	--
Virginia	2013	All	A/C	7	--	7*	--	--	--	--	--	--	--	--

Table 3 (continued)

State	Years of Data	PIPs Validated[a]	PIP Population[b]	Number of PIPs	Asthma/ COPD	Behav. Health[c,d]	Cancer Screening	Cardiac Care	Care Transitions	Diabetes Care	ED Visits	Hospital Readmissions	Weight/ BMI	Other[e]
Washington	2014	All	A	8	--	2	2	--	--	--	1	2	1	1
			U	15	--	8	--	--	6*	--	--	5*	1	2
West Virginia	2013	All[f]	A	3	--	--	--	--	--	3	--	--	--	--
			A/C	3	3*	--	--	--	--	--	3*	--	--	--
Wisconsin	FY2013–2014	Some	A	24	--	--	8	3	--	12	--	1	--	3
			A/C	7	--	7	--	--	--	--	--	--	--	--
			U	15	2	8	1	--	1	--	1	1	--	1

Source: EQR technical reports submitted to CMS for the 2014–2015 reporting cycle, as of April 30, 2015.

Notes: During the 2014–2015 reporting cycle, the following states and territories did not contract with any MCOs or PIHPs: AL, AK, AR, CT, GU, ME, MT, OK, SD, VI, and WY. ND only had CHIP managed care. ID recently implemented an MCO for its dual eligible population; it has not yet produced an EQR report. In addition, IN, PR, and TX did not submit an EQR technical report before April 30, 2015 for inclusion in this analysis. While VT is required to conduct an EQR under the terms of its section 1115 demonstration, its managed care entity is neither an MCO nor PIHP and therefore is excluded from this analysis.

Four states that submitted EQR technical reports are excluded from this table. EQR technical reports for DE and NY did not include any information about PIPs. The only PIPs reported in the EQR technical reports for DC and ND focused exclusively on children or pregnant women and are not included in this table.

This table includes PIPs targeting adults from the submitted EQR technical reports, including PIPs that also targeted children and pregnant women. PIPs that exclusively target children or pregnant women are included in Table 3 of the 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP.

PIPs that focused on multiple topic areas are shown in all of the relevant topics. Each PIP is included only once in the number of PIPs for each state, so the number of PIPs in the topic areas may not sum to the total count in some states.

[a] Use of the term "validation" differed across EQR reports. In this analysis, validation indicates that the EQRO reported reviewing information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accordance with standards for data collection and analysis. Some PIPs that were reviewed in the validation process did not meet all of the review criteria.

[b] PIPs are categorized based on the target population as described in the EQR technical reports. A=Adults Only; A/C = Adults and Children; U = Unspecified ages. PIPs that target children or pregnant women exclusively are not included in this table.

[c] The Behavioral Health category includes PIPs that focus on tobacco cessation and treatment of mental health and substance use disorders (SUDs) including use of alcohol and other drugs.

[d] During the 2014–2015 reporting cycle, the following states had PIPs that focused on substance use disorder: Arizona (1 PIP and 1 collaborative PIP across 13 MCOs); California (1 PIP); Hawaii (1 PIP); Kansas (1 PIP); Massachusetts (7 PIPs); Oregon (3 PIPs); Tennessee (1 PIP); Utah (1 PIP); Wisconsin (11 PIPs).

[e] Other PIP topic areas include member satisfaction (FL, GA, NH, SC), advance care directives (CA, FL, OR), balance billing (FL, TN), access to care (MI, SC), fall rate (PA, WI), care for older adults (CA), use of high-risk medication in the elderly (CA), annual monitoring for patients on persistent medication (CA), patient experience (CA), medication review (FL), call center timeliness (FL), use of a patient-centered care plan (FL), satisfaction with health plan (FL), improving access to culturally and linguistically appropriate services (FL), reducing disparities in cultural competence among practicing physicians (FL), first call resolution (FL), telephone answer speed (FL), using an organization assessment to implement trauma-informed care (FL), improved satisfaction with cultural and language services with people living with HIV/AIDS (FL), timeliness of services for long-term care services (FL), electronic health records with meaningful use (FL), number of health risk assessments (FL), number of community health workers (FL), home-based medication reconciliation after hospital discharge (MN), increasing annual preventive and diagnostic dental services (MN), medication management (NJ), call rollover (NC), decreasing concurrent requests for reauthorization of care while in an inpatient setting (NC), improving the accuracy of level of care assessments on authorization requests (NC), improving compliance with first appointment time frames for urgent cases (NC), increasing provider networks use and implementation of evidence-based practices (NC), timely submission of update assessments (NC), stakeholder access to patient information (NC), community outreach program for members who are super-utilizers (OR), number of patient-centered primary care medical home users (OR), initial health screens for special enrollment populations (RI, WA), timely recredentialing of providers (TN), cultural assessment and cultural integration survey (TN), accountable and collaborative care (WA), and reducing member grievance calls (WA). CD4 count and viral load testing (CA, FL), access to preventive/ ambulatory care services (CO), chlamydia screening in women (MN, RI), improving adherence to statins (NJ), and integrating chronic pain management into primary care (OR).

Table 3 (continued)

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

* PIP topic was mandated by the state.

A = Adults only; A/C = Adults and children; Behav. = Behavioral; BMI = body mass index; CHIP = Children's Health Insurance Program; COPD = chronic obstructive pulmonary disease; EPSDT = Early and Periodic Screening, Diagnostic and Treatment; EQRO = External Quality Review Organization; FY = fiscal year; MCO = managed care organization; PIHP = prepaid inpatient health plan; U = Unspecified ages.

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FIGURES

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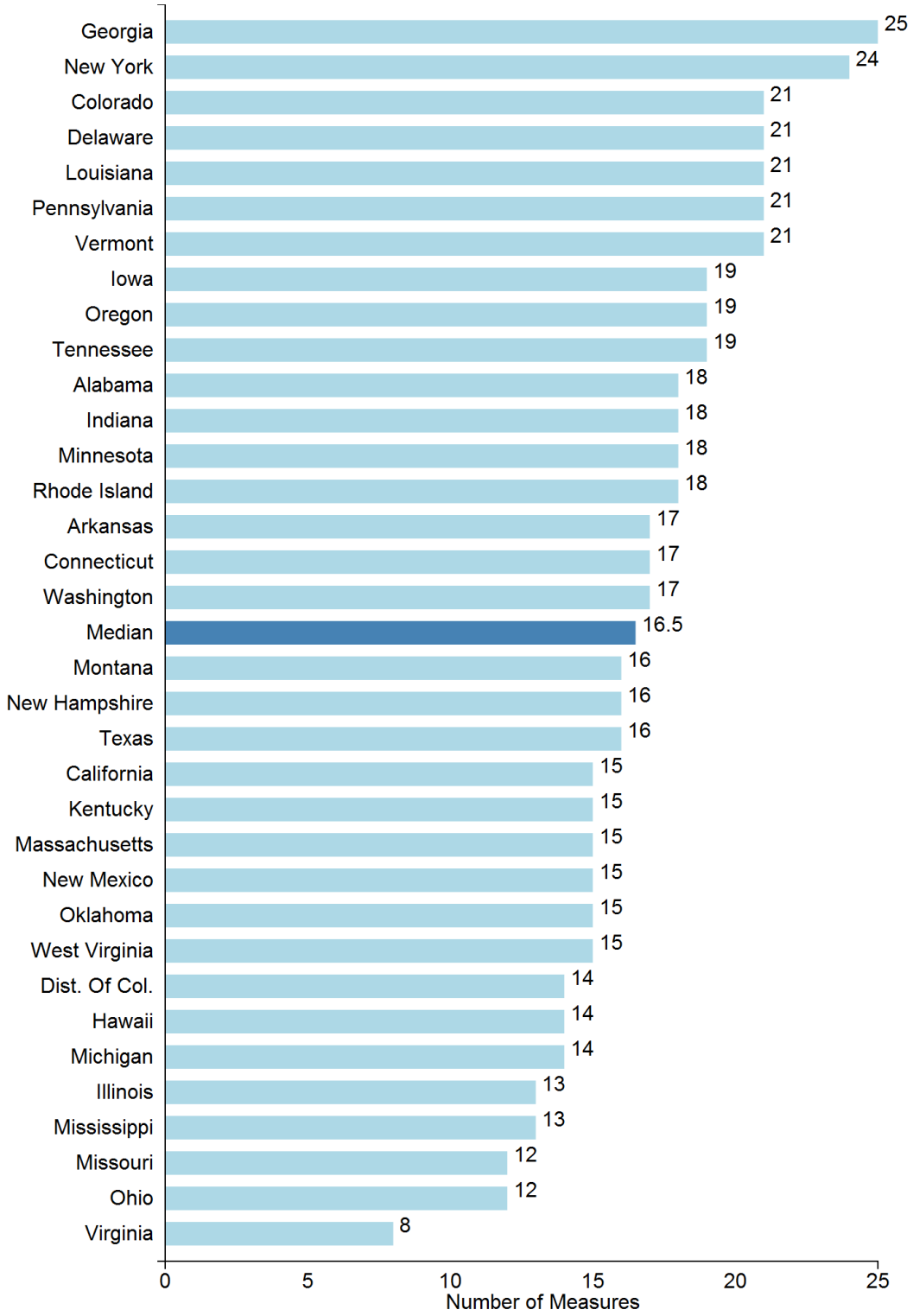
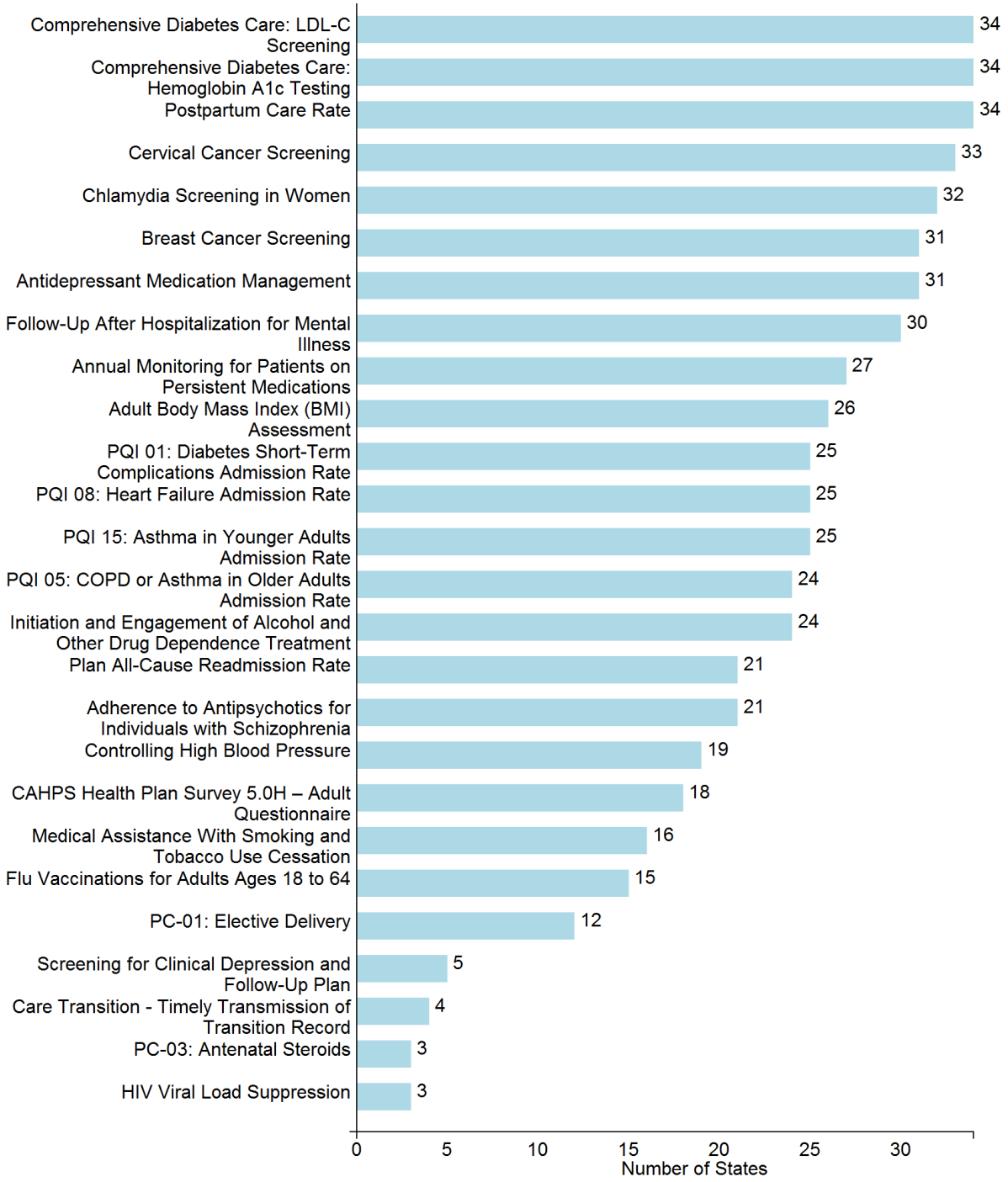
Figure 1. Number of Medicaid Adult Core Set Measures Reported by States, FFY 2014



Source: Mathematica analysis of FFY 2014 Adult CARTS reports as of May 8, 2015.

