NATIONAL QUALITY FORUM

Agenda

MAP Medicaid Task Forces In-Person Meeting

Child Task Force: June 9-10, 2015

Adult Task Force: June 10-11, 2015

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

Remote Participation Instructions:

Streaming Audio Online

- Direct your web browser to: http://nqf.commpartners.com.
- Under "Enter a Meeting" type in the meeting number for June 9: **386849;** June 10: **664661**; June 11: **984359**.
- In the "Display Name" field, type in your first and last names and click "Enter Meeting."

Teleconference

- Dial **(888) 802-7237** for task force members or **(877) 303-9138** for public participants; use conference ID code for June 9: **34296965**; June 10: **34296966**; June 11: **34296985** to access the audio platform.

Meeting Objectives:

- Consider states' experiences implementing the Medicaid Child and Adult Core Sets
- Develop concrete recommendations for strengthening the Medicaid Child and Adult Core Sets through identification of:
  - Most important measure gaps and potential measures to address them
  - Measures found to be ineffective, for potential removal
- Formulate strategic guidance to CMS about strengthening the measure set over time to meet program goals

June 9: MAP Medicaid Child Task Force

8:30 am **Breakfast for Task Force Members**

9:00 am **Welcome, Introductions, and Review of Meeting Objectives**

Foster Gesten, Medicaid Child Task Force Chair

Sarah Lash, Senior Director, NQF

9:15 am **Overview of Meeting Materials and Key Points from Staff Review of Core Set**

Nadine Allen, Project Manager, NQF
Shaconna Gorham, Senior Project Manager, NQF

- Background on enrollee population
- What do we know about states' uptake of measures?
- What do we know about states' performance on measures?
- Patterns apparent in technical assistance requests
- Identify any measures for potential removal

10:30 am **Status of PQMP Measure Development and Endorsement**

Sarah Lash, NQF

10:45 am **State Perspectives Panel – Part 1**

Jeff Schiff, Medical Director for Minnesota Health Care Programs

- Measures selected for reporting and why
- Data collection challenges and potential solutions
- Taking action to improve quality – what are states doing in response?
- What measure gap areas do states perceive?

11:35 am **Public Comment**

11:45 pm **Lunch**

12:30 pm **State Perspectives Panel – Part 2**

Rebekah Gee, Louisiana Medicaid Medical Director
Sandra Blake, University of Louisiana at Monroe
Eddy Myers, University of Louisiana at Monroe

1:15 pm **Measure-Specific Recommendations on Strengthening the Child Core Set**

Foster Gesten
Shaconna Gorham

- Examine measures with low reporting uptake
- Review and select measures to fill gap areas
- Rank new measures selected for potential addition to the set

2:30 pm **Opportunity for Public Comment and Break**

2:45 pm **Continue Measure-Specific Recommendations on Strengthening the Child Core Set**

Foster Gesten

Shaconna Gorham

- Continue reviewing and selecting measures to fill gap areas
- Rank new measures selected for potential addition to the set

4:00 pm **Prioritizing Remaining Measure Gap Areas**

Foster Gesten
Nadine Allen

- Set the stage for MAP's next review and/or guide development efforts

4:30 pm **Opportunity for Public Comment and Adjourn for the Day**

Foster Gesten

June 10: Joint Meeting of Child and Adult Task Forces

8:30 am **Breakfast for Task Force Members**

9:00 am **Welcome**

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

- Welcome and introductions of the Adult Task Force members and invited state panelists
- Review objectives for joint discussion
- Share relevant highlights from previous day

9:30 am **Measure Alignment**

Harold Pincus
Sarah Lash, Senior Director, NQF

- Identify opportunities presented by alignment between core sets
- Alignment in measure selection influenced by other federal, state, and private-sector programs

10:00 am **Break**

10:15 am **Issue of Shared Importance: Measurement of Maternity Care**

Foster Gesten
Shaconna Gorham, Senior Project Manager, NQF

- Point of view from state representative(s)
- Identify measures to fill gap areas in the Child and Adult Core Sets
- Vote on inclusion of measures in Child Core Set, if any, and relative priority for addition based on previous day's discussion
- Vote on inclusion of measures in Adult Core Set, if any

12:15 pm **Opportunity for Public Comment**

12:30 pm **Lunch**

1:00 pm **Issues of Shared Importance: Data Collection, Balancing Process and Outcome Measurement, Motivating Quality Improvement Action within States**

Harold Pincus
Foster Gesten
Sarah Lash, Senior Director, NQF

- Point of view from state representative(s)
- Task Force discussion and recommendations

2:45 pm **Opportunity for Public Comment and Break**

3:00 pm **Supporting States' Ability to Report Measures and Other Cross-Cutting Recommendations to Strengthen the Core Sets**

Harold Pinus
Sarah Lash

- Incentives for state participation
- Forecasting potential impact of Medicaid trends: e.g., increasing enrollment, payment and delivery system reforms
- Other strategic or implementation issues
- Topics to be revisited during MAP's 2016 review

4:00 pm **Summarize Progress and Adjourn for the Day**

Foster Gesten
Harold Pincus

June 11: MAP Medicaid Adult Task Force

8:30 am **Breakfast for Task Force Members**

9:00 am **Welcome Back**

Harold Pincus

- Review the day's objectives
- Share relevant highlights from previous day

9:15 am **Overview of Meeting Materials and Key Points from Staff Review of Core Set**

Zehra Shahab, Project Manager, NQF

Shaconna Gorham

- Background on enrollee population
- What do we know about states' uptake of measures?
- What do we know about states' performance on measures?
- Patterns apparent in technical assistance requests
- Identify any measures for potential removal

10:15 am **Break**

10:30 am **State Perspectives Panel**

Beverly Court, State of Washington Department of Social and Health Services

David Kelly, Chief Medical Officer, Pennsylvania Department of Human Services

- Measures selected for reporting and why
- Data collection challenges and potential solutions
- Taking action to improve quality – what are states doing in response?
- What measure gap areas do states perceive?

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

12:15 pm **Lunch**

1:00 pm **Measure-Specific Recommendations on Strengthening the Adult Core Set**

Harold Pincus

Sarah Lash

- Review measures with low uptake
- Review and select measures to fill gap areas
- Rank measures selected for potential addition to the set

3:15 pm **Opportunity for Public Comment and Break**

3:30 pm **Prioritizing Remaining Measure Gap Areas**

Harold Pincus
Zehra Shahab

- Set the stage for MAP's next review and/or guide development efforts

4:00 pm **Summarize Next Steps and Adjourn Meeting**

Harold Pincus

Measure Applications Partnership

Medicaid Child and Adult Task Forces
In-Person Meeting

June 9-11, 2015

Welcome, Introductions, and Review of Meeting Objectives

Medicaid Child Task Force Membership

Task Force Chair: Foster Gesten, MD, FACP

Organizational Members

Aetna	Sandra White, MD, MBA
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
American Academy of Pediatrics	Terry Adirim, MD, MPH, FAAP
American Nurses Association	Susan Lacey, RN, PhD, FAAN
America's Essential Hospitals	Denise Cunill, MD, FAAP
Blue Cross and Blue Shield Association	Carole Flamm, MD, MPH
Children's Hospital Association	Andrea Benin, MD
Kaiser Permanente	Jeff Convissar, MD
March of Dimes	Cynthia Pellegrini
National Partnership for Women and Families	Carol Sakala, PhD, MSPH
Patient-Centered Primary Care Collaborative	Amy Gibson

Medicaid Child Task Force Membership

Subject Matter Experts

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

Federal Government Members

Agency for Healthcare Research and Quality	Denise Dougherty, PhD
Health Resources and Services Administration (HRSA)	Ashley Hirai, PhD
Office of the National Coordinator for Health IT (ONC)	Kevin Larsen, MD, FACP

In-Person Meeting Objectives

- Consider states' experiences implementing the Medicaid Child Core Set
- Develop concrete recommendations for strengthening the Medicaid Child Core Set through identification of:
  - Most important measure gaps and potential measures to address them
  - Measures found to be ineffective, for potential removal
- Formulate strategic guidance to CMS about strengthening the measure set over time to meet program goals

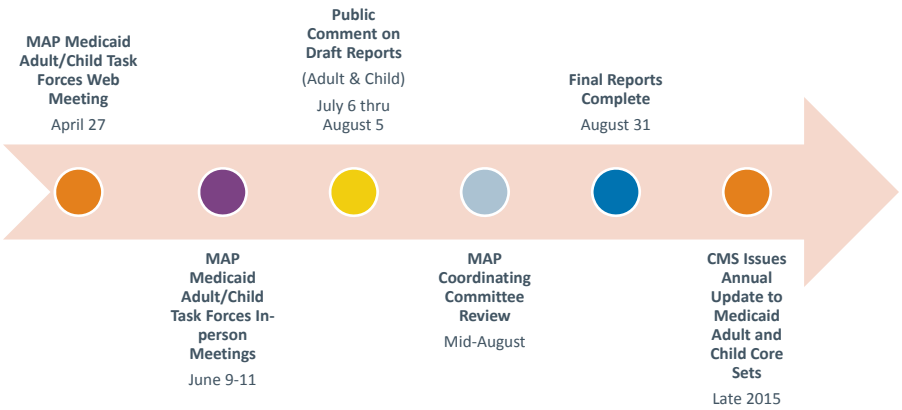
MAP Medicaid Child Task Force Charge

- For this review, the charge of the MAP Medicaid Child Task Force 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.

Themes from April's Web Meeting

- Decision-making should be informed by MAP's understanding of how states use measures, the challenges, and factors that influence reporting.
- Look for gap-filling measures from the AHRQ-CMS Pediatric Quality Measures Program (PQMP) and revisiting MAP's previous recommendations that were not added to the 2015 Child Core Set.

2015 Timeline



Overview of Meeting Materials and Key Points from Staff Review of Core Set

CMS Goals
Child and Adult Core Sets

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

How CMS Uses Core Set Data

CMS uses core set data to obtain a snapshot of quality across Medicaid and CHIP

- Annual Child Health Quality Report
- Annual Adult Health Quality Report
- Chart pack and other analyses
- Inform policy and program decisions

MAP Measure Selection Criteria

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

Potential Reasons for Removal from Core Set

If a measure has:

- Consistently high levels of performance (e.g., >95%), indicating little room for additional improvement
- Multiple years of very low numbers of states reporting, indicating low feasibility or low priority of the topic
- Change in clinical evidence has made the measure obsolete
- Measure does not provide actionable information for state Medicaid program and/or its network of plans/providers
- Superior measure on the same topic has become available
- Et cetera

Decision Categories

- Support (for immediate use)
- Conditional Support
  - Pending endorsement by NQF
  - Pending a change by the measure steward
  - Pending CMS confirmation of feasibility
  - Et cetera
- Do Not Support

Health Issues for Children in Medicaid/CHIP

Understanding the health-related needs of the population contributes to the selection of appropriate measures

- Primary Care Access and Preventive Care
  - Well-child visits
  - Developmental and preventive screenings
- Perinatal Health
- Management of Acute and Chronic conditions
  - Children with complex health needs
- Behavioral Health
- Dental and Oral Health

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

- A substantial body of evidence regarding pediatric health risk and treatment standards underscores EPSDT's continuing importance.
- As acute health conditions in children have declined, the relative importance of serious and chronic health conditions, and risks for such conditions, has grown.
- Today, a significant proportion of children live with chronic illnesses such as asthma, autism, sickle cell disease, or cystic fibrosis.
- Other conditions such as obesity and its physical and mental health consequences, or the effects of conditions of birth that might have claimed children's lives a generation ago, are also a reality in modern pediatrics.
- Taken together, these chronic conditions account for the majority of pediatric hospitalizations and health care spending.
- The health care system has improved its capacity to detect, treat, manage, and reduce the impact of (if not eliminate) chronic physical and mental conditions that affect development.
- The implications of this research are particularly important for low-income children, who face the most significant health risks.

CHCS. EPSDT at 40. (2008) http://www.chcs.org/media/EPSDT_at_40.pdf

EPSDT: Previous Recommendations on High-Value Well-Child Care

Domains in preventive care with implications for long-term physical, emotional, social, educational, and functional outcomes:

- Anticipatory guidance for parents
- Immunization
- Preventive dental care
- Vision and hearing screening
- Lead screening
- Mental health screening
- Developmental screening
  - Resources from APA: http://www2.aap.org/sections/dbpeds/screening.asp
- Body mass index

CHCS. EPSDT at 40. (2008) http://www.chcs.org/media/EPSDT_at_40.pdf

Other High-Impact Health Conditions

- Premature Birth
  - In 2009, one of every eight babies in the U.S. was born prematurely (defined as birth before 37 weeks' gestation), according to CDC's National Center for Health Statistics.
  - About 75 percent of the infants who use a NICU do so because they're premature; the other 25 percent have other medical problems.
- Behavioral Health
  - 2.8 million children with Medicaid used behavioral health services, of which 1.7 million used psychotropic medication (2005 data, CHCS analysis)

S. Pines et al. Faces of Medicaid: Examining Children's Behavioral Health Utilization and Expenditures. Center for Healthcare Strategies. December 2013 S. Pines et al. Faces of Medicaid: Examining Children's Behavioral Health Utilization and Expenditures. Center for Healthcare Strategies. December 2013

Other High-Impact Health Conditions

Use of Antipsychotic Medication among Medicaid-Enrolled Children

- In 2012, a Government Accountability Office (GAO) report found that on average, 6.2% of noninstitutionalized children with Medicaid took psychotropic medications during a calendar year, and 21 percent of those children took an antipsychotic medication.
- Other studies show increased prescribing of antipsychotics to children. One study estimated that antipsychotic use increased from 8.9% in 2002 to **11.8% in 2007**. State-specific rates of any antipsychotic use were significantly increased in 45 states from 2002–2007 (Rubin et al, 2012).

Source: GAO report (http://www.gao.gov/assets/660/650716.pdf).
Source: Rubin et al, 2012 (http://www.sciencedirect.com/science/article/pii/S0190740912001648/pdfft?md5=d929ca4c1cce9c51a7a68796ca254627&pid=1-s2.0-S0190740912001648-main.pdf)

CMS - Child Core Set Update for 2015 Reporting

Issued December 30, 2014

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

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

Medicaid Child Core Set Measures for FFY 2015 Use

NQF #	Measure Name	Measure Steward
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/Adolescents	NCQA
0033	Chlamydia Screening in Women	NCQA
0038	Childhood Immunization Status	NCQA
0108	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA
0139	Pediatric Central-line Associated Bloodstream Infections–Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CDC
0471	Cesarean Rate for Nulliparous Singleton Vertex (PC-02)	Joint Commission
0576	Follow-up After Hospitalization for Mental Illness	NCQA
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment*	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

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

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

Medicaid Child Core Set Measures for FFY 2015 Use - Continued

NQF #	Measure Name	Measure Steward
1407	Immunization Status for Adolescents	NCQA
1448	Developmental Screening in the First Three Years of Life	OHSU
1516	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA
1517	Timeliness of Prenatal Care	NCQA
1799	Medication Management for People with Asthma	NCQA
1959	Human Papillomavirus (HPV) Vaccine for Female Adolescents	NCQA
2508	Prevention: Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk*	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

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

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

MAP Measure-Specific Recommendations – Fall 2014, Continued

MAP had recommended six measures for phased addition. Those in orange are still "on the table" for future action:

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

2. #2548 Child HCAHPS

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

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

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

6. #0480 PC-05 Exclusive Breast Milk Feeding

Staff Review of FFY 2014 State Reporting

Overview of Medicaid Child Core Set FFY 2014 Reporting

Child Core Set participation is strong, with room for improvement

- Most states submitted data for FFY2014.
- All 22 measures were reported by at least four states.
- Most frequently reported measures include well child visits, adolescent well-care visits, access to primary care practitioners

Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia
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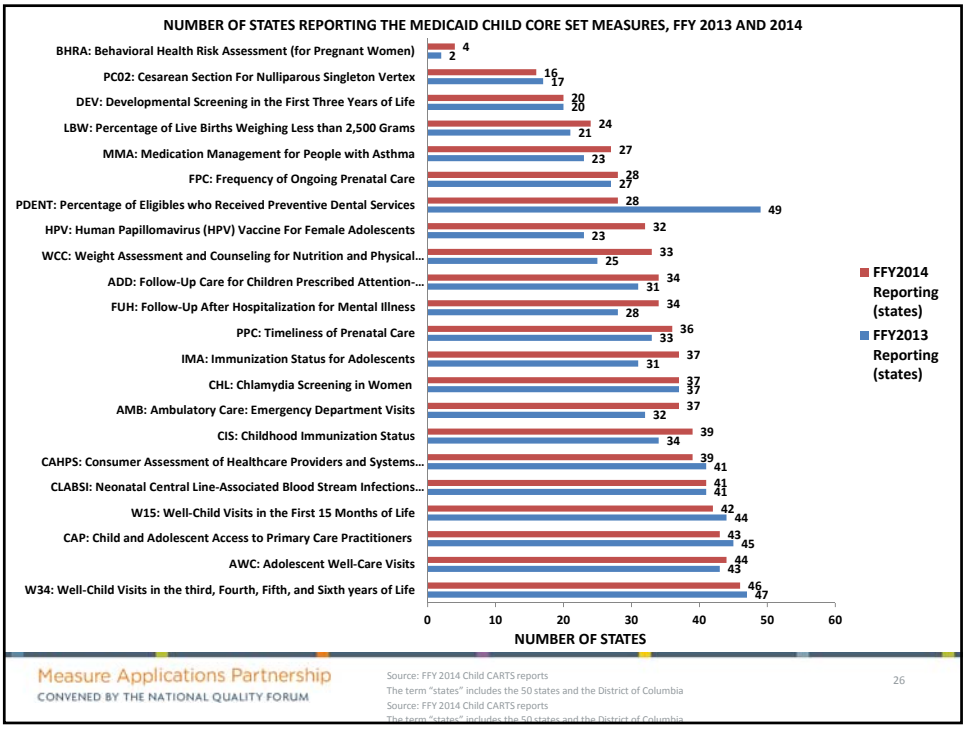
The term "states" includes the 50 states and the District of Columbia