Notes: The term "states" includes the 50 states and the District of Columbia.
This figure is based on state reporting of 26 Core Set measures for FFY 2014.

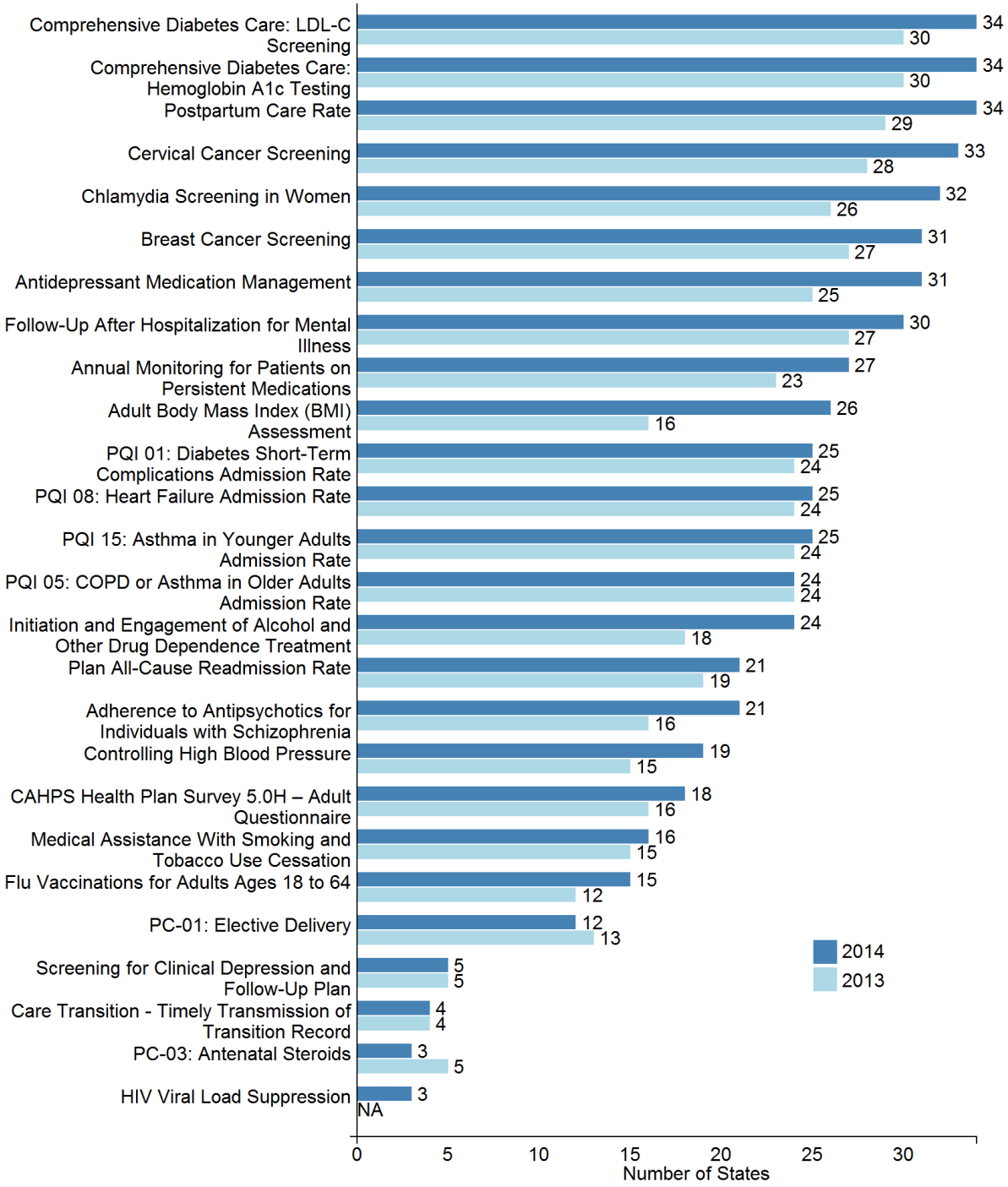
Figure 2. Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2014



Source: Mathematica analysis of FFY 2014 Adult CARTS reports as of May 8, 2015.

Notes: The term "states" includes the 50 states and the District of Columbia.
This figure is based on state reporting of 26 Core Set measures for FFY 2014.

Figure 3. Changes in the Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2013–2014



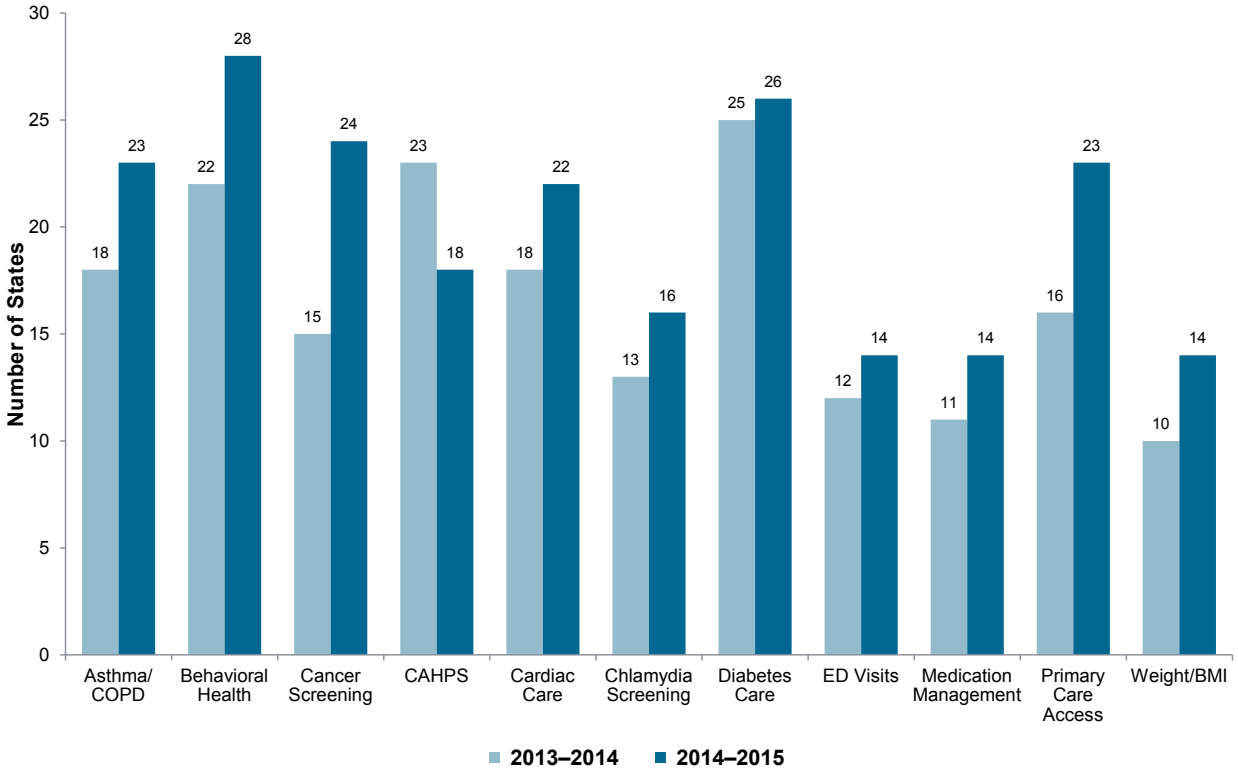
Source: Based on Mathematica analysis of FFY 2013–2014 Adult CARTS reports as of May 8, 2015.

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

The FFY 2013 and FFY 2014 Medicaid Adult Core Sets both include 26 measures. The Annual HIV Medical Visit measure was included in the FFY 2013 Core Set, but was retired for FFY 2014 reporting. This measure was replaced by the HIV Viral Load Suppression measure for FFY 2014.

NA = measure was not collected for FFY 2013.

Figure 4. Comparison of Performance Measures Evaluating Adults' Health Care Quality that were Reported in External Quality Review (EQR) Technical Reports for the 2013–2014 and 2014–2015 Reporting Cycles for 33 States, by General Topic



Sources: Performance measures for 2013–2014 obtained from the 2014 Secretary's Report on the Quality of Care for Adults in Medicaid. Performance measures for 2014–2015 are based on Mathematica Policy Research analysis of 2014–2015 EQR technical reports.

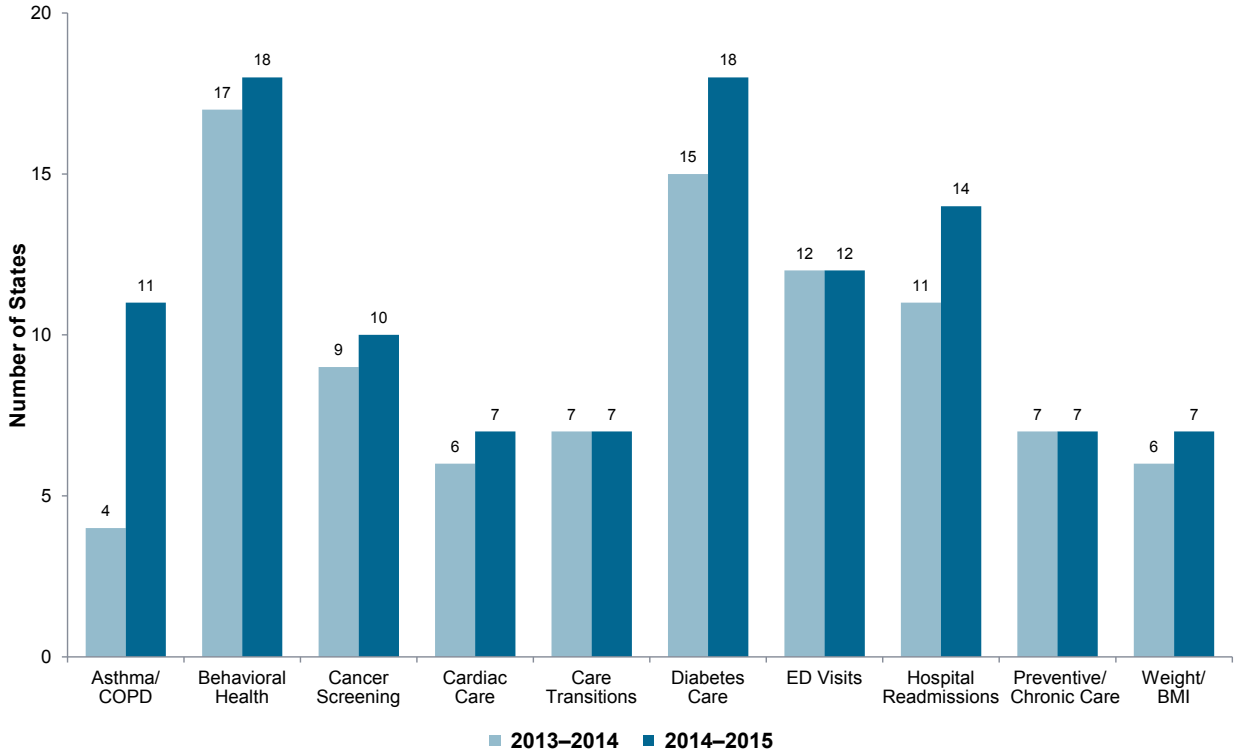
Notes: States include AZ, CA, CO, DC, FL, GA, HI, IL, IA, KS, KY, LA, MD, MA, MI, MN, MO, NE, NV, NJ, NM, NY, NC, OH, OR, PA, RI, SC, TN, VA, WA, WV, and WI. These are the states that reported performance measures in both comparison years.

The Behavioral Health category includes performance measures that focus on tobacco cessation and treatment of mental health and substance use disorders (SUDs) including use of alcohol and other drugs.

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

BMI = body mass index; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CHIP = Children's Health Insurance Program; COPD = chronic obstructive pulmonary disease; ED = emergency department; MCO = managed care organization; PIHP = prepaid inpatient health plan; PIP = performance improvement project; SUD = substance use disorder.