Source: FFY 2014 Child CARTS reports
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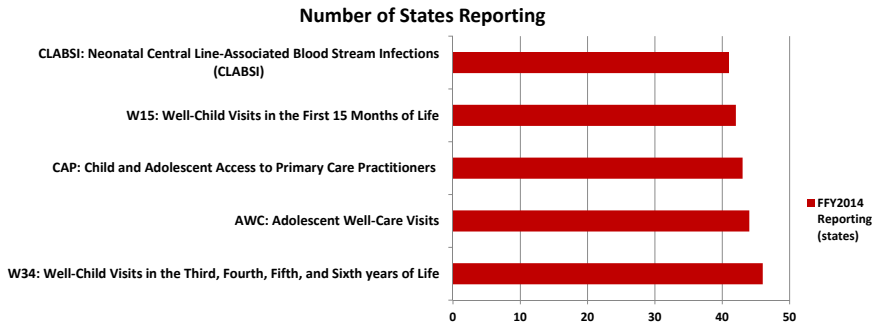
Measures with High Levels of Reporting (5)

Measures with consistently high reporting by ≥ 41 states in 2013 and 2014

- Tend to be claims-based HEDIS measures and most are reflective of primary care encounters



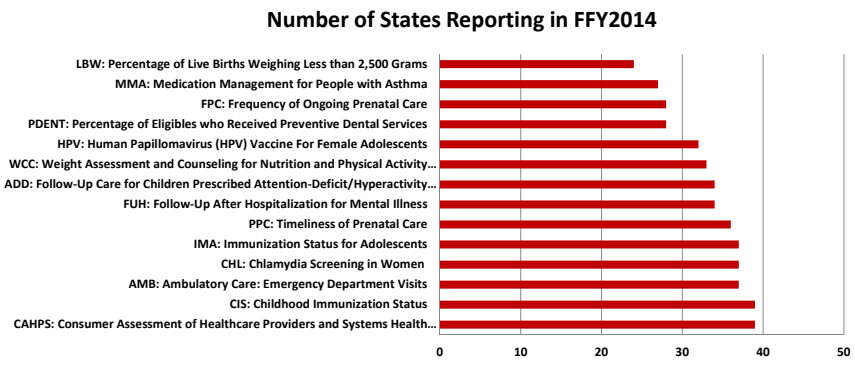
Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

Measures Reported More Frequently in FFY 2014 (14)

Measures with 24 – 39 states reporting, gaining ground from FFY2013

- Most measures have increased uptake by three or more states



Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

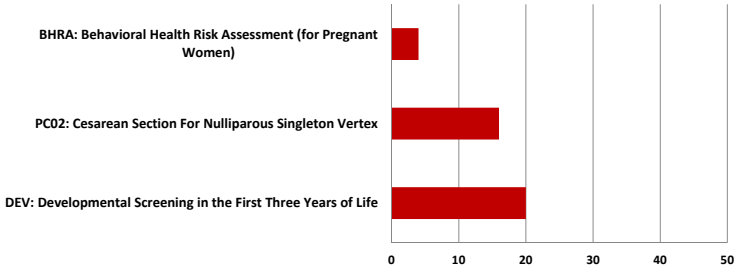
Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

Measures with Relatively Low Levels of Reporting (3)

Measures with 4 to 20 states reporting

- Behavioral Health Risk Assessment was reported for the first time in FFY2013

Number of States Reporting in FFY2014



Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia
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Staff Review: Reasons Given for Not Reporting and Measures for Potential Removal

- Most commonly cited reason for not reporting most measures was "data not available"
- Relatively few Technical Assistance (TA) requests
  - 0-3 requests per measure
  - TA team conducted a webinar on collecting and using the measure of Developmental Screening
- Based on staff review, none of the measures currently being reported were identified for potential removal.
- Do any members of the Task Force wish to propose a measure for removal? Please explain why.

Status of PQMP Measure Development and Endorsement

MAP's 2014 Input

- In 2014 review, MAP noted measures in various stages of development under the auspices of the AHRQ-CMS Pediatric Quality Measures Program (PQMP)
  - Measures will help address relative lack of measures designed for use with the pediatric population

Pediatric Quality Measures Program (PQMP) Background

- Established under the Children's Health Insurance Program Reauthorization Act (CHIPRA, Public Law 111-3), Section 401(b), PQMP is intended to:
  - Improve and strengthen the core set of children's health care quality measures.
  - Expand on existing pediatric quality measures used by public and private health care purchasers and advance the development of such new and emerging quality measures.
  - Increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's health care services, providers, and consumers.

Source: CHIPRA Pediatric Quality Measures Program. July 2014. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/policymakers/chipra/pqmpback.html Source: CHIPRA Pediatric Quality Measures Program. July 2014. Agency for Healthcare Research and Quality, Rockville, MD.

PQMP Background, Continued

The PQMP is comprised of…

- Seven CHIPRA Pediatric Healthcare Quality Measures Program Centers of Excellence (CoE) supported by cooperative agreement grants with AHRQ, funded by the Centers for Medicare & Medicaid Services (CMS).
- A CHIPRA Coordinating and Technical Assistance Center (CTAC), under contract with RTI International.
- Two CHIPRA quality demonstration project grantees (Illinois, a partner to the Florida grantee, and Massachusetts) funded by CMS are undertaking new quality measure development as part of their demonstration grants.

Pediatric Quality Measures Program (PQMP) : Measures (NQF Endorsed, Available, and in Development)

- Two NQF-endorsed measures:
  - 2393 Pediatric All-Condition Readmission Measure
  - 2414 Pediatric Lower Respiratory Infection Readmission
- 76 measures available including perinatal care, child clinical preventive services, management of acute conditions and chronic conditions, patient reported outcomes, duration of enrollment and coverage, availability of services, and medication reconciliation
- 24 measures in development including perinatal/prenatal care, child clinical preventive services, management of acute conditions and chronic conditions, and other

Source: Agency for Healthcare Research and Quality:. Pediatric Quality Measures Program. Table 2. PQMP Pediatric Quality Measure Topics for Measures in Development http://www.ahrq.gov/policymakers/chipra/factsheets/factsheets2.html#tab2
Table 1. Available Measures Developed by PQMP Grantees http://www.ahrq.gov/policymakers/chipra/factsheets/index.html#tab1

State Perspectives Panel, Part 1

Jeff Schiff, MD, MBA
Medical Director, Minnesota Department of Human Services

Measurement and reporting from a state perspective

Jeff Schiff, MD MBA
Medical director, Minnesota DHS

Key Aspects of Minnesota's Measurement Journey

- Early adopter of Managed Care
- Development of Minnesota Community Measurement
  - Measures at the provider group level
  - Funded by the Managed Care organizations
- 2008 Health Reform legislation
  - State Quality Measurement and Reporting System
  - Provider Per Grouping
- Effectiveness of shift to provider group level reporting

Can we measure value?

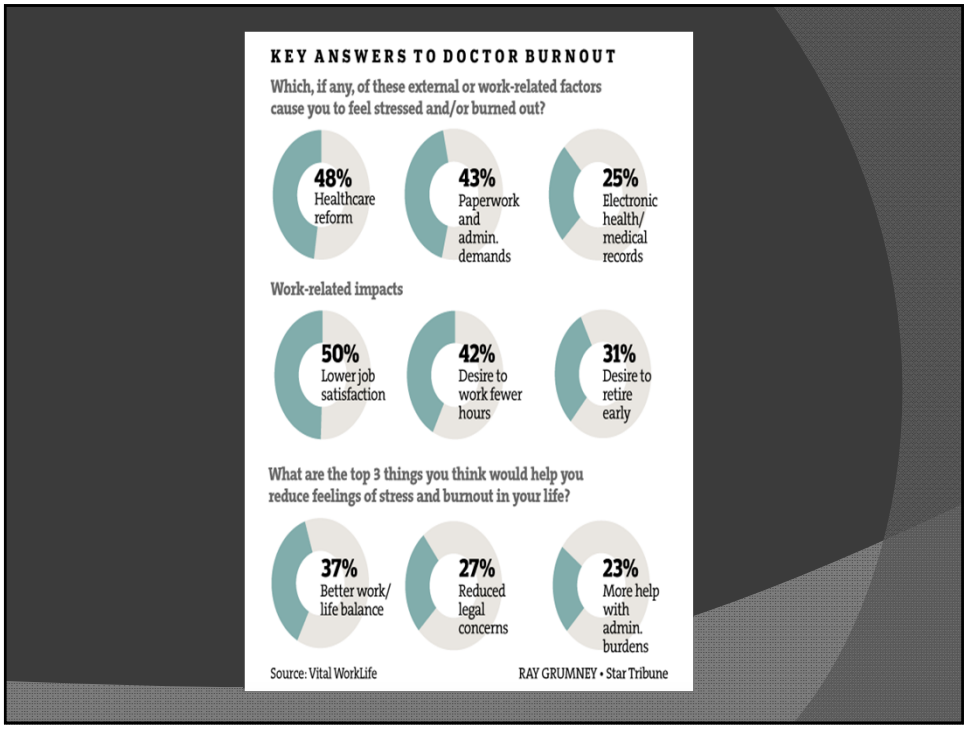
- If value = cost/quality, then what's role of quality in new payment mechanisms
- 2009 – implementation of patient centered medical home
- 2012 – Integrated health partnerships (Medicaid ACOs)

Doctor burnout is a rising problem in Minnesota medicine

Epidemic of burned-out doctors threatens care.