Figure 5. Comparison of Performance Improvement Projects (PIPs) Targeting Adults that were Reported in External Quality Review (EQR) Technical Reports for the 2013–2014 and 2014–2015 Reporting Cycle for 32 States, Selected Topics



Sources: PIPs for 2013–2014 were obtained from the 2014 Secretary's Report on the Quality of Care for Adults in Medicaid and CHIP. PIPs for 2014–2015 are from Mathematica Policy Research analysis of 2014–2015 EQR technical reports.

Notes: States include AZ, CA, CO, FL, GA, HI, IL, IA, KS, KY, LA, MD, MA, MI, MN, MS, MO, NE, NV, NJ, NM, NC, OH, OR, PA, RI, SC, TN, VA, WA, WV, and WI. These are the states that reported PIPs in both comparison years.

The Behavioral Health category includes PIPs that focus on tobacco cessation and treatment of mental health and substance use disorders (SUDs) including use of alcohol and other drugs.

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

BMI = body mass index; CHIP = Children's Health Insurance Program; COPD = chronic obstructive pulmonary disease; ED = emergency department; MCO = managed care organization; PIHP = prepaid inpatient health plan; PIP = performance improvement project; SUD = substance use disorder.

GLOSSARY

ABA	Adult Body Mass Index Assessment
Affordable Care Act	The Patient Protection and Affordable Care Act
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
AMM	Antidepressant Medication Management
AOD	Alcohol or Other Drug
BCS	Breast Cancer Screening
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBP	Controlling High Blood Pressure
CCS	Cervical Cancer Screening
CD4	Cluster of Differentiation 4
CDF	Screening for Clinical Depressions and Follow-Up Plan
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHL	Chlamydia Screening in Women
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPA	CAHPS Health Plan Survey 5.0H – Adult Questionnaire
CTR	Care Transition – Timely Transmission of Transition Record
ED	Emergency Department
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFY	Federal Fiscal Year
FUH	Follow-Up After Hospitalization for Mental Illness
FVA	Flu Vaccinations for Adults Ages 18 to 64
FY	Fiscal Year
HA1C	Comprehensive Diabetes Care: Hemoglobin A1c Testing
HbA1c	Hemoglobin A1c
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIO	Health Insuring Organization
HIV	Human Immunodeficiency Virus
HVL	HIV Viral Load Suppression
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
LDL	Comprehensive Diabetes Care: LDL-C Screening

LEP	Limited English Proficiency
LTSS	Long-Term Services and Supports
MAP	Measure Applications Partnership
MAX	Medicaid Analytic eXtract
MCO	Managed Care Organization
MPM	Annual Monitoring for Patients on Persistent Medication
MSC	Medical Assistance with Smoking Cessation
NA	Not Available
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PC-01	Elective Delivery
PC-03	Antenatal Steroids
PCP	Primary Care Practitioner/Provider
PCR	Plan All-Cause Readmission Rate
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPC	Postpartum Care Rate
PQI 01	Diabetes Short-Term Complications Admission Rate
PQI 05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
PQI 08	Hearth Failure Admission Rate
PQI 15	Asthma in Younger Adults Admission Rate
SAA	Adherence to Antipsychotics for Individuals with Schizophrenia
SUD	Substance Use Disorder
TA/AS	Technical Assistance and Analytic Support
TEFT	Testing Experience and Functional Assessment Tools

MEASURE APPLICATIONS PARTNERSHIP

Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2015

FINAL REPORT

AUGUST 31, 2015

NATIONAL QUALITY FORUM

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I, Task Order HHSM-500-T0011.

CONTENTS

EXECUTIVE SUMMARY

Medicaid, the primary health insurance program for low-income Americans, served 72.8 million individuals in 2013.[1] Enrollment is growing as people become newly eligible for Medicaid under the low-income adult group established by the Affordable Care Act (ACA).[2] Medicaid has also traditionally offered healthcare coverage to many of the individuals with the highest medical and social needs. Among current working age Medicaid enrollees—the segment of the Medicaid population growing most rapidly—an estimated 57 percent of adults are overweight, have diabetes, hypertension, high cholesterol, or a combination of these conditions.[3,4,5] Understanding the needs of the adult Medicaid population in order to improve health and the quality of health care is paramount.

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

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

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

MAP received numerous public comments on its draft recommendations as part of its transparent and open process. Most comments supported the measurement changes MAP recommended and further amplified the strategic issues noted. These include the alignment of measures across programs, an approach to selecting measures that will maximize health outcomes, and enabling quality improvement activities within states.

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

Rank	Measure Name and NQF Number, if applicable
1	Use of Contraceptive Methods by Women Aged 21-44 Years (not NQF-endorsed)
2	NQF #2602: Controlling High Blood Pressure for People with Serious Mental Illness
3/4/5 (tie)	NQF #1927: Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
	NQF #1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
	Effective Postpartum Contraception Access (not NQF-endorsed)
6	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multiple-provider, high dosage (not NQF-endorsed)
7	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multiple prescribers and multiple pharmacies (not NQF-endorsed)
8/9 (tie)	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage (not NQF-endorsed)
	NQF #1799: Medication Management for People with Asthma

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

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

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

BACKGROUND ON MEDICAID AND THE ADULT CORE SET

Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals. Medicaid is financed through a federal-state partnership, in which each state designs and operates its own program within federal guidelines. Medicaid is a longstanding program that served 72.8 million individuals in 2013, about half of whom were adults.[6] This figure is expected to grow as it includes an increasing number of people newly eligible for Medicaid under the low-income adult group established by the Affordable Care Act.[7] Medicaid also provides coverage for low-income individuals with disabilities and those who are elderly, along with supplemental coverage for Medicare enrollees, also known as dual eligible beneficiaries.[8]

Medicaid covers a broad range of services to meet the diverse needs of its enrollees, and performance measurement should also be designed to address these diverse needs. States determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory" services through the Medicaid program (e.g., hospital care, laboratory services, and physician/nurse midwife/certified nurse practitioner services).[9] Many states also cover services that federal law designates as optional for adults, including prescription drugs, dental care, and durable medical equipment. Notably, Medicaid also covers a broad spectrum of long-term services and supports (LTSS) not provided by Medicare or private payers. As a result, Medicaid is the most significant source of financing for nursing home and community-based long-term care.

Medicaid Adult Population

Medicaid offers healthcare coverage to many of the individuals with the highest medical and social needs, many of whom could not obtain commercial insurance in the past. As a result, adults with Medicaid are both poorer and sicker than low-income adults with private health insurance. Even among adults with similarly low incomes, those with Medicaid report both worse health and worse mental health.[10] Adults with Medicaid also have higher rates of both multiple chronic conditions and functional activity limitations than those of the same income levels with employer sponsored insurance or even those who are uninsured.[11]

Among current working age adult Medicaid enrollees—the segment of the Medicaid population growing most rapidly—an estimated 57 percent of adults are overweight, have diabetes, hypertension, high cholesterol, or a combination of these conditions.[12,13,14] Behavioral health conditions are prevalent and often complicate the course of other medical conditions.[15] Racial and ethnic minority populations are disproportionately represented among Medicaid enrollees, warranting attention to addressing health disparities. All of these factors, and others, contributed to MAP's understanding of the healthcare needs of the adult Medicaid population and influenced its recommendations on the most important measures of quality.

Medicaid Adult Core Set

Legislation called for the creation of a core set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid. HHS established the Adult Core Set to standardize the measurement of healthcare quality across state Medicaid programs, assist states in collecting and reporting on the measures, and facilitate use of the measures for quality improvement.[16] HHS published the initial Adult Core Set of measures in January 2012 in partnership with a subcommittee to the Agency for Healthcare Research and

Quality's (AHRQ) National Advisory Council.[17] It has been updated annually since that time, with recent iterations reflecting input from MAP.

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

The Adult Core Set is often regarded as providing a snapshot of quality within Medicaid. It is not comprehensive, but prior to its creation and implementation, performance measurement varied greatly by state, and it was not possible to discern an overall picture of quality. Statute requires CMS to release annual reports on behalf of the Secretary on the reporting of state-specific adult Medicaid quality information. CMS also issues reports to Congress on this subject every three years.

Characteristics of the Current Adult Core Set

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

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

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

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

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

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

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

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

STATE EXPERIENCE COLLECTING AND REPORTING THE ADULT CORE SET

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

Washington

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

Washington's medical and mental health delivery systems are currently operated through separate managed care plans. Long-term care and home and community-based services (HCBS) are outside the managed care plans, and therefore dual eligible beneficiaries are mainly in fee-for-service

programs. Among the state's quality improvement activities is a focus on building cross-system integration, including reducing re-hospitalizations from both psychiatric facilities and nursing homes. Both initiatives have resulted in system-wide savings and fewer readmissions by targeting consumers with repeat readmissions and engaging them in care.

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

Pennsylvania

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

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

MAP REVIEW OF THE ADULT CORE SET

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

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

MAP examined NQF-endorsed measures and other measures in the development pipeline. MAP generally favored measures that are able to be implemented at the state level, promote parsimony and alignment, and address prevalent and/or high-impact health conditions for adults enrolled in Medicaid. NQF-endorsed measures were also favored because they have been successfully evaluated through a separate consensus-based process for importance, evidence, scientific acceptability of measure properties, and other rigorous criteria. Following discussion of each measure, MAP voted to determine if there was sufficient support from Task Force members to consider it for addition to the Core Set. Measures MAP examined but did not ultimately support for use in the program at this time are listed in Appendix F.

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

Measure-Specific Recommendations

Current Measures and Recommendation for Removal

MAP noted that states' participation in reporting the Adult Core Set is strong, though there is much room for improvement in both the total number of states submitting measurement data and the number of states reporting each measure. Given the relative newness of the program, participation is expected to be lower than for the Child Core Set, but ideally would increase each year. Not finding many significant implementation problems with the current measures, MAP was comfortable supporting all but one for continued use. Maintaining stability in the measure set will allow states to continue to gain experience reporting the measures, potentially increasing the number of states submitting quality information to CMS and using the measures locally to drive quality improvement.

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

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

Multiple state representatives gave negative feedback about their attempts to collect and use measure #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care). While generally supportive of the need to measure care coordination, this measure was thought to be too facility-centric for the state Medicaid agency to influence quality improvement. States also faced difficulty collecting all of the data required for the measure. Low feasibility is evident in the consistently low levels of state reporting of the measure, with just four states submitting data for the past two years. MAP recommends CMS remove this measure from the Adult Core Set since doing so may free up bandwidth to use more effective measures. Public commenters generally agreed with the MAP recommendation to remove this measure, though one comment dissented due to the importance of care coordination.

Measures for Phased Addition to the Adult Core Set

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

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

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

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

The use of recommended measures would strengthen the measure set by promoting measurement of a variety of high-priority quality issues, including reproductive health, chronic disease management for people with serious mental illness, and the prevention of substance abuse. Further explanation and rationale regarding MAP's support for these measures follows, in order of topic area beginning with maternal/perinatal care. Overall, public comments indicated support for MAP's recommended additions to the measure set. A small number of commenters requested addition of other measures; these were either reviewed and failed to gain MAP's support or did not correspond to a gap area noted by MAP.

Recognizing that three-quarters of women enrolled in Medicaid are in their reproductive years, MAP conducted a lengthy discussion of the maternal and perinatal care measures.[18] Measures in this topic area are currently included in both the Child Core Set and Adult Core Set of measures. The group reviewed a large volume of available measures to determine which measures would be the most effective additions to state-level reporting. MAP conditionally supports two reproductive health measures related to contraception use.

Use of Contraceptive Methods by Women Aged 21-44 Years (not NQF-endorsed)

This measures the rate of contraceptive use among women who could experience unintended pregnancy. It complements a related measure of a different age group (15-20) that MAP conditionally supported for the Child Core Set. The measure captures use of both moderately (e.g., injectables) and highly (e.g., LARC)

effective forms of contraception. After detailed discussion of potential ethical implications and strong agreement that the target rate for this measure would be well below 100 percent, MAP conditionally supported the measure and recommended that it be reviewed by NQF for endorsement. Several commenters supported the inclusion of this contraceptive measure, but emphasized the importance of NQF endorsement to clarify and make transparent the detailed measure specifications.

Effective Postpartum Contraception Access (not NQF-endorsed)

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

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

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

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

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

Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer; Opioid High Dosage, Multiple Prescribers and Multiple Pharmacies, and Multi-Provider/High Dosage (not NQF-endorsed)

After hearing from states that early intervention for people who are prescribed opioid medications is important to prevent addiction and a pathway to illegal heroin use, MAP conditionally supported three measures recently developed by the Pharmacy Quality Alliance (PQA). They are three closely related measures of potential overuse that address the epidemic of narcotic morbidity and mortality.[19] All are supported conditionally pending successful NQF endorsement.

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

MAP conditionally supports NQF measure #1799 pending completion of the measure's annual

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

MAP received comments that alternative asthma medication management measures, NQF #1800: Asthma Medication Ratio (AMR) and NQF #0548: Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT), may be superior. Because MAP did not have the opportunity to conduct a detailed review of the suggested measures prior to these recommendations being due, it was determined that all of the asthma measures will be deliberately examined in the next annual review of the Adult and Child Core Sets.

Remaining High Priority Gaps

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

Adult Core Set Measure Gaps

- Access to primary, specialty, and behavioral health care
- Beneficiary-reported outcomes
  - Health-related quality of life*
- Care coordination
  - Integration of medical and psychosocial services
  - Primary care and behavioral health integration
- Cultural competency of providers
- Efficiency
  - Inappropriate emergency department utilization
- Long-term supports and services
  - Home and community-based services*
- Maternal health
  - Inter-conception care to address risk factors
  - Poor birth outcomes (e.g. premature birth)
  - Postpartum complications
  - Support with breastfeeding after hospitalization*
- Promotion of wellness
- Treatment outcomes for behavioral health conditions and substance use disorders
  - Psychiatric re-hospitalization*
- Workforce
- New chronic opiate use (45 days)*
- Polypharmacy*
- Engagement and activation in healthcare*
- Trauma-informed care*

Public commenters supported MAP's assessment of high priority measure gaps for the Adult Medicaid population, noting the relevance of these issues in the enrollee population. One commenter particularly emphasized the gap areas of psychiatric re-hospitalizations, new chronic opiate use, polypharmacy, trauma-informed care, and engagement and activation in health care. Another comment suggested MAP could more systematically analyze measurement needs to determine if current efforts are adequate.

STRATEGIC ISSUES

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

Alignment

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

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

MAP's discussion also acknowledged that if alignment is over-emphasized, it could lead to a few measures having an outsized effect on provider behavior. For example, if a small number of measures become part of multiple influential programs, it could sharpen focus on them to the detriment of other opportunities. When measures are used across multiple programs simultaneously, it is especially important that they warrant the compounded incentives. Measures best suited for widespread use should be able to influence desirable health outcomes, as opposed to minute process steps.

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

Reproductive Health

One of Medicaid's core functions is to ensure that pregnant women and young children have access to health services that are vital for a healthy birth and lifelong wellness. Female reproductive healthcare continues from puberty to menopause, and the health outcomes of a woman and her child

or children are highly intertwined. As a result, MAP considered measurement of reproductive health across the lifespan and its implications for both the Child and Adult Core Sets.

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

Reproductive health is already the most frequently measured topic across the Child and Adult Core Sets, and MAP's 2015 recommendations would further expand it. Measures of contraceptive access and use gained strong, albeit conditional, support from MAP because of the robust and growing evidence that well-timed, intentional pregnancies are associated with better health outcomes for both the mother and the infant. Additionally, there is significant opportunity for improvement and cost effectiveness in this area. For example, 11 states have made specific policy changes to encourage placement of long-acting reversible contraception immediately postpartum, with the potential for others to follow.

Increasing State-Level Capacity for Quality Improvement

Peer-to-Peer Learning and Collaboration

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

Strategies to Understand and Address Disparities

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

Stratification of measures by such factors of interest is one strategy that can be used to better understand and address disparities. For

example, MAP members suggested that states and CMS more deeply examine the performance of certain measures, such as screenings for breast and cervical cancer, to ensure care is equitable. Different strata could be created for other measures, as appropriate. Once made transparent, any disparities discovered are more easily understood and addressed with targeted action.

Appropriate Performance Benchmarks

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

MAP discussed that setting appropriate performance expectations is especially important for measures where 100 percent compliance is either unrealistic or potentially harmful. This is the case for the conditionally supported measures of contraceptive use, though it applies to other topics as well. The framing of how the measures should be interpreted is both important and sensitive to many stakeholder groups. It must be clear that by measuring rates of contraceptive use, the program would not be setting a universal expectation that all women should use contraceptives. Many women, in collaboration with their healthcare providers, choose to forego contraception for a variety of reasons. It is imperative that this choice be honored. However, many women who are interested in avoiding or delaying pregnancy lack access to effective family planning education and resources. To use another example, measurement of emergency department utilization would be expected to operate in much the same way. The expectation of the measure is not to reach zero percent; rather, it is to ensure that consumers are able to have routine health needs met in less costly and less acute environments before conditions are exacerbated to the point that urgent treatment is required.

Comments from hospitals, health plans, and other stakeholders were supportive of each of these strategic issues. They amplified MAP's discussion that encouraged use of measures derived from administrative and survey data, rather than chart review. Additionally, they strongly supported emphasis on behavioral and reproductive health, including synchronizing and aligning the Adult and Child Core Sets to provide a view of quality across an individual's lifespan.

CONCLUSION

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

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

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

ENDNOTES

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APPENDIX A:
MAP Background

Purpose

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

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

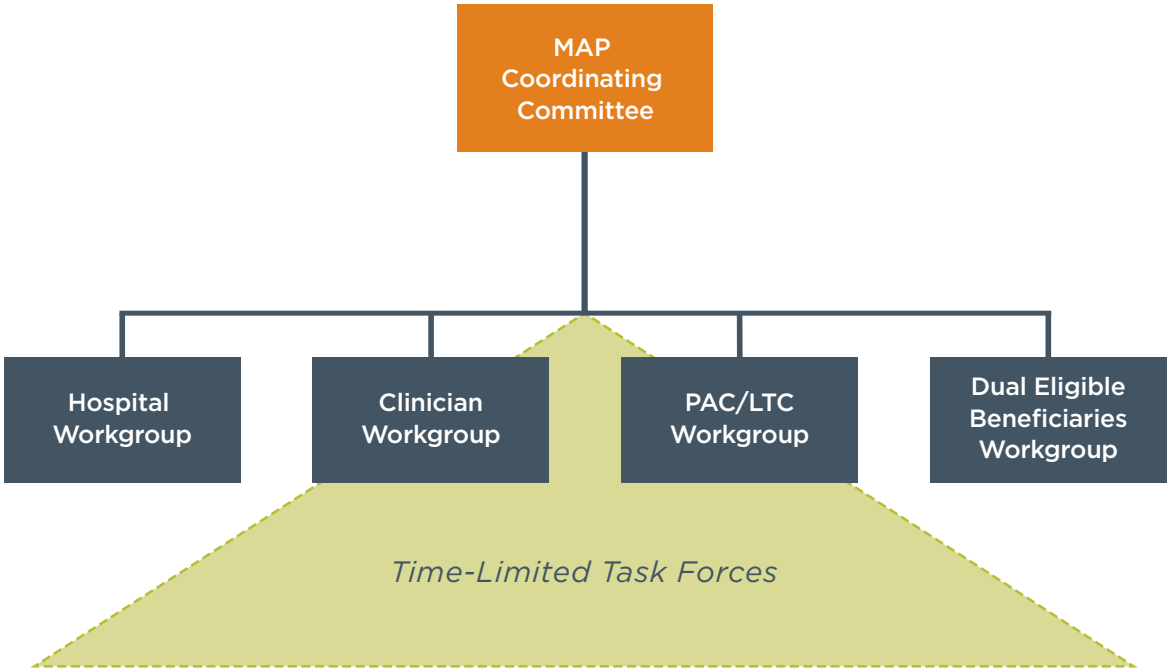
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for 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 whether measures are having their intended impact and are driving improvement, transparency, and value. Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements. MAP seeks to engage in bidirectional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

Structure

MAP operates through a two-tiered structure (see Exhibit A1). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and provides final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with 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.

EXHIBIT A1. MAP STRUCTURE



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

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see MAP 2015 Pre-Rulemaking Deliberations).

Additionally, MAP engages in strategic activities throughout the year to inform MAP's pre-rulemaking input. To date MAP has issued a series of reports that:

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

ENDNOTE

1 Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014.2010: p.260. Available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Last accessed August 2015.

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

Measure Applications Partnership Medicaid Adult Task Force

CHAIR (VOTING)
Harold Pincus, MD

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

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

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

Measure Applications Partnership Coordinating Committee

CO-CHAIRS (VOTING)
Elizabeth McGlynn, PhD, MPP
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Lynda Flowers, JD, MSN, RN
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Shaun O'Brien
America's Health Insurance Plans	Aparna Higgins, MA

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
American Board of Medical Specialties	R. Barrett Noone, MD, FAcS
American College of Physicians	Amir Qaseem, MD, PhD, MHA
American College of Surgeons	Frank Opelka, MD, FACS
American HealthCare Association	David Gifford, MD, MPH
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
Blue Cross and Blue Shield Association	Trent T. Haywood, MD, JD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip N. Kahn, III, MPH
Healthcare Financial Management Association	Richard Gundling, FHFMA, CMA
The Joint Commission	Mark R. Chassin, MD, FACP, MPP, MPH
The Leapfrog Group	Melissa Danforth
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Steve Wojcik
National Committee for Quality Assurance	Mary Barton, MD, MPP
National Partnership for Women and Families	Carol Sakala, PhD, MSPH
Network for Regional Healthcare Improvement	Elizabeth Mitchell
Pacific Business Group on Health	William E. Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher M. 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

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

NQF Project Staff

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

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

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

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

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

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

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

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

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

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

Subcriterion 2.3 Affordable care

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

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

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

Subcriterion 3.2 Measure sets for public reporting programs should be meaningful for consumers and purchasers

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

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

Subcriterion 3.5 Emphasize inclusion of endorsed measures that have eMeasure specifications available

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

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

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

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

Subcriterion 4.3 Payment program measure sets should include outcome measures linked to cost measures to capture value