By Jeremy Olson Star Tribune | MAY 24, 2015 — 6:48AM

ILLUSTRATION BY ROB DOBI, SPECIAL TO THE STAR TRIBUNE



Physician burnout…

…is on the rise in Minnesota and across the country, as the traditional strains of a medical practice — long hours and draining cases — are compounded by new challenges, such as computerized records and **payment reforms that judge doctors by their patients' health**. A series of influential studies by Minnesota researchers suggest that burnout could aggravate the state's shortage of primary care doctors by driving some into early retirement and undermine the quality of patient care by eroding doctors' compassion and attention to detail.

Medicaid levers to improve quality of care at the state level

- MCO contracting
- Changes to payment models – FFS and MCO – dental
- Direct to provider relationships – PCMH/ACO
- Focused policy/payment initiatives
  - Payment for social/emotional screening
  - Early elective delivery

MCO contracting

- Withholds and incentives
- Limited bandwidth to impact clinical care
  - Better for access issues
- Multiple messages that are subtly different
  - Better with community measurement
- Providers question importance and are concerned about bandwidth

Changes to payment rates –FFS and MCO

- Changes in rates to improve access
- Changes in rates to drive behavior

Direct to provider relationships – PCMH/ACO/ Accountable communities

- Outcomes jointly decided
- Outcomes are broad, but can get more specific
- Allows for provider level innovation

Focused policy/payment initiatives

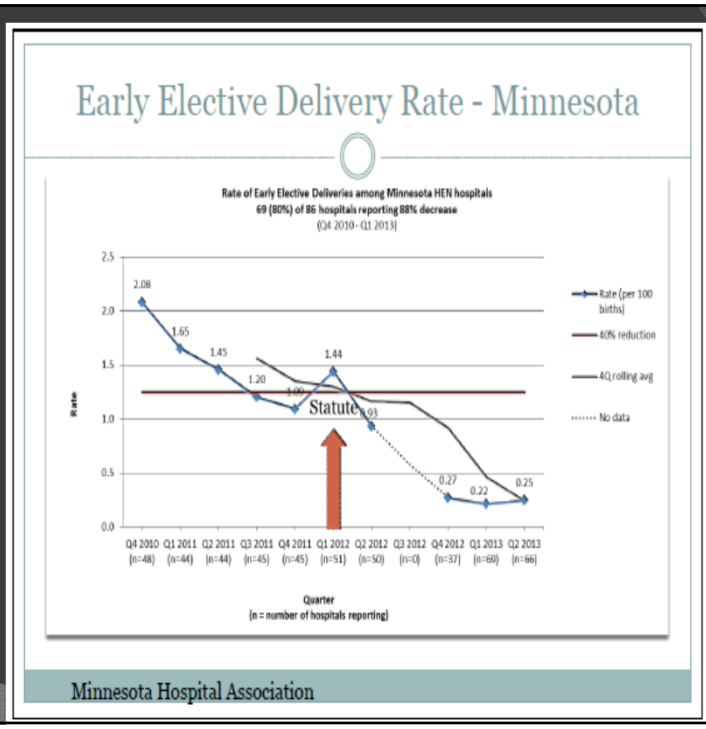
- Topic specific
- Engage provider community
  - Leadership
  - Acceptance of measure
- Process or program underlies the measure
  - Community agreement on importance
    - Measure a health outcome or a big process step to get there
    - Established evidence
    - Relevance to the population
    - Health care system able to impact
    - Solvable system / process issues

Focused policy/payment initiatives (continued)

- Measure is seen as sentinel
  - Acceptance of multitude of steps to get to the measure
- State as a convener
  - Establish consensus
  - Support a process – infrastructure to get to the change
  - Support provider practice change – financially or via technical support/information

Evidence-based childbirth program

- Hospitals attest to:
  - Hard stop policy except for
    - Predetermined medical indications
    - By review other medical or non-medical exceptions
    - Locally developed set of indications
  - Internal quality review of all planned deliveries under 39 weeks
  - Consistent efforts to estimate gestational age by 20 weeks
  - Patient / family education
- Hospital to report aggregate results
- Non-participating hospitals report results by patient
- NO non-payment policy



Vertical linkage of national NQF measures to patients and providers

- Establish local relevance
- Track the measure as a sentinel outcome of a performance improvement effort measured by structural and process steps
- Support and define the performance improvement effort

What is the developmental capacity of this part of the system to use the measure to improve care?

Decisions guided by the purpose of measurement

- Measurement for accountability
- Measurement for quality improvement
- Measurement to compare populations/ identify disparities
- Measurement to develop policy

In Minnesota

- What do we measure and report?
- What do we measure and not report?
- What would we like to measure?

DHS Children's Medicaid Core Set Measures Annually Reported:

- Child and Adolescents' Access to Primary Care Practitioners (CAP)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

Children's Medicaid Core Set Measures that DHS could collect and report:

- Chlamydia Screening in Women (CHL)
- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Human Papillomavirus Vaccine for Female Adolescents (HPV)
- Adolescent Well-Care Visit (AWC)
- Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Medication Management for People with Asthma (MMA)
- Prevention: Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL)
- Percentage of Eligibles Who Received Preventive Dental Services (PDENT)
- Cesarean Section rates

Data on post partum visit

- 2010 – 49%
- 2013 – 42%
- 2013 by race
  - White 41%
  - Black 36%
  - American Indian 34%
  - Hispanic 60%

Children's Medicaid Core Set Measures that DHS *should* collect and report

- Outcome measures
  - Live birth under 2500 grams
- Process measures
  - Developmental screening <3 year olds
  - Frequency of ongoing prenatal care

Projects we are working on where we'd like better measures

- Children's mental health care outcomes
- Integration of behavioral and physical health
- Care coordination / case management
- Social determinants of health
- Specific challenges – opioid use; disparities in autism diagnosis

Measure depth???

- Infrastructure
- Process
- Health outcome

Measure depth???

- Deep infrastructure – team cohesion/provider satisfaction
- Infrastructure – Health care home certification
- Process – care plans and screening
- Health outcome – early elective deliveries
- Well being – SF 12/ PROMIS

Which is better?

- A good measure of infrastructure
- An incomplete measure of process/ health outcome

Example: Infrastructure measure to support trauma informed behavioral health care vs. follow up for ADHD

Opportunities

Link measures to quality improvement and policy

- CMS expert panel/ strong start/ adult quality measures grants

Future

- Medicaid Medical Directors Network
- Linkages with AAP/ABP others

Group Discussion: Key Themes from State Experiences

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

Opportunity for Public Comment

Lunch

State Perspectives Panel, Part 2

Rebekah Gee, MD, MPH, FACOG
Medicaid Medical Director, State of Louisiana

Sandra Blake, PhD, MBA
Director

Eddy Myers, MBA, CPA
Assistant Director
University of Louisiana at Monroe
Office of Outcomes Research and Evaluation

Collecting and Reporting Medicaid Children's Core Set Quality Measures in Louisiana

Rebekah Gee, MD, MPH, MS, FACOG
Medicaid Medical Director
Louisiana Department of Health and Hospitals

Sandra Blake, PhD, MBA
Director
& Eddy Myers, MBA, CPA
Assistant Director
University of Louisiana at Monroe
Office of Outcomes Research and Evaluation

June 9, 2015

BAYOUHEALTH
Your Health | Your Choice

Overview

- CHIPRA Selected Measures for Louisiana Medicaid
- Selected Results for 2014
- Successes
- Challenges
- Quality Improvement
- Recommendations
- Questions

Louisiana's Medicaid Delivery Model for Children and Youth < Age 19

- Statewide mandatory Medicaid managed care as of June 2012 for most children and pregnant women
- Two managed care models operated concurrently 2012 through January 2015
  - Three Risk bearing managed care organizations (MCOs)
  - Two Primary care case management (PCCM) entities that operated like MCO's
- Fewer than 10,000 children remained in fee-for-service Medicaid