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

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

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

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

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

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

APPENDIX D:
Adult Core Set and MAP Recommendations for Addition

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

EXHIBIT D1. CURRENT ADULT CORE SET FOR FFY 2015

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0004 Endorsed **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment** Measure Steward: National Committee for Quality Assurance (NCQA)	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	18 states reported FFY 2013 Alignment: Meaningful Use Stage 2 – Eligible Professionals (MU-EP), PQRS, HEDIS, Health Insurance Marketplace Quality Rating System (HIX-QRS), Physician Value-Based Payment Modifier	Support for continued use in the program
0006 Endorsed **CAHPS Health Plan Survey - Adult Questionnaire** Measure Steward: NCQA	30-question core survey of adult health plan members that assesses the quality of care and services they receive.	16 states reported FFY 2013 Alignment: Medicare Shared Savings Program (MSSP), HEDIS, HIX-QRS	Support for continued use in the program
0018 Endorsed **Controlling High Blood Pressure** Measure Steward: NCQA	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	15 states reported FFY 2013 Alignment: MU-EP, MSSP, PQRS, HEDIS, HIX-QRS, Physician Compare, Physician Value-Based Payment Modifier	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0027 Endorsed **Medical Assistance With Smoking and Tobacco Use Cessation** Measure Steward: NCQA	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.	15 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program
0032 Endorsed **Cervical Cancer Screening** Measure Steward: NCQA	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	28 states reported FFY 2013 Alignment: MU-EP, PQRS, HEDIS, HIX-QRS, Physician Value-Based Payment Modifier	Support for continued use in the program
0033 Endorsed **Chlamydia Screening in Women [ages 21-24 only]** Measure Steward: NCQA	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	26 stated reported FFY 2013 Alignment: MU-EP, PQRS, HEDIS, HIX-QRS, Physician Value-Based Payment Modifier, Medicaid Child Core Set (ages 16-20)	Support for continued use in the program
0039 Endorsed **Flu Vaccinations for Adults Ages 18 and Over** Measure Steward: NCQA	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.	12 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0057 Endorsed **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing** Measure Steward: NCQA	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	30 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program
0059 Endorsed **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)** Measure Steward: NCQA	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	0 states reported FY 2013 (New for 2015) Alignment: MU-EP, PQRS, MSSP, Physician Compare, Physician Value-Based Payment Modifier	Support for continued use in the program
0105 Endorsed **Antidepressant Medication Management (AMM)** Measure Steward: NCQA	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	25 states reported FFY 2013 Alignment: MU-EP, PQRS, HEDIS, Physician Value-Based Payment Modifier, HIX-QRS	Support for continued use in the program
0272 Endorsed **Diabetes Short-Term Complications Admissions Rate (PQI 1)** Measure Steward: Agency for Healthcare Research and Quality (AHRQ)	The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	24 states reported FFY 2013 Alignment: N/A	Support for continued use in the program
0275 Endorsed **Chronic obstructive pulmonary disease (PQI 5)** Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	24 states reported FFY 2013 Alignment: MSSP	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0277 Endorsed **Heart Failure Admission Rate (PQI 8)** Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	24 states reported FFY 2013 Alignment: MSSP	Support for continued use in the program
0283 Endorsed **Asthma in Younger Adults Admission Rate (PQI 15)** Measure Steward: AHRQ	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.	24 states reported FFY 2013 Alignment: N/A	Support for continued use in the program
0418 Endorsed **Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan** Measure Steward: Centers for Medicare and Medicaid Services (CMS)	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.	5 states reported FFY 2013 Alignment: MU-EP, MSSP, PQRS, Physician Compare, Physician Value-Based Payment Modifier	Support for continued use in the program
0469 Endorsed **PC-01 Elective Delivery** Measure Steward: The Joint Commission	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)	14 states reported FFY 2013 Alignment: Meaningful Use Stage 2 -Hospitals and CAHs	Support for continued use in the program
0476 Endorsed **PC-03 Antenatal Steroids** Measure Steward: The Joint Commission	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	5 states reported FFY 2013 Alignment: N/A	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
0576 Endorsed **Follow-Up After Hospitalization for Mental Illness** Measure Steward: NCQA	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	27 states reported FFY 2013 Alignment: Medicaid Child Core Set, HEDIS, HIX-QRS	Support for continued use in the program
0648 Endorsed **Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)** Measure Steward: AMA-convened Physician Consortium for Performance Improvement (AMA-PCPI)	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	4 states reported FFY 2013 Alignment: N/A	MAP recommends the removal of this measure from the program. Measure requires data exchange with facilities and discharge processes are not felt to be appropriate for state-level accountability. Additionally, only 4 states have reported on this measure for both FFY 2013 and FFY 2014.
1517 Endorsed **Prenatal & Postpartum Care [postpartum care rate only]** Measure Steward: NCQA	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	29 states reported FFY 2013 Alignment: Medicaid Child Core Set, HEDIS, HIX-QRS	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
1768 Endorsed **Plan All-Cause Readmissions** Measure Steward: NCQA	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/ Denominator) 5. Total Variance Note: For commercial, only members 18-64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	18 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program In 2014 MAP recommended the development and application of a risk-adjustment model for the Medicaid population.
2082 Endorsed **HIV Viral Load Suppression** Measure Steward: HRSA	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. A medical visit is any visit in an outpatient/ ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.	17 states reported FFY 2013 Alignment: PQRS, Physician Value-Based Payment Modifier	Support for continued use in the program
2371 Endorsed **Annual Monitoring for Patients on Persistent Medications** Measure Steward: NCQA	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the four rates separately and as a total rate : Rates for each: Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), Digoxin, diuretics, or anticonvulsants Total rate (the sum of the four numerators divided by the sum of the four denominators)	23 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment	MAP Recommendation and Rationale
2372 Breast Cancer Screening Measure Steward: NCQA	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	27 states reported FFY 2013 Alignment: HEDIS, HIX-QRS	Support for continued use in the program.
Not NQF-endorsed **Adult Body Mass Index Assessment** Measure Steward: NCQA	The percentage of Medicaid Enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	16 states reported FFY 2013 Alignment: HEDIS	Support for continued use in the program
Not NQF-endorsed **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)** Measure Steward: NCQA	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).	16 states reported FFY 2013 Alignment: HEDIS	Support for continued use in the program

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

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

Measure & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
Not NQF-endorsed **Use of Contraceptive Methods by Women Aged 21-44 Years** Measure Steward: Centers for Disease Control and Prevention/ Office of Population Affairs	The percentage of women aged 21-44 years who are at risk of unintended pregnancy and who: 1) Adopt or continue use of the most effective or moderately effective FDA-approved methods of contraception. 2) Adopt or continue use of a long-acting reversible method of contraception (LARC). The first measure is an intermediate outcome measure, and it is desirable to have a high proportion of women at risk of unintended pregnancy using most or moderately effective contraceptive methods. The second measure is an access measure, and the focus is on making sure that some minimal proportion of women have access to LARC methods.	N/A	Conditional Support, pending successful NQF endorsement. Enhances maternal/perinatal measures and would reduce the risk of unplanned pregnancy and pregnancy-related complications by increasing access to high-quality care before and between pregnancies.
2602 Controlling High Blood Pressure for People with Serious Mental Illness Measure Steward: NCQA	The percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.	N/A	Support Addresses behavioral health gap area with a focus on an intermediate clinical outcome that is important for managing co-occurring chronic conditions such as cardiovascular disease and diabetes.
1927 Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications Measure Steward: NCQA	The percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.	N/A	Support Addresses behavioral health gap area in the Core Set and focuses on the identification of cardiovascular disease, a leading cause of morbidity and mortality in this population.

Measure & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Measure Steward: NCQA	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Alignment: HEDIS	Support Addresses behavioral health gap area in the Core Set and focuses on the identification of cardiovascular disease, a leading cause of morbidity and mortality in this population.
Not NQF-endorsed **Effective Postpartum Contraception Access** Measure Steward: TBD	The percentage of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the utilization of postpartum contraception. Part A: Highly effective postpartum contraception access. The percentage of women who received contraceptives such as implants, intrauterine devices or systems (IUD/IUS), or female sterilization within 99 days after birthing. Part B: Moderately effective postpartum contraception access. The percentage of women who received contraceptives such as injectables, oral pills, patch, or ring within 99 days after birthing.	N/A	Conditional Support, pending successful NQF endorsement Enhances maternal/perintatal measures and intended to reduce the risk of unplanned pregnancy and pregnancy-related complications by increasing access to high-quality care between pregnancies.
Not NQF-endorsed **Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer: Multiple-provider, high dosage** Measure Steward: Pharmacy Quality Alliance	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.	N/A	Conditional Support, pending successful NQF endorsement Addresses behavioral health gap and provides an opportunity to intervene in substance abuse pattern. Opioid overuse and addiction is more common in some minority groups, including Native Americans.
Not NQF-endorsed **Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer: Multiple prescribers and multiple pharmacies** Measure Steward: Pharmacy Quality Alliance	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.	N/A	Conditional Support, pending successful NQF endorsement Addresses behavioral health gap and provides an opportunity to intervene in substance abuse pattern. Opioid overuse and addiction is more common in some minority groups, including Native Americans.

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

APPENDIX E:
Public Comments Received

General Comments on the Report

American Academy of Otolaryngology - Head and Neck Surgery

Caitlin Drumheller

The American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) recommends the consideration of two NQF-endorsed measures for acute otitis externa (AOE) for inclusion in the 2015 Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid. Available AOE measures owned and stewarded by the AAO-HNS include: NQF #0653: Topical Therapy, and NQF #0654: Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use. These measures satisfy the NQS domains of effective clinical care, and efficiency and cost reduction. Both measures are currently in use in the PQRS program, and capture processes directly related to improved patient outcomes.

2013 PQRS data indicate that over 85,000 providers were eligible to report these measures; a number that includes primary care and emergency medicine physicians, as well as specialist clinicians treating conditions of the head, neck, ears, nose, and throat.

Acute otitis externa is one of the most common infections encountered by clinicians, and data from ambulatory care centers and emergency departments indicate that in 2007 there were roughly 2.4 million visits for AOE, affecting 1 in 123 persons in the United States. Despite their limited utility, many patients with AOE inappropriately receive systemic antimicrobial therapy, risking significant adverse effects from oral antibiotic use, including rashes, vomiting, diarrhea, allergic reactions, altered nasopharyngeal flora, and development of bacterial resistance. Topical preparations should be used to treat AOE, as they are active against the most common bacterial pathogens in AOE and have demonstrated efficacy in the treatment of AOE.

American College of Obstetricians and Gynecologists

Sean Currigan

The American College of Obstetricians and Gynecologists, the nation's leading group of professionals providing health care for women representing more than 58,000 physicians and educational affiliate members and over 90% of America's board-certified obstetrician-gynecologists, strongly supports the inclusion and widespread implementation of the contraception composite and postpartum contraception access measures across all age groups in the Adult Medicaid and Children's Health Insurance Program Reauthorization Act Core Sets.

We applaud the National Quality Forum's efficient overlap of the Adult Medicaid and Child Measurement Application Panels' discussions of measures affecting women's health care including both perinatal and well-woman clinical topics.

ACOG strongly supports each MAP's majority vote to recommend inclusion of the contraceptive composite and postpartum contraceptive access measures in the voluntary Adult Medicaid and CHIPRA Core Measure Sets conditionally on endorsement of the measures by a standing NQF consensus development panel. We note that neither MAP was afforded the opportunity to vote for any of these measures without the condition of endorsement. We understand the oversight as these may have been the first measures that did not achieve NQF endorsement prior to MAP consideration. We also note that start date of the next standing consensus development panel addressing perinatal and reproductive health is unknown.

ACOG is also actively seeking to include these measures in the voluntary OBGYN core measure set for commercial health plans, in a project led by America's Health Insurance Plans, the Centers for Medicare and Medicaid Services, and the National

Quality Forum. ACOG has also nominated these measures for consideration within the AHIP/ CMS/NQF development of the Accountable Care Organization/Patient Centered Medical Home measure set.

America's Health Insurance Plans

Carmella Bocchino

We support the effort to include reproductive health, chronic disease, mental illness, and substance abuse into this report. Furthermore, we appreciate the alignment with and recommendation of NCQA HEDIS measures.

We also recommend that measures track quality improvement and quality of care in the most efficient and accurate manner. Medical record review is unduly burdensome and vital statistics data are often not available, may not be timely and may be incorrect. These barriers result in a lack of complete and reliable data, which is necessary for effective interventions such as with the elective delivery or antenatal steroid measures. We encourage the use of clinical registries to capture reliable and accurate data for use in quality measurement so long as appropriate third party audit protocols for the data are in place.

We also recommend that certain measures be broken into sub-measures to provide a more detailed and effective measure of quality. For example, #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care)measure could be broken into sub-measures which would provide more detail as to the existence of gaps in the transition record. This measure not only requires the timely transition record (within 24 hour of discharge) but also requires multiple data elements in the transition record: advance planning, medication list, reasons for inpatient, etc. When all these data elements are bundled in one numerator, it becomes difficult to have clarity into all the aspects of the measure.

AWHONN

Kerri Wade

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) represents the interests of 350,000 nurses across the country working to promote the health of women and newborns.

AWHONN strongly supports the inclusion and widespread implementation of the contraception composite and postpartum contraception access measures across all age groups in the Adult Medicaid and Children's Health Insurance Program Reauthorization Act Core Sets. We applaud the National Quality Forum's efficient overlap of the Adult Medicaid and Child Measurement Application Panels' discussions of measures affecting women's health care including both perinatal and well-woman clinical topics.

AWHONN strongly supports each MAP's majority vote to recommend inclusion of the contraceptive composite and postpartum contraceptive access measures in the voluntary Adult Medicaid and CHIPRA Core Measure Sets conditionally on endorsement of the measures by a standing NQF consensus development panel. We note that neither MAP was afforded the opportunity to vote for any of these measures without the condition of endorsement. We understand the oversight as these may have been the first measures that did not achieve NQF endorsement prior to MAP consideration. We also note that start date of the next standing consensus development panel addressing perinatal and reproductive health is unknown.

Florida Hospital

John Hood

I am writing on behalf of Adventist Health System (AHS) to share our comments on the National Quality Forum (NQF) Measure Applications Partnership's (MAP) report on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid. AHS includes 44 hospital campuses located across 10 states and comprises more than 8,000 licensed beds. Our organization provides inpatient, outpatient and emergency room care for four million patient visits each year.

AHS strongly agrees with MAP's assessment of the key issues facing the Medicaid Adult population. We believe that quality measurement for this population is important because more adults are enrolling in Medicaid yet resources in many states remain constrained.

We believe MAP has correctly identified that reproductive health and behavioral health are important areas of focus for the Medicaid Adult population. However, we are concerned that several of the measures MAP has recommended for phased addition to the Medicaid Adult Core Measure Set are not endorsed by the NQF. While we applaud MAP's underlying rationale for support, we caution against premature support for measures that have not been fully evaluated and endorsed by the NQF.

We think MAP's emphasis on alignment is particularly important. AHS believes that quality measurement programs must reach a balance between alignment that reduces the administrative burden of data collection and comprehensiveness that ensures quality improvement efforts are not being unduly focused on one area of need to the disadvantage of other critical areas.

Finally, we support MAP's efforts to collaborate with the Centers for Medicare and Medicaid Services (CMS) to grow and support quality infrastructure and diffuse quality measurement best practices at the state-level.