2015 CHIPRA Measures Reported (2014 Measurement Year)

- Child and Adolescents' Access to Primary Care Practitioners
- Chlamydia Screening in Women
- Childhood Immunization Status
- Well-Child Visits in the First 15 Months of Life
- Immunizations for Adolescents
- Developmental Screenings in the First Three Years of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Human Papillomavirus Vaccine for Female Adolescents
- Adolescent Well-Care Visit
- PC-02: Cesarean Section
- Live Births Weighing Less Than 2500 Grams
- Frequency of Ongoing Prenatal Care
- Prenatal & Postpartum Care: Timeliness of Prenatal Care
- Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication
- Follow-Up After Hospitalization for Mental Illness
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents-BMI
- Medication Management for People with Asthma
- Ambulatory Care-ED
- Percentage of Eligibles Who Received Preventive Dental Services
- CAHPS 5.0 Child Version

Selected 2014 Results (2013 Measurement Year)

Measure Name	Rate
Adolescent Well-Care Visit (AWC)	35.99%
Cesarean Rate for Nulliparous Singleton Vertex (CSEC PC-02)	29.01%
Immunization Status for Adolescents (IMA) -Combination 1	88.17%
Live Births Weighing Less than 2,500 Grams (LBW)	12.14%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)	56.91%

Focusing on Continuous Improvement

- Number of Children's Health Quality Measures collected
  - 2013 Measurement Year: 6 CHIPRA measures
  - 2014 Measurement Year: 16 measures
  - 2015 Measurement Year: Planning for 20 of the 24 measures
- Synergies with CMS Adult Core Grant helped facilitate programming/development of new CHIPRA measures:
  - Chlamydia Screening in Women
  - Timeliness of Prenatal Care
  - Follow-Up After Hospitalization for Mental Illness
- Worked with our public health agency to create innovative Medicaid/Vital Records data match to facilitate data collection for following CHIPRA measures:
  - PC-02 Cesarean Section
  - Live Birth Weighing Less Than 2,500 Grams
  - Frequency of Ongoing Prenatal Care

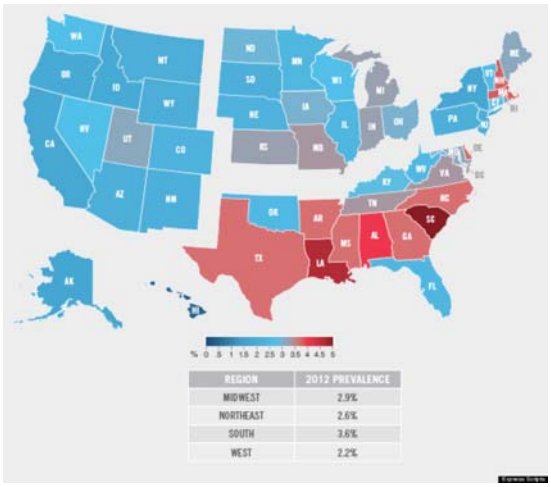
Data Collection is Moving Beyond Using Exclusively Claims Data

- Administrative claims data measures utilized when possible to streamline data collection
- Chart reviews currently being performed through the partnership with the University of Louisiana at Monroe Office of Outcomes Research and Evaluation will generate data for measures not available from claims data
- Electronic immunization records from Office of Public Health's Louisiana Immunization Network for Kids Statewide (LINKS) incorporated with claims data to get more complete and accurate immunization results for following measures:
  - Childhood Immunization Status
  - Immunizations for Adolescents

Some Initial Challenges Faced with Children's Core Set Measures

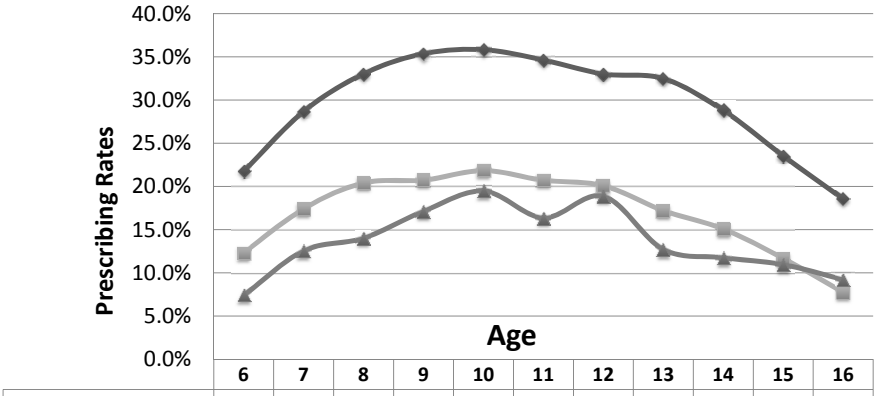
- Measures planned for reporting adjusted after assessing feasibility/data availability
  - *e.g.* Data required for Pediatric Central Line-Associated Bloodstream Infections is not readily available
- Medicaid data to Vital Records data matching process-- complex and time-consuming to create
- Chart review process-- initial learning curve for determining most efficient ways of obtaining necessary medical records

The Geography of ADHD Drug Utilization



TURNING ATTENTION TO ADHD
AN EXPRESS SCRIPTS REPORT | MARCH 2014
U.S. MEDICATION TRENDS
for **ATTENTION DEFICIT HYPERACTIVITY DISORDER**

Prevalence of Louisiana Males (6-16) Enrolled in Medicaid with at Least 1 Psychostimulant Prescribed



	6	7	8	9	10	11	12	13	14	15	16
non-Hispanic White	21.8%	28.7%	33.0%	35.4%	35.8%	34.6%	33.0%	32.5%	28.8%	23.5%	18.5%
non-Hispanic Black	12.3%	17.4%	20.4%	20.7%	21.8%	20.7%	20.1%	17.2%	15.1%	11.7%	7.8%
Other Races	7.4%	12.6%	14.0%	17.1%	19.5%	16.4%	18.9%	12.7%	11.7%	10.9%	9.2%

Strategies to Reduce Inappropriate Prescribing of Psychostimulants

- Mandatory Performance Improvement Project (PIP) for MCOs
- Performance measure with financial implications (withhold) in MCO contract: modified HEDIS measure (Follow-up Care for Children Prescribed ADHD Medication, expanded to younger children and adolescents)
- Claims edits for dispensing for children age five and under
- Provider education—
  - ADHD treatment guidelines and assessment tools
  - Standard assessment packets and processes for data collection at practice level
  - Assistance to practices for provision of care coordination
- Engaging parents and schools --development of handout and other educational materials

Collecting CHIPRA Core Set Data Is Driving Quality Improvement

- Capacity for analyzing and reporting quality measures across all Medicaid programs has been increased
- Results of these analyses is now driving Medicaid policy and interventions to improve health outcomes
- Capabilities have been added that can be utilized in other measures, systems or initiatives (*e.g.* Vital Records matching and successful chart review methods/processes)

Recommendations to MAP for Strengthening Measures

- Enhance process for obtaining clarifications about specifications to minimize programming delays (e.g. possible webpage with FAQs)
- Address identified quality measure gaps
  - Potentially avoidable emergency room visits
  - Prematurity
  - Cross Sector measures
  - Measures linking public health with Medicaid data
  - Measures that effectively measure individual physician performance
  - ADHD and Behavioral Health measures relevant to pediatric populations

Questions and More Information

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Bureau of Health Services Financing
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P.O. Box 91030
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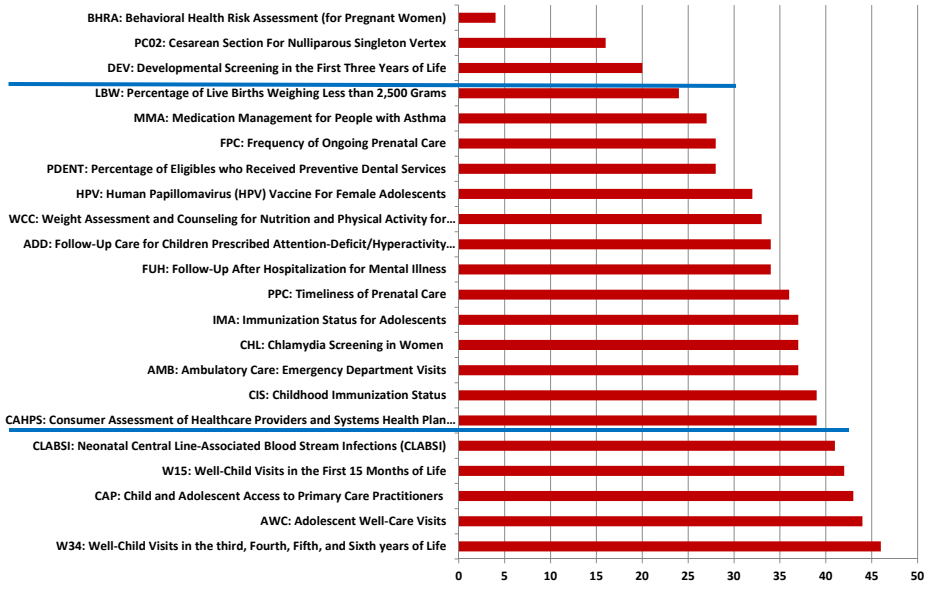
Group Discussion: Key Themes from State Experiences

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

Measure by Measure Review

Number of States Reporting Measures in Medicaid Child Core Set FFY 2014



Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

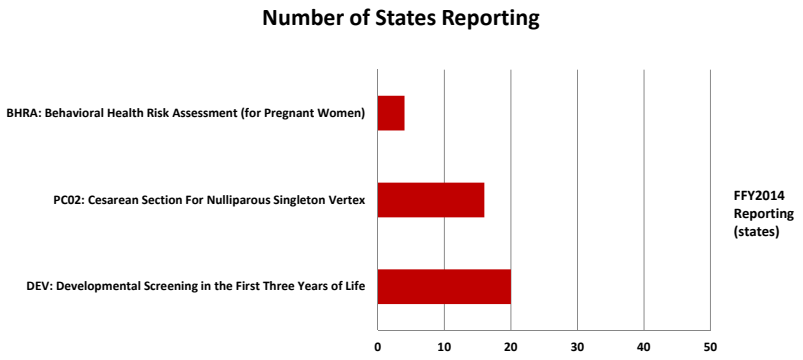
Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

Measure by Measure Review

- The majority of the measures appear to be functioning well and do not warrant detailed discussion.
- Focus on measures with low levels of reporting
- What can we learn about the measures that are (or are not) a good fit for this program based on the handful that relatively few states report?