AHS appreciates the opportunity to comment on MAP's draft recommendations to the Department of Health and Human Services (HHS) on the Medicaid Adult Core Set of quality measures. We think that MAP has accurately identified highly impactful measures and has prioritized gaps where meaningful quality measures are needed. We have included additional thoughts about specific items included in this report in our comments on measure specific recommendations and gaps as well as our 3) Comments on MAP's Strategic Recommendations.

PPFA

Carolyn Cox

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") are pleased to submit these comments in response to two draft reports for public comment regarding core set of health care quality measures for adults and children enrolled in Medicaid. We appreciate the opportunity to provide feedback on the draft recommendations and have submitted the same comments to MAP's Child Task Force.

We strongly support MAP's recommendations to include additional quality measures on contraception access in the Adult Medicaid and Children's Health Insurance Program (CHIP) Core Sets. We urge MAP to adopt and support these recommendations regardless of whether NQF endorses the measures. Medicaid plays a critical role for women and their families. The vast majority of women enrolled in Medicaid are of reproductive age (18-44), and across all ages, the majority of Medicaid enrollees are female. In addition, nearly half of U.S. births are funded by the Medicaid program. Including contraceptive quality measures into the core sets for women ages 21-44, teens ages 15-20, and postpartum women will complement the other existing reproductive health-related quality measures (e.g., Chlamydia screenings), ensure future Medicaid payment reforms reflect the majority of the Medicaid population, and improve access to the care women need.

As noted in the draft report, contraceptive access and use improves the ability to have planned pregnancies, which are associated with better health outcomes for women and their children. However, birth control adherence requires each woman having the opportunity to select the method of contraception that best meets her needs, including her medical history, age, and lifestyle. We appreciate the draft measures are defined to include use of moderately and highly effective contraceptive methods so that neither a woman nor a provider is inadvertently pressured toward a specific contraceptive method. Patients should be provided with accurate information and counseling about all of their options, but ultimately, each woman must make the decision about whether to use contraception and which family planning method to employ.

We thank MAP for its dedication to improve access to quality care, and we look forward to working with MAP and NQF in this important work.

Comments on MAP's Measure Specific Recommendations and Gaps

Academy of Managed Care Pharmacy

Susan Oh

Academy of Managed Care Pharmacy (AMCP) supports the inclusion of 'use of opioids at high dosage in persons without cancer' PQA measure.

AMCP conditionally supports the below opioid measures if a specific meaningful time period is identified as part of the measure.

Use of Opioids from multiple providers in persons without cancer – for example, the PQA measure of 4 prescribers AND 4 pharmacies over a time frame of 12 months could identify false positives.

Use of Opioids at high dosage and from multiple providers in persons without cancer.

American Academy of Allergy, Asthma and Immunology

Shazia Ali

The American Academy of Allergy Asthma and Immunology (AAAAI) does not support inclusion of NQF measure #1799: Medication Management for People with Asthma (MMA), in the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid. Most significantly, the MMA measure has not been shown to be associated with improved health outcomes and no clinically significant difference in hospitalizations, emergency department visits, or rescue inhaler dispensing has been demonstrated in compliant and non-compliant patients (Yoon et al. 2015). The AAAAI fully supports implementing quality measures that help achieve the goals of asthma control and encourages the committee to consider replacing this MMA measure with NQF Measure #1800, Asthma Medication Ratio (AMR), a measure that has been shown to be associated with improved asthma outcomes in diverse populations (Schatz, et al., 2006; Yong and Werner, 2009).

Due to the MMA measure format, timing becomes an unintended component of the measure. When compared, patients with similar controller dispensing were considered MMA-compliant or MMA-noncompliant depending solely on the timing of medication dispensing, and both groups were found to have similar asthma outcomes (Yoon, et al. 2015). Additionally, national asthma guidelines recommend adjusting asthma medication through a step-up or step-down approach (NHLBI/NAEPP 2007), but the MMA measure risks potentially penalizing the appropriate step-down of well-controlled asthma patients to lower doses of controller medication (Yoon, et al. 2015).

In contrast, the AMR measure has been shown to be associated with improved asthma utilization and patient-reported outcomes in many studies (e.g. Schatz, et al, 2006, Yong and Werner, 2009). When studied, patients compliant with this measure reported significantly better quality of life, asthma control and symptom severity compared to patients who were not compliant with the AMR measure (Schatz 2006). Additionally, patients with high AMRs were less likely to experience asthma hospitalizations or emergency department visits (Schatz 2006). Furthermore, when asthma exacerbations were studied in the Medicaid population, beneficiaries meeting the AMR measure were 23% less likely to experience asthma exacerbations (Yong and Werner 2009).

According to the CDC, asthma is a common chronic illness that affects 18.9 million American adults and 7.1 million children and results in direct and indirect health care costs estimated at $19.7 billion annually. The AAAAI stresses the importance of identifying measures to improve the quality of asthma care, lower costs and improve outcomes. While the AAAAI does not support the MMA measure, we hope the committee will consider inclusion of the AMR measure in the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid. We thank you for your consideration.

A list of references is available upon request.

American College of Obstetricians and Gynecologists

Sean Currigan

ACOG, the nation's leading group of professionals providing health care for women, strongly supports the inclusion of the contraception composite and postpartum contraception measures in the Adult Medicaid Set.

These measures require no medical chart review and can be done in administrative claims data. The testing data from national Title X and CA shows variation across settings. ACOG can facilitate presentation of the testing data.

We understand the sensitivity around coercion that these measures require which is why they are specified with a larger denominator at a population health level. ACOG is working within EHRs to create data elements specific to pregnancy intention and sexual activity that would support future refinement and the development of new measures. There are no other nationally specified and pilot-tested performance measures within the family planning space. Waiting for electronic clinical quality measures that are ready for national implementation will require a minimum of 4 years because the structured data elements do not exist.

We do not seek 100% on any of these measures. Women must be given the opportunity to make a choice that fits their lifestyle and values. Women should be given all of their options and should be educated and counseled on the most effective options available. Please note The Joint Commission-stewarded PC-05: Exclusive Breastmilk Feeding in the Hospital is a NQF-endorsed measure being used for accreditation in birthing facilities with more than 1100 births (soon to be 300 births in 2016) and also has anecdotal concerns for coercion. The goal for exclusive breastmilk feeding in the hospital is not 100%, TJC and ACOG believe the benchmark is closer to 70%. ACOG fully supports this measure until we are able to systematically capture patient experience of breastfeeding support. http://www.jointcommission.org/annualreport.aspx

In April 2015, the IOM released Vital Signs: Core Metrics for Health and Health Care Progress, a report examining measures that will yield the clearest understanding and focus on better health in the US. The IOM Committee on Core Metrics for Better Health at Lower Cost identified unintended pregnancy (teen or otherwise) as one of 15 core national measures. The Committee advises that the National Quality Forum "consider how they can orient their work to reinforce the aims and purposes of the core measure set." Contraceptive use is a related priority measure and also addresses health inequities across racial and ethnic minorities. http://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Vital_Signs/VitalSigns_Recs.pdf

These measures align with the National Quality Strategy Triple Aim addressing better care, population health, and cost-effectiveness.

In the United States, almost half of all pregnancies are unintended and one-third of all pregnancies are conceived within 18 months of a previous birth (Healthy People 2020). The United States continues to have the highest teen birth rate in the developed world, twice the rate of Canada and one and a half times the rate of the United Kingdom (Martin et al, 2013).

In 2001, 49% of births were unintended and 21% of women gave birth within 24 months of a previous birth (CDC MMWR, 2009). In 2006, the rate of unintended pregnancies remained at 49%, accounting for some 3.2 million pregnancies. Among women aged 19 years and younger, more than 4 out of 5 pregnancies were unintended. Between 2001 and 2006, the proportion of pregnancies that were unintended declined from 89% to 79% among teens aged 15–17 years but increased from 79% to 83% among women aged 18 and 19 years and from 59% to 64% among women aged 20–24 years (Finer and Zolna, 2011). In women ages 20-29 during 2008, 69% of almost two million pregnancies were unplanned (Special Tabulations from The National Campaign, 2012).

The US DHHS has included family planning goals in Health People 2020 in the hopes of improving pregnancy planning and birth spacing as well as preventing unintended pregnancy. Its objectives include increasing the proportion of females at risk of unintended pregnancy or their partners who used contraception at most recent sexual intercourse, reducing the proportion of females experiencing pregnancy despite use of a reversible contraceptive method and reducing the proportion of pregnancies conceived within 18 months of a previous birth (Healthy People 2020). In order to more effectively reach these goals, it will be important to increase access to more effective and longer acting reversible forms of contraception for those who wish to delay or avoid pregnancy.

any public health and reproductive health experts, including the American College of Obstetricians and

Gynecologists (ACOG) recommend that LARC be used as a first-line option for all women. And while LARC use in the U.S. has increased significantly from 2.4% in 2002 to 8.5% in 2009, usage remains relatively low compared to other, less effective, forms of birth control (Finer et al, 2012). Most of the increase occurred among women with at least one child, particularly in women younger than 30 years old. Use of LARC in parous women increased from 8% in 2007 to 17% in 2009. The increase in LARC use is primarily driven by increased use of IUD's and is accompanied by a small and not statistically significant decrease in rates of sterilization.

Of note, the use of LARC is lower in the U.S. than in British (11%), French (23%), Norwegian (27%) and Chinese (41%) users. The majority of LARCs in these countries are also IUDs (Finer et al, 2012).

In 2008, 48% of all births in the U.S. were paid for by public insurance through Medicaid, CHIP and IHS. 1.7 million of those births were a result of unintended pregnancies – both unwanted and mistimed – and it is estimated that public insurance programs paid for 65% of these births along with 36% of births resulting from intended pregnancies. A Guttmacher Institute report estimates that government expenditures on births resulting from unintended pregnancies totaled $12.5 billion in 2008 (Sonfield and Kost, 2013). With the expansion of Medicaid in many states beginning in 2014 with the Affordable Care Act, these public costs will likely rise.

Government expenditures for family planning services are also substantial and it has been estimated that publicly funded services helped avert $12.7 billion in costs by preventing unintended pregnancies in 2010. (Sonfield and Kost, 2013). Contraceptive use saves nearly $19 billion in direct medical costs every year (Trussell, 2007). In FY 2010, public expenditures for family planning services totaled $2.37, including counseling, education and provision of contraceptives. Medicaid covered 75% of the total cost with state and Title X funding covering the remaining cost. In 2010, there were about 181,000 abortion procedures for low-income women, costing $68 million. The states covered the vast majority of these procedures and the federal government, which restricts funding to cases of life endangerment, rape and incest, contributed to the cost of 331 procedures (Sonfield and Gold, 2012).

A 2013 study constructed an economic model to estimate all direct costs of unintended pregnancies to third party payers as well as the proportion of that cost attributed to imperfect contraceptive adherence. These costs included births, induced abortions, miscarriages, and ectopic pregnancies. Annual medical costs attributed to unintended pregnancies were estimated at $4.6 billion and 53% of these costs were attributed to imperfect use of contraception. The study also estimates that if just 10% of women aged 20-29 switched to from oral contraceptives to LARCs, the total cost would be reduced by $288 million per year (Trussell et al, 2013).

There are persistent and, in some cases, worsening disparities in unintended pregnancy rates among subgroups with minority and low-income white women more likely to have short birth intervals as a result of unintended pregnancy than white or middle-class women (Zhu et al, 2001). Women with the lowest levels of education, black and Hispanic women, and poor and low-income women had significantly higher rates of unintended pregnancies. In 2006, 43% of unintended pregnancies ended in abortion, a decline from 47% in 2001. The proportion of unintended pregnancies ending in abortion decreased from 2001 to 2006 across all racial/ethnic groups. Black women were most likely to end an unintended pregnancy with abortion. However, black and Hispanic women were more than twice as likely to have an unintended birth (Finer and Zolna, 2011).

Though racial/ethnic discrepancies in use of LARC was seen in 2002 and continued through 2007, they were largely gone by 2009. 2009 data also did not show significant differences by income level. However, LARC use was found to be higher among women on Medicaid and women offered no-cost contraception, suggesting that if the high up-front cost of LARC is no longer a barrier, more women would use LARC (Finer et al, 2012).

America's Health Insurance Plans

Carmella Bocchino

Harmonization between these measures and those recommended in the dual eligible report is encouraged to the extent that is possible. We agree with the gap areas proposed by the Taskforce.

We suggest that the MAP consider measures

or measure updates that are aligned with more comprehensive coverage of ages and insurance statuses (e.g. Medicare, Medicaid, and Commercial). For example, measure #0033 Chlamydia Screening should be applicable to both male and females and to age groups beyond 16-24.

We also continue to suggest the MAP recommend measures that focus on outcomes of care such as those recently included in the Physician Quality Reporting System program.

For use-rate measures such as Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multi-provider, High Dosage we suggest that more clarity be provided around definitions regarding terms such as "multiple" or "high dosage" and note the challenges that may exist due to benefit carve-outs. Furthermore, these measures often have data collection issues related to chart abstraction.

Implementation challenges exist with contraception measures and it is important to consider that most of the women that become eligible for Medicaid through pregnancy and delivery while on Medicaid may lose eligibility within 90 days of delivery.

AWHONN

Kerri Wade

AWHONN, representing the interests of 350,000 nurses across the country working to promote the health of women and newborns strongly supports the inclusion of the contraception composite and postpartum contraception measures in the Adult Medicaid Set.

We understand the sensitivity around the perception of coercion that these measures require. Thus is is critical that they are specified with a larger denominator at a population health level.

We do not seek 100% compliance on any of these measures. Women must be given the opportunity to make a choice that fits their lifestyle and values. Women should be given all of their options and should be educated and counseled on the most effective options available.

Please note The Joint Commission-stewarded PC-05: Exclusive Breastmilk Feeding in the Hospital is a NQF-endorsed measure being used for accreditation in birthing facilities with more than 1,100 births (soon to be 300 births in 2016) and also has anecdotal concerns for coercion. The goal for exclusive breastmilk feeding in the hospital is not 100%, TJC and AWHONN believe the benchmark is closer to 70%. AWHONN fully supports this measure until we are able to systematically capture patient experience of breastfeeding support. http://www.jointcommission.org/annualreport.aspx

In April 2015, the IOM released Vital Signs: Core Metrics for Health and Health Care Progress, a report examining measures that will yield the clearest understanding and focus on better health in the US. The IOM Committee on Core Metrics for Better Health at Lower Cost identified unintended pregnancy (teen or otherwise) as one of 15 core national measures. The Committee advises that the National Quality Forum "consider how they can orient their work to reinforce the aims and purposes of the core measure set." Contaceptive use is a related priority measure and also addresses health inequities across racial and ethnic minorities. http://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Vital_Signs/VitalSigns_Recs.pdf

These measures align with the National Quality Strategy Triple Aim addressing better care, population health, and cost-effectiveness.

BlueCross BlueShield Association

Kerri Fei

Use of Contraceptive Methods by Women Aged 21-44 YearsWhile Plans agree that women's reproductive health is a high priority area and understanding that MAP is conditionally supporting this measure pending NQF endorsement, it may be premature to consider this measure for inclusion in the Adult Core Set. As the specifications provided are not clear as to how "risk for unintended pregnancy" is defined, it appears that Plans will not be able to rely on administrative claims for data collection/reporting as identification of the denominator will require medical record data. This requires time for implementation as well as additional cost. Additionally, even with setting an expected performance threshold below 100%, the potential for unintended consequences with this measure (e.g., potential pressure into using a certain contraceptive method) remains a concern. This measure may

have limitations as an improvement measure and is not in and of itself and outcome. Given the high rates of change in eligibility status in the Medicaid population, it is unclear that the majority of women could be followed long term. Mostly likely, they can only be followed up to 60 days post-partum as that is when the majority of benefits end. We would like to see additional testing information regarding implementation and performance as well as for the measure to obtain NQF-endorsement prior to consideration for inclusion in the Adult Core Set.

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

Plans support behavioral health measures as an important priority, however the current measure included in the Adult Core Set (NQF #0018: Controlling High Blood Pressure) could be stratified to evaluate at this population. It does not necessarily require a new measure.

Effective Postpartum Contraception Access

As mentioned previously, women's reproductive health measures are a priority for Plans. We are unsure as to why the measure requires looking out up to 99 days for contraception use, when most Medicaid benefits end for women at 60 days post-partum. Please clarify the specifications prior to considering for inclusion in the Adult Core Set.

Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Multi-Provider, High Dosage

Use of Opioids from Multiple Providers at High Dosage in Persons without Cancer: Multiple Prescribers and Multiple Pharmacies

Use of Opioids from Multiple Providers at High Dosage in Persons without Cancer: High Dosage

Overutilization of opioids is a priority area for some Plans. Would like to see that the measure specifications are clear and provide definitions of terms such as "multiple" and "high dosage". Additionally, medical appropriateness criteria that can be used for instances where opioid use outside of a cancer diagnosis is warranted? Support inclusion of this measure in the Adult Core Set pending clarification of specifications and NQF endorsement.

NQF #1799: Medication Management for People With Asthma

This measure is widely used and accepted by Plans. Given Plan experience with this measure and in order to align with how the measure is used for NCQA Health Plan Accreditation for Medicaid service line products, it is recommended that the 75% rate be utilized.

CVS Health

Marissa Schlaifer

Recommendations

CVS Health is pleased to provide comments in response on the draft report. CVS Health supports the task force's recommendation of the removal of measure #0648 due to reports of low feasibility and lack of reporting by states.

CVS Health would like to recommend reprioritizing measure #1799 'Medication Management for People with Asthma' as a top three priority. The task force conditionally supported measure #1799 pending completion of the measure's annual update. MAP initially recommended this measure during its 2014 review, but CMS has not yet added it to the Adult Core Set.

According to the CDC:

Asthma: affects 25.7 million people, including 7.0 million children under 18,

Is a significant health and economic burden to patients, their families, and society

In 2010, 1.8 million people visited an emergency department for asthma-related care and 439,000 people were hospitalized because of asthma and

People with lower annual household income are more likely to have asthma.[1]

CVS Health recommends that MAP continues to recommend the Medication Adherance for people with Asthma measure be considered for phased addition.

Prescription medications have been shown to lower overall medical costs through reduced hospitalization, emergency room utilization and outpatient visits, while medication therapy management programs and pharmacy counseling play an important role in optimizing prescription adherence to improve quality outcomes for individuals with chronic conditions.

CVS Health recommends adding "The Proportion of Days Covered (PDC) – three rates" measure for

inclusion into the Medicaid core adult set. Proportion of Days Covered (PDC) is the PQA-recommended metric for estimation of medication adherence for patients using chronic medications. This metric is also endorsed by the National Quality Forum (NQF). The metric identifies the percentage of patients taking medications in a particular drug class that have high adherence (PDC > 80% for the individual). The measure tracks medication adherence for conditions that are highly prevalent in the Medicaid population and is aligns with other programs managed by CMS. CVS Health generally supports the remaining the task force recommendation.

These comments are submitted on behalf of CVS health and are independent of my role as a member of the MAP Coordinating Committee and Medicaid Adult Core Set task force. If you have any questions, please feel free to contact me at (202) 772-3538 or marissa.schlaifer@cvshealth.com.

[1]Centers for Disease Control and Prevention: http://www.cdc.gov/asthma/asthmadata.htm

Florida Hospital

John Hood

In the report, MAP recommends that CMS remove the Care Transition — Timely Transmission of Transition Record measure (NQF #0648) from the Adult Core Set. AHS disagrees with this recommendation. We believe that this is an important measure given the nature of health care delivery model reform efforts that seek to achieve greater coordination of health care services. As the U.S. health care delivery system transitions to a payment system that emphasizes value over volume it will be increasingly important that providers deliver timely and well-informed care. The ability to do this will hinge on the availability of adequate information. We think that it is critical for providers to receive patients' transition records within 24 hours of discharge if they are to ensure that services are provided in a timely and well-coordinated fashion across the continuum of care. In addition, Alternative Payment Models (APMs), such as Medicare's Bundle Payments for Care Improvement (BCPI) program and Medicare Shared Savings Program (MSSP), require that providers work to together to boost quality and efficiency. Delays in the transmission of important patient information, such as transition records, impede efforts to reduce overutilization and emphasize well-informed care. While these APMs do not necessarily apply to the Medicaid beneficiary population, the overall goal of improving the coordination of care is highly relevant. AHS believes that health care outcomes and overall costs can be improved if transitions of care are better coordinated. For this reason, we encourage MAP to continue to recommend that the Care Transition — Timely Transmission of Transition Record, measure remain in the Adult Core Set. We believe that care coordination is a high priority for the Adult Medicaid beneficiary population.

While AHS agrees with the measures MAP has recommended for phased addition to the Adult Core Set, we caution MAP against "conditional support." We believe that support should be binary. We think that MAP should either "support" or "not support" measures. We find that CMS often takes conditional support to mean full support and uses this as an argument in favor of implementing measures into programs, including highly impactful payment programs, prior to completion of the NQF endorsement process. The NQF endorsement process requires measures to undergo rigorous evaluation. Often, measure weaknesses are identified and corrected as a result of this process. We believe MAP can note in the report that it is interested in a particular measure and feels that it has the potential to be useful. However, we urge MAP to refrain from issuing any support based on conditions.

MAP should state clearly in the report that it is not supporting the measure because it has not been evaluated or endorsed by the NQF.

AHS supports MAP's assessment of high priority measure gaps for the adult Medicaid population. We think the newly identified gap areas identified by the report are highly relevant. In particular, we believe that beneficiary reported measures of health-related quality of life will enable informed assessment of state programs designed to improve population health. We also support the prioritization of measures related to psychiatric re-hospitalization, new chronic opiate use, polypharmacy, trauma-informed care and engagement and activation in health care.

GlaxoSmithKline

Christopher Cook

GSK commends MAP for recognizing the need to support improvements in asthma care by supporting the phase-in of NQF #1799 Medication Management for People with Asthma (MMA) into the Adult Medicaid Core Set. While we see value in the adoption of NQF #1799 to harmonize with the Childhood Medicaid Core Set we respectfully suggest MAP support adoption of NQF#1800 Asthma Medication Ratio (AMR) in addition to or as a replacement to their recommendation for NQF #1799.

Achieving and maintaining control of asthma is a challenge for patients and physicians. Lack of control is not only costly, it can also be lethal. In 2010, hospital inpatient costs due to asthma totaled $1.9 billion, [1] and uncontrolled patients cost approximately $4,400 more in direct costs per year than their counterparts who have well controlled asthma. [2] According to the CDC, in 2009 there were 2.1 million emergency room visits and nine deaths per day due to asthma. [3]

Unlike NQF#1799, NQF #1800 achieves the dual purpose of identifying patients who are not adequately persistent in their use of controller medication AND identifying patients who are high utilizers of rescue medications. While NQF#1799 promotes asthma control by assessing controller adherence, the measure lacks a component to evaluate the patient use of rescue medications or short-acting beta agonists (SABAs). Overuse of SABAs is associated with increased risk of hospitalization and is a marker for poor control and disease severity. [4] NQF #1800 in contrast takes into consideration the burden of asthma on the patient by assessing the relative use of SABA to that of controllers. Studies suggest that a higher ratio for NQF #1800, is a predictor of better patient outcomes (e.g., decreased emergency department visits, hospitalizations and exacerbations). [5], [6], [7], [8], [9] For these reasons, we believe NQF #1800 is a better measure of assessing quality of care for asthma patients. As CMS programs continue the quality measure harmonization efforts, we believe alignment to better measures of care remains an equal priority.

[1] AHRQ Statistical Brief #151, March 2013. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb151.jsp.

[2] Sullivan PW, et al. J Asthma. 2014;51(7):769-778.

[3] Moorman JE, et al. Vital Health Stat 3. 2012(35):1-67

[4] Shireman, et.al. Ann Pharmacother 2002;36:557-64.

[5] Schatz M, et al. Chest 2006; 130:43–50.

[6] Schatz M, et al. Ann Allerg Asthma Immunol. 2008;101(3):235-239.

[7] Broder MS, et al. Am J Manag Care. 2010;16(3):170-178.

[8] Schatz, M, et al. Am J Manag Care. 2010;16(5):327-333.

[9] Stanford, R, et al. Am J Manag Care. 2013;19(1):60-67.

Healthfirst

Abby Maitra

General Comment: We suggest that minimizing the administrative burden on states and plans be explicitly considered when contemplating new additions to the MAP Family of Measures (FOM) for Medicaid Adult Beneficiaries. Measures which require medical record review are particularly challenging and involve resources, time and effort for data collection and evaluation.

Use of Contraceptive Methods by Women Aged 21-44 Years

Healthfirst supports emphasis on the importance of reproductive health as a significant issue relevant to the adult Medicaid population. However, we are concerned that this measure will require medical record review. Further, data collection would be complex, involving numerous health care settings in which contraceptive methods could be dispensed. For these reasons, the full set of encounter data may not be fully captured, impacting measure performance. For instance, it will be difficult to obtain utilization information about women who are using moderate or highly effective contraception methods received from health care settings (e.g., Planned Parenthood) which are outside of a plan's network.