- We will reserve MAP's time for review of potential gap-filling measures.

Measure by Measure Review: Measures with Low Levels of Reporting (3)



Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

1448 – Developmental Screening the First Three Years of Life

NQF Endorsed – Steward: Oregon Health & Science University

QPS Link: http://www.qualityforum.org/qps/1448

Description:	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.
Exclusions:	None
Data Source:	Administrative claims, Electronic Clinical Data, Paper Medical Records
Type:	Process

1448 – Developmental Screening the First Three Years of Life

NQF Endorsed – Steward: Oregon Health & Science University

- 20 states reported FFY 2014
  - 18 states reported the measure using Oregon Health & Science University specifications
- Reasons states did not report (n=31):
  - The data were not available (22)
  - Other reasons: Information was not collected because of budget constraints, data inconsistencies/accuracy, requires medical record review, and information not collected by provider (hospital/health plan) and other.

Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia
Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

0471 – PC-02: Cesarean Section (PC02)

NQF Endorsed – Steward: The Joint Commission

QPS Link: http://www.qualityforum.org/qps/0471

Description:	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).
Exclusions:	• ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for contraindications to vaginal delivery as defined in Appendix A, Table 11.09 • Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Enrolled in clinical trials • Gestational Age < 37 weeks
Data Source:	Administrative claims, Paper Medical Records
Type:	Outcome

0471 – PC-02: Cesarean Section (PC02)

NQF Endorsed – Steward: The Joint Commission

- 16 states reported FFY 2014
  - 10 states reported the measure using the Child Core Set specifications, which were based on The Joint Commission 2014 specifications
- Reasons states did not report (n=35):
  - The data were not available (20)
  - Other reasons: Information was not collected because of budget constraints, staff constraints, data inconsistencies/accuracy, data source not easily accessible (i.e., requires medical record review and data linkage which does not currently exist), and information not collected by provider (hospital/health plan)

Not endorsed – Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)

Steward: American Medical Association-Physician Consortium for Performance Improvement

Description:	Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: screening for depression, alcohol use, tobacco use, drug use, and intimate partner violence screening.
Exclusions:	None
Data Source:	Electronic Health Records
Type:	Process

Not Endorsed – Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)

Steward: AMA-PCPI

- Four states reported FFY 2014
  - Three states reporting the measure using the Child Core Set specifications for FFY 2014
- Reasons states did not report (n=47):
  - The data were not available (35)
  - Other reasons: Information was not collected because of budget constraints, staff constraints, data source not easily accessible (i.e., requires medical record), information not collected

Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia
Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

Discussion

- How might participation in reporting these measures be increased?
- What can we learn about the measures that are (or are not) a good fit for this program based on the handful that relatively few states report?

Opportunity for Public Comment

Measure by Measure Review: Measures for Potential Addition

Previously Identified Gaps in the Medicaid Child Core Set – Fall 2014

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

Gap Areas with Measures Currently Available

- Cost measures (on the topic of readmissions) (2)**
- Mental and behavioral health measures (10)**
- Care coordination measures (4)*
- Inpatient measures (7)**
  - *Some measure gap areas do not have strong enough measures for addition at this time. New measures will become available for later reviews.*
  - *Staff performed a preliminary analysis of measures and have highlighted **three** that appear to be a good fit.*

** Denotes both NQF endorsed and PQMP measures
* Denotes PQMP measures only ** Denotes both NQF endorsed and PQMP measures
* Denotes PQMP measures only

Decision Categories

- Support (for immediate use)
- Conditional Support
  - Pending endorsement by NQF
  - Pending a change by the measure steward
  - Pending CMS confirmation of feasibility
  - Et cetera
- Do Not Support

Medicaid Child Core Set: Cost/Readmission Gap Area

Available Measures

NQF #	Measure Name	Measure Steward
2393	**Pediatric All-Condition Readmission Measure**	**Center of Excellence for Pediatric Quality Measurement**
2414	Pediatric Lower Respiratory Infection Readmission Measure	Center of Excellence for Pediatric Quality Measurement

Analysis favored the all-condition, rather than condition-specific, measure of readmission.

Medicaid Child Core Set: Mental/Behavioral Health Gap Area

Available Measures

NQF #	Measure Name	Measure Steward
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	National Committee for Quality Assurance
n/a	Reporting on supplemental CAHPS data regarding availability of treatment or counseling services for children on Medicaid for whom the family sought treatment or counseling for an emotional, developmental, or behavioral problem	NCINQ
2337	**Antipsychotic Use in Children Under 5 Years Old**	**Pharmacy Quality Alliance, Inc.**
n/a	Use of first-line psychosocial care for children and adolescents on antipsychotics	NCINQ
n/a	Follow-up visit for children and adolescents on antipsychotics	NCINQ

Medicaid Child Core Set: Mental/Behavioral Health Gap Area Continued

NQF #	Measure Name	Measure Steward
n/a	Metabolic screening for children and adolescents newly on antipsychotics	NCINQ
n/a	Metabolic monitoring for children and adolescents on antipsychotics	NCINQ
n/a	**Use of multiple concurrent antipsychotics in children and adolescents**	**NCINQ**
n/a	Safe and judicious antipsychotic use in children and adolescents	NCINQ
n/a	Use of antipsychotic medications in very young children	NCINQ

Analysis favored the endorsed measure for use in very young patients, and the complementary topic of multiple concurrent meds.

Medicaid Child Core Set: Care Coordination Gap Area

Available Measures

NQF #	Measure Name	Measure Steward
n/a	Transition from pediatric-focused to adult-focused health care	CEPQM
n/a	Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-focused Health Care	CEPQM
n/a	Pediatric Medical Complexity Algorithm Family Experiences with Coordination of Care (FECC)	COE4CCN
n/a	Timeliness of follow-up visits following hospital discharge of children with a primary mental health diagnosis	CAPQUAM

Medicaid Child Core Set: Inpatient Gap Area

Available Measures

NQF #	Measure Name	Measure Steward
0138	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	Centers for Disease Control and Prevention
1360	Audiological Evaluation no later than 3 months of age (EHDI-3)	Centers for Disease Control and Prevention
1659	Influenza Immunization	Centers for Medicare & Medicaid Services
n/a	Pediatric Medical Complexity Algorithm	COE4CCN
n/a	Accurate ADHD diagnosis	PMCOE
n/a	Behavior therapy as first-line treatment for preschool-aged children with ADHD	PMCOE
n/a	Pediatric global health	CHOP

2393 – Pediatric All-Condition Readmission Measure

NQF Endorsed – Steward: Center of Excellence for Pediatric Quality Measurement

QPS Link: http://www.qualityforum.org/qps/2393

Description:	This measure calculates case-mix-adjusted readmission rates, defined as the percentage of admissions followed by 1 or more readmissions within 30 days, for patients less than 18 years old. The measure covers patients discharged from general acute care hospitals, including children's hospitals.
Numerator Statement	The numerator consists of hospitalizations at general acute care hospitals for patients less than 18 years old that are followed by 1 or more readmissions to general acute care hospitals within 30 days. Readmissions are excluded from the numerator if the readmission was for a planned procedure or for chemotherapy. The measure outcome is a readmission rate, defined as the percentage of index admissions with 1 or more readmissions within 30 days. The readmission rate, unadjusted for case-mix, is calculated as follows: number of index admissions with 1 or more readmissions within 30 days/ total number of index admissions
Denominator Statement	Hospitalizations at general acute care hospitals for patients less than 18 years old.
Exclusions:	We exclude certain hospitalizations from the measure entirely (i.e., from the numerator and denominator) based on clinical criteria or for issues of data completeness or quality that could prevent assessment of eligibility for the measure cohort or compromise the accuracy of readmission rates. We also apply further exclusions to the denominator only (i.e., these hospitalizations are excluded from index hospitalizations but could still meet criteria for readmissions).
Data Source:	Administrative claims
Type:	Outcome

2337 – Antipsychotic Use in Children Under 5 Years

NQF Endorsed – Steward: Pharmacy Quality Alliance (PQA, Inc.)

QPS Link: http://www.qualityforum.org/qps/2337

Description:	The percentage of children under age 5 who were dispensed antipsychotic medications during the measurement period.
Numerator Statement	The number of patients under 5 years of age with one or more prescription claims for an antipsychotic medication with days supply that total greater than or equal to 30 days.
Denominator Statement	Children who are less than 5 years old at any point during the measurement period, and also enrolled in a health plan for one month or longer during the measurement period.
Exclusions:	None
Data Source:	Administrative claims
Type:	Process

Use of Multiple Concurrent Antipsychotics in Children and Adolescents

Not Endorsed – Steward: NCINQ

Description:	The percentage of children 0 to 20 years of age on any antipsychotic medication for longer than 90 days during the measurement year who were on two or more concurrent antipsychotic medications for longer than 90 days.
Numerator Statement	Those on two or more concurrent antipsychotic medications for at least 90 days during the measurement year
Denominator Statement	Children ages 0 to 20 years on any antipsychotic medication during the measurement year, with at least 3 months of continuous health plan eligibility for medical and pharmacy benefits. Age stratification: 0-5 years, 6-11 years, 12-17 years, 18-20 years
Exclusions:	None
Data Source:	Administrative claims
Type:	Process

Recommendations for Strengthening the Child Core Set

Task Force Votes to Recommend Each Measure for Inclusion

- Vote to support (or conditionally support) inclusion of:
  - *#2393 Pediatric All-Condition Readmission Measure*
  - *#2337 Antipsychotic Use in Children Under 5 Years*
  - *(not endorsed) Use of Multiple Concurrent Antipsychotic in Children and Adolescents*
- Are there other measures Task Force members would propose for addition?

Recommendations for Strengthening the Child Core Set

Ranking Measures with Support for Addition

- Task Force will prioritize measures selected for use. Priority will indicate the order in which MAP recommends CMS add the measures to the set.

- New measures (TBD)
  and
- Measures recommended in 2014
  - PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice
  - Under 1500g infant Not Delivered at Appropriate Level of Care
  - Dental Sealants for Children Ages 10-14

Prioritizing Remaining Gap Areas

Gaps in the Medicaid Child Core Set

Have any of the gap areas been satisfied?
Do others need to be added?

- Care coordination
- Screening for abuse and neglect
- Injuries and trauma
- Mental health
- Overuse/medically unnecessary care
- Inpatient measures
- Durable medical equipment (DME)
- Cost measures

Strategy for Filling High Priority Measure Gaps

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

Opportunity for Public Comment

Adjourn for the Day

Measure Applications Partnership

Medicaid Child and Adult Task Forces
In-Person Meeting

Day 2 – June 10, 2015

NATIONAL QUALITY FORUM

Introductions of the Adult Task Force Members

Medicaid Adult Task Force Membership

Task Force Chair: Harold Pincus, MD

Organizational Members

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

Medicaid Adult Task Force Membership

Subject Matter Experts

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

Federal Government Members

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

In-Person Meeting Objectives

- Consider states' experiences implementing the Medicaid Child and Adult Core Sets
- Develop concrete recommendations for strengthening the Medicaid Child and Adult Core Sets through identification of:
  - Most important measure gaps and potential measures to address them
  - Measures found to be ineffective, for potential removal
- Formulate strategic guidance to CMS about strengthening the measure set over time to meet program goals

MAP Medicaid Adult Task Force Charge

- For this review, the charge of the MAP Medicaid Adult Task Force 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 convened the task force in April 2015, with a report due to CMS by August 2015.

Today's Action Items

Combined Adult and Child Task Force Discussion

- Measure Alignment
- Issues of Shared Importance:
  - Perinatal / Maternity Care Measures
  - Moving from Process to Outcome Measurement
  - Motivating Quality Improvement Action
  - Supporting States' Ability to Participate in Reporting

Recap of Relevant Points from Previous Day

CMS Goals
Child and Adult Core Sets

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

How CMS Uses Core Set Data

CMS uses core set data to obtain a snapshot of quality across Medicaid and CHIP

- Annual Child Health Quality Report
- Annual Adult Health Quality Report
- Chart pack and other analyses
- Inform policy and program decisions

MAP Measure Selection Criteria

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

Potential Reasons for Removal from Core Set

If a measure has:

- Consistently high levels of performance (e.g., >95%), indicating little room for additional improvement
- Multiple years of very low numbers of states reporting, indicating low feasibility or low priority of the topic
- Change in clinical evidence has made the measure obsolete
- Measure does not provide actionable information for state Medicaid program and/or its network of plans/providers
- Superior measure on the same topic has become available
- Et cetera

Decision Categories

- Support (for immediate use)
- Conditional Support
  - Pending endorsement by NQF
  - Pending a change by the measure steward
  - Pending CMS confirmation of feasibility
  - Et cetera
- Do Not Support

Measure Alignment

Measure Alignment

To what degree are the Adult and Child Core Sets already aligned?

- Shared measures with different age groups reported
  - Chlamydia Screening (#0033)
  - Follow-up After Hospitalization for Mental Illness (#0576)
- Single measure with rates split across the measure sets (#1517)
  - Timeliness of Prenatal Care (Child)
  - Postpartum Care (Adult)
- Similar but separate measures for different age groups
  - BMI Screening/Counseling (not endorsed)

Measure Alignment: Task Force and State Panelist Discussion

Opportunities for Alignment

- Between Core Sets
  - Is further alignment of measures needed between the Adult and Child Core Sets?
- With Other Programs
  - Does it help states if measures selected for the Core Sets are used for other reporting requirements?
  - If so, which other measurement programs are most important for alignment purposes?
- Does the recent IOM report offer relevant guidance?

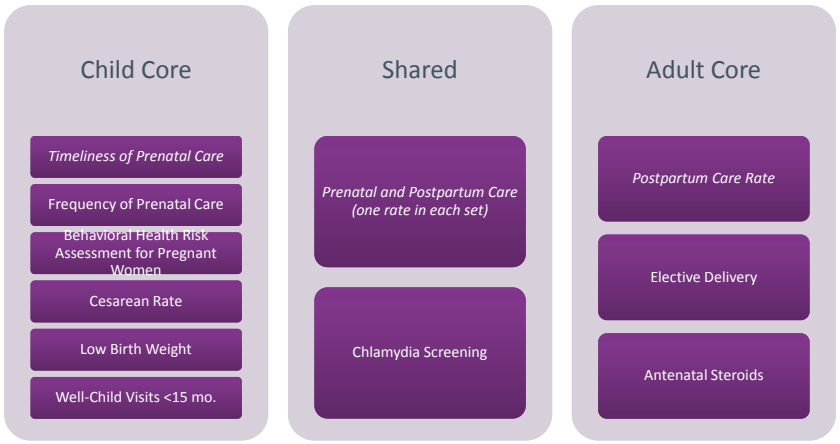
Break

Measurement of Maternity Care

Perinatal / Maternity Care Is a Measurement Priority

- With ~11 total measures, Perinatal / Maternity Care is the most frequently measured topic across the Child and Adult Core Sets.
- Relevant measures are present in both sets and need to be viewed together to see the full picture of quality.
- Despite the relatively large number of measures, some MAP members continue to regard this as a gap area – specifically, measures that relate to mitigating the risk of poor birth outcomes

Overlapping Maternal and Child Health Measures



Potential Perinatal / Maternity Care Measures

- 20 total measures on perinatal/maternity care could be considered
  - 5 endorsed
  - 15 not endorsed, mostly from Pediatric Quality Measures Program
- Includes 2 measures recommended in 2014 and not yet added
- ACOG recommended measures during Task Force's April Web Meeting
- Topics include:
  - Capacity of facility to handle high-risk delivery
  - Temperature management
  - Safety / complications / obstetric trauma
  - Contraception access/use
  - Other

Available Perinatal / Maternity Care Measures

NQF #	Measure Name	Measure Steward
0470	Incidence of Episiotomy	Christiana Healthcare System
0477	**Under 1500g infant Not Delivered at Appropriate Level of Care**	**California Maternal Quality Care Collaborative**
0478	Neonatal Blood Stream Infection Rate (NQI #3)	Agency for Healthcare Research and Quality
0480	**PC-05 Exclusive Breast Milk Feeding**	**The Joint Commission**
0716	Healthy Term Newborn	California Maternal Quality Care Collaborative
n/a	*Use of Contraceptive Methods by Women Aged 15-20*	*CDC/OPA*
n/a	*Use of Contraceptive Methods by Women Aged 21-44*	*CDC/OPA*
n/a	*Effective Postpartum Contraception Access*	*AHRQ*
n/a	Perinatal I: Timely temperature for all low birthweight neonates	CAPQuaM
n/a	Perinatal II: Timely temperatures upon arrival in Level 2 or higher nurseries for LBW neonates	CAPQuaM