Healthfirst has reservations concerning the methodology which would be required to make this an unbiased reliable performance measure.

At minimum, this measure would need to be risk adjusted to account for factors known to affect contraceptive use among women, including level of education, race, and income. These factors could be determined at the plan level. However, there are many other factors impinging on contraceptive use among women ranging from social norms, embarrassment over discussing or obtaining birth control, worry about side effects, condom use, perceived risk of pregnancy, cultural and religious beliefs and values, and relative influence of partners, peers and family. These factors may not reliably be determined at the plan level. Because of these numerous factors which affect contraceptive use, we are concerned that risk adjustment would be imperfect. Furthermore, there is considerable variation in public funding for contraceptive methods which impacts access to and utilization rates. These factors are also difficult to capture within a risk-adjustment methodology.

Finally, we are in strong agreement that a low target rate for this measure would need to be established, given all the factors that influence contraception usage and adherence, and that the measure be reviewed by NQF for endorsement.

Effective Postpartum Contraception Access

Healthfirst supports emphasis on family planning and spacing of births to provide both health and social benefits to mothers and their children. We suggest that technical specifications for this measure be publicly available, in order for stakeholders to be able to fully comment on the proposed performance measure. We are concerned that another measure that would require medical record review may potentially be added to the FOM, posing a burden to plans to collect and evaluate data. We are in strong agreement that the measure be reviewed by NQF for endorsement before being considered for inclusion in the FOM.

Controlling High Blood Pressure for People with Serious Mental Illness

Controlling blood pressure is a highly desirable clinical outcome. However, Healthfirst does not support a separate measure to examine blood pressure with people with serious mental illness. Instead, we suggest that that the measure be restricted to individuals diagnosed with schizophrenia. In this way, the measure will parallel the HEDIS measure "Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia".

Further, we recommend that this not be a separate performance measure. Instead, we suggest that it be a stratified performance measure, in which blood pressure rates for members with schizophrenia would be blended into a combined rate for all members. We feel that this this methodology would be more desirable, in that the overall performance measure would be adjusted to reflect the volume and proportion of members with schizophrenia; this would not the be the case if the performance measure were separate. Additionally, this measure will require medical record review which is burdensome to plans, involving resources, time and effort for data collection and evaluation.

Opioids Utilization:

There are patients using greater than 120mg MED for a medically necessary diagnosis as confirmed by their provider and are using a reasonable amount of prescribers and pharmacies (less than 3). Under the current specifications, these patients would remain in the denominator indefinitely. Healthfirst urges that these members should be excluded from the measure.

Michigan Department of Health and Human Services

Meta Kreiner

The Quality Improvement and Program Development Section of the Bureau of Medicaid Care Management and Quality Assurance, Michigan Department of Health and Human Services has reviewed the draft report entitled "Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2015". We think the report represents a positive direction for the Adult Core Set and that the new measures identified in Exhibit 4 fill gaps in the current set and promote measurement in high-priority areas for quality assurance and quality improvement. We support all of the measures that are recommended for phased addition to the Adult Core Set and think the attention to behavioral health and reproductive health is well placed. We also support sustained attention to the importance of addressing health disparities.

When considering new measures, we would like to highlight the importance of a greater balance of measures that use administrative claims or survey data. As was mentioned in regards to other state experiences with the Adult Core Set, measures that require extensive chart audit are less feasible for Michigan. We are very supportive of the exploration of using survey data in conjunction with administrative data, such as in the "Use of Contraceptive Methods by Women Aged 21-44 Years" measure, to estimate data which would otherwise need to be collected through medical record review. Similarly, guidance and technical assistance from CMS and partner agencies to assist with setting reasonable benchmarks in place of complex denominator exclusions that require medical record review would be of great value. Other identified challenges with the Adult Core Set that Michigan has also experienced include issues with data for services that are reimbursed as a bundle, the need for greater clarity regarding Medicaid-specific inclusion/exclusion criteria, the importance of developing Medicaid-specific risk adjustment, and the alignment of measure specifications across programs.

National Partnership for Women & Families

Carol Sakala

The National Partnership for Women & Families supports inclusion of Effective Postpartum Contraception Access in the Medicaid adult core set. It would report the percentage of women covered by Medicaid who gave birth during the year and who had access to postpartum contraception within 99 days after giving birth. An important feature of this measure is the ability to examine contraceptive access by increments of time from the birth. It would have two parts: one reporting on use of a highly effective method, the second a moderately effective one. Clinical research has well documented the health benefit to both mother and baby of avoiding closely-spaced pregnancies. Especially for communities where a pattern of closely spaced births exists, the adoption of this measure would be a valuable tool in identifying the extent to which lack of contraception access is a crucial factor.

The National Partnership for Women & Families strongly supports inclusion of Use of mContraceptive Methods by Women Aged 21-44 Years in the Medicaid adult core set. This access measure, developed by CDC but not yet considered for endorsement by NQF, it has two parts. The first part would measure the utilization of one of the most or moderately effective FDA-approved methods of contraception by women enrolled in the state's Medicaid program. The second part would narrow the numerator definition and report the number of these women specifically using a Long Acting Reversible Contraception method. Its adoption will permit women and women's health advocates to identify program successes and opportunities for improvement. Given the diversity of the Medicaid population across the states, it is important to recognize any target rate would be well below 100% nationwide.

We applaud the MAP's recognition of the importance of this indicator by voting it as the #1 priority for inclusion in the adult set.

Pharmacy Quality Alliance

Woody Eisenberg

PQA (Pharmacy Quality Alliance) supports the MAP's conditional support of three related measures recently developed by PQA that address potential misuse/abuse of opioid analgesics:

1. Use of Opioids at High Dosage in Persons Without Cancer

2. Use of Opioids from Multiple Providers in Persons Without Cancer

3. Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer.

Medicaid offers healthcare coverage to many of the individuals with the highest medical and social needs. Behavioral health conditions are prevalent and often complicate the course of other medical conditions. State Medicaid programs have described to the MAP that early intervention for people who are prescribed opioid medications is important to prevent addiction and a pathway to illegal heroin use.

There is no FDA-approved maximum dosage for any opioid. However, the Washington State Agency Medical Directors Group has suggested 120 morphine equivalent dosage (MED) as a dosage level that should not be exceeded without special consideration. Additionally, 120mg MED is used by

the CMS Part D opioid monitoring program to alert health plans for potentially inappropriate doses of opioids. Other studies suggest that high opioid dosage increases the risk of overdoses, fractures and death. Further, people who see multiple prescribers or use multiple pharmacies are more likely to die of drug overdoses. Data from the California Prescription Drug Monitoring Program indicates that people with higher daily dosages are more likely to see multiple prescribers or go to multiple pharmacies.

The data suggest that efforts to prevent opioid overdose deaths should focus on strategies that target (1) high-dose opioid users as well as (2) persons who seek care from multiple prescribers and pharmacies. The data also suggests that these criteria can be considered separately, as measures related to prescribed opioids for appropriate clinical uses versus inappropriate uses. Thus, we support three measures: one for each set of criteria and one that is the intersection of both sets of criteria. This approach will also assist health plans in managing the number of patients who meet the measure criteria and planning their respective interventions, so that a balance of identification and intervention can be determined.

Comments on MAP's Strategic Recommendations

America's Health Insurance Plans

Carmella Bocchino

We agree with the recommendations as stated. Furthermore, reproductive and behavioral health are important issues to the adult Medicaid populations and we support the emphasis on these areas within the strategic recommendations. Lastly, we support the concept of synchronizing the Child Core set and Adult Core set to provide a clearer view of quality across an individual's lifespan.

Florida Hospital

John Hood

AHS commends MAP for its assessment of the Medicaid Adult Core set. We believe that MAP has correctly identified several of the strategic issues facing quality measurement for this beneficiary population.

We agree that alignment of measures across the health system is of critical importance. This is especially true, "in the context of resource-constrained" state Medicaid programs. We also agree that caution must be exercised when selecting measures. An over-emphasis on alignment can lead to an overly narrow measure set. Such a measure set could cause outsized quality improvement efforts in one area while another important area receives inadequate attention.

AHS agrees with MAP's recommendation that CMS help states enhance their ability to communicate and share best practices or other quality measurement resources.

AHS strongly supports MAP's recommendation that measures be stratified by factors of interest in order to identify disparities. We believe this will enable greater multivariate analysis of measures to identify disparities and other confounding factors that are influencing the health of the Medicaid beneficiary population. As MAP has noted, due to their low income, this population is a group that experiences inequities in health. The extent to which these inequities are due to disparities in health care or other disparities such as income, nutrition, education, transportation or environmental health is not fully understood. Stratification of these measures will enable further research into this area. One finding may be that providers with overall quality scores that are lower than average may in fact be performing better than the norm within certain low income population subsets. Highlighting the performance of these providers may help identify best practices.

AHS commends MAP for suggesting that states should ensure performance benchmarks are appropriate and achievable. Reasonable benchmarks can safeguard against overly burdensome measures while still encouraging meaningful improvement. In addition, we believe it is critically important to ensure appropriate performance benchmarks are used for measures where 100 percent compliance is unrealistic or potentially harmful. For instance, emergency department utilization measures should be carefully calibrated in order to reduce inappropriate utilization while also avoiding incentivizes that could encourage behavior that may discourage necessary utilization.

In the draft report, MAP encourages CMS to enhance states' abilities to communicate with each other via reporting program technical assistance processes. We think this, and similar strategies, may enable states to overcome budgetary and other resource constraints that limit the ability to collect measure data. CMS should identify similar strategies to address resource constraints and provide greater economies of scale across the Medicaid program.

U Mass Medical School

Louise Bannister

MassHealth appreciates the opportunity to comment on the Measure Applications Partnership's (MAP) report and supports the continued collection and reporting of the Adult Core Set by State Medicaid programs.

The MAP report thoroughly describes the process by which current and new measures are assessed and identifies clear criteria for the addition of new and retirement of existing measures. MassHealth particularly appreciates the inclusion of prior state experience with measure collection and reporting as a key criterion when considering a retirement of a measure. MassHealth notes that there is only one measure recommended for retirement: #0648 Care Transition – Timely Transmission of Transition Record. While we recognize the challenges in collecting this measure, MassHealth would like to reiterate the importance of communication among and between providers in achieving better care and recommends that this be an area of consideration for future measures.

The Map report identifies "maintaining stability" as a key consideration in defining the Adult Core Set for 2015. Maintaining stability of the measure set will allow MassHealth and other states to continue to refine its processes as well as expand on currently existing improvement projects initiated as part of the Adult Medicaid Quality Grant. Moreover, the 'growing pains' experienced during the first several years of the program will decline as states become more proficient with measure specifications. MassHealth also appreciates efforts to align the Adult Core measures with measures contained in other measure sets used by CMS, including the Child Core Measures Set. MassHealth recommends that this alignment be consistent not only across measure sets but also measure specifications, especially with the HEDIS specifications as many states spend significant time and effort collecting and reporting HEDIS data. MassHealth noted several instances in which the Adult Core Set specifications differed with regard to populations. For example, the breast cancer screening measure in Exhibit D-1, shows an "outdated" age range of 40-69 for the population measure and is not consistent with the HEDIS 2014 revised age range of 50-74 years of age. Additionally, we strongly encourage CMS and MAP to prioritize adding new measures which are part of the HEDIS measure set.

MassHealth agrees with MAP's observation that gaps in the current Adult Core Set exist and additional measures are needed to address those gaps especially with regard to high priority, quality issues, such as reproductive health, chronic disease management for people with serious mental illness, and the prevention of Substance Abuse. The proposed list of new measures is lengthy (n=9) however, the phased in implementation approach will allow states to ensure the acquisition of adequate resources prior to measurement.

APPENDIX F:
Additional Measures Considered

MAP considered several measures that did not pass the consensus threshold (>60 percent of voting members) to gain MAP's support or conditional support for use in the Adult Core Set. MAP needed to limit the number of measures it supported for the sake of parsimony and practicality; lack of support for one of these measures does not indicate that the measures are flawed or unimportant. These and other measures could be reconsidered during a future review of the Adult Core Set.

NQF Measure Number	Measure Title	Measure Steward
0480	PC-05 Exclusive Breast Milk Feeding	The Joint Commission
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)	AMA-convened Physician Consortium for Performance Improvement
1927	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	National Committee for Quality Assurance (NCQA)
1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA
2599	Alcohol Screening and Follow-up for People with Serious Mental Illness	NCQA
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA
2601	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	NCQA
2603	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing	NCQA
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	NCQA
2608	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA
n/a	Adults' access to preventive/ambulatory health services: percentage of members 20 years and older who had an ambulatory or preventive care visit.	NCQA

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