Available Perinatal / Maternity Care Measures, Continued

NQF #	Measure Name	Measure Steward
n/a	Perinatal III: Distribution of temperatures for LBW admitted to Level 2 or higher nurseries in first 24 hours of life	CAPQuaM
n/a	Perinatal IV: Thermal condition for LBW neonates admitted to Level 2 or higher nurseries in first 24 hours of life	CAPQuaM
n/a	Assessing the availability of the preconception component of high-risk obstetrical services by estimating the use of teratogenic medications before and during pregnancy	CAPQUAM
n/a	High-risk deliveries at facilities with 24/7 in-house physician capable of safely managing labor and delivery, and performing a cesarean section, including an emergent cesarean section	CAPQUAM
n/a	High-risk deliveries at facilities with 24/7 in-house physician coverage dedicated to the obstetrical service by a qualified anesthesiologist	CAPQUAM
n/a	High-risk deliveries at facilities with 24/7 in-house blood banking/transfusion services available	CAPQUAM

Available Perinatal / Maternity Care Measures, Continued

NQF #	Measure Name	Measure Steward
n/a	High-risk deliveries at facilities with Level 3 or higher NICU services	CAPQUAM
n/a	Availability of OPD maternal fetal medicine and specialty care for women with high-risk pregnancies	CAPQUAM
n/a	Availability of multidisciplinary OPD care for women with high-risk pregnancies	CAPQUAM
n/a	Episiotomy (overuse)	PMCoE
n/a	Obstetric trauma (3rd or 4th degree lacerations): rate per 1,000 vaginal deliveries without instrument assistance.	AHRQ
n/a	Severe Maternal Morbidity	

0477 – Under 1500g Infant Not Delivered at Appropriate Level of Care

NQF Endorsed – Steward: California Maternal Quality Care Collaborative

QPS Link: http://www.qualityforum.org/qps/0477

Description:	The number per 1,000 livebirths of <1500g infants delivered at hospitals not appropriate for that size infant.
Numerator Statement	Liveborn infants (<1500gms but over 24 weeks gestation) born at the given birth hospital
Denominator Statement	All live births over 24 weeks gestation at the given birth hospital. NICU Level III status is defined by the State Department of Health or similar body typically using American Academy of Pediatrics Criteria.
Exclusions:	Stillbirths and livebirths <24weeks gestation.
Data Source:	Electronic Clinical Data: Registry, Other
Type:	Outcome

0480 – PC-05 Exclusive Breast Milk Feeding

(TJC is implementing significant revisions)

NQF Endorsed – Steward: The Joint Commission

QPS Link: http://www.qualityforum.org/qps/0480

Description:	PC-05 assesses the number of newborns exclusively fed breast milk during the newborn´s entire hospitalization. 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-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns).
Numerator Statement	PC-05 Newborns that were fed breast milk only since birth
Denominator Statement	PC-05 Single term liveborn newborns discharged from the hospital with ICD-9-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table 11.20.1 available at: http://manual.jointcommission.org
Exclusions:	• Admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization • ICD-9-CM Other Diagnosis Codes for galactosemia as defined in Appendix A, Table 11.21 • ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for parenteral infusion as defined in Appendix A, Table 11.22 • Experienced death • Length of Stay >120 days • Enrolled in clinical trials • Patients transferred to another hospital • ICD-9-CM Other Diagnosis Codes for premature newborns as defined in Appendix A, Table 11.23
Data Source:	Administrative claims, Electronic Clinical Data, Paper Medical Records
Type:	Process

Changes to breast milk feeding performance measures PC-05

- The Joint Commission revised PC-05 so that maternal medical conditions are no longer excluded.
- This change was made because these conditions are unusual (affecting approximately 2 percent of patients), and they cannot be modeled in the electronically specified version of PC-05.
- The removal of measure exclusions will significantly reduce the burden of data abstraction.
- PC-05 will continue to be an accountability measure that is publicly reported on The Joint Commission's Quality Check® website.
- PC-05 will not be included in the Top Performer on Key Quality Measures® recognition program (as reported in the March 18, 2015 issue of Joint Commission Online), nor will it be included in the composite rate for the performance improvement accreditation standard, PI.02.01.03, element of performance 1).

Source: http://www.jointcommission.org/issues/article.aspx?Article=pJCsvXv90qaFH1kqHuOfZKK4vViVWgWawEj1AvLtPQ= Source: http://www.jointcommission.org/issues/article.aspx?Article=pJCsvXv90qaFH1kqHuOfZKK4vW0WgWawEj1AvLtPQ=

Changes to PC-05a

- The Joint Commission is retiring the Perinatal Care (PC) core measure PC-05a: Exclusive breast milk feeding considering mother's initial feeding plan, effective with October 1, 2015, discharges.
- Feedback from key stakeholders indicates that:
  - capturing data on the mother's preferences to not exclusively breast feed has been challenging
  - some organizations may be concentrating on data collection as much or more than on strategies to increase exclusive breast milk feeding
  - retirement of PC-05a allows hospitals to focus their resources on improving rates for PC-05: Exclusive breast milk feeding
  - performance on this measure continues to be below 50 percent at approximately half of Joint Commission accredited hospitals.

Source: http://www.jointcommission.org/issues/article.aspx?Article=pJCsvX v90qaFH1kqHuOfZXK4vViVWgWawEj1AvLtPQ= Source: http://www.jointcommission.org/issues/article.aspx?Article=pJCsvX v90qaFH1kqHuOfZXK4vViVWgWawEj1AvLtPQ=

Committee Decision on Updated PC-05

- Does the Task Force continue to recommend PC-05 Exclusive Breast Milk Feeding for use in the Child Core Set?
- Does the Task Force intend that CMS should use The Joint Commission's most recent version of the measure, without the subset regarding preference?
  - *[Note: May impact inclusion in the 2016 Child Core Set if specification is not available to CMS in time for annual tech specs release.]*

Use of Contraceptive Methods by Women Aged 15-20 Years

Not Endorsed – Steward: Centers for Disease Control and Prevention/Office of Population Affairs

Description:	The percentage of women aged 15-20 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 (e.g., by calculating the median and focusing on those providers/entities that are performing well below the mean).
Numerator Statement	1: The eligible population that is using a most or moderately effective method of contraception. 2: The eligible population that is using a LARC method.
Denominator Statement	The eligible population that is at risk of unintended pregnancy.
Exclusions:	Women who are not capable of getting pregnant: women with a code for hysterectomy, bilateral oophorectomy, natural menopause (or premature menopause due to surgery, radiation or other factors); any women who were pregnant and/or received prenatal care or delivery care at any point in the 12-month reporting period.
Data Source:	Administrative Data
Type:	Intermediate Outcome (as defined by the developer)

Use of Contraceptive Methods by Women Aged 21-44 Years

Not Endorsed – Steward: Centers for Disease Control and Prevention/Office of Population Affairs

Description:	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 (e.g., by calculating the median and focusing on those providers/entities that are performing well below the mean).
Numerator Statement	1: The eligible population that is using a most or moderately effective method of contraception. 2: The eligible population that is using a LARC method.
Denominator Statement	The eligible population that is at risk of unintended pregnancy.
Exclusions:	Women who are not capable of getting pregnant: women with a code for hysterectomy, bilateral oophorectomy, natural menopause (or premature menopause due to surgery, radiation or other factors); any women who were pregnant and/or received prenatal care or delivery care at any point in the 12-month reporting period.
Data Source:	Administrative Data
Type:	Intermediate Outcome (as defined by the developer)

Effective Postpartum Contraception Access

Not Endorsed – Steward: Agency for Healthcare Research and Quality

Description:	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.
Numerator Statement	Part A: 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: The percentage of women who received contraceptives such as injectables, oral pills, patch, or ring within 99 days after birthing.
Denominator Statement	All continuously enrolled women with a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year.
Exclusions:	Exclude cases: With instrument-assisted delivery With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)
Data Source:	
Type:	Process

Committee Decision on Contraceptive Measures

- Does MAP support or conditionally support the addition of any of the following measures?
  - *Use of Contraceptive Methods by Women Aged 15-20 Years (for the Child Core Set)*
  - *Use of Contraceptive Methods by Women Aged 21-44 Years (for the Adult Core Set)*
  - *Effective Postpartum Contraception Access (for the Adult Core Set, also for Child Core Set?)*
- There may not be capacity to include multiple measures on the same topic, so MAP should weigh the pros and cons of the proposed measures.

Prioritization of Child Core Set Additions

- Does the Child Task Force need to reconsider yesterday's prioritization of measures to be added based on the discussion of maternity care?

Opportunity for Public Comment

Lunch

Issues of Shared Importance: Data Collection, Balancing Process and Outcome Measurement, Motivating Quality Improvement Action within States

Enabling Outcome Measurement

What we know about this issue:

- Inability to access data is the most consistently reported barrier to reporting
- Chart review and other manual methods of data extraction are expensive and time-consuming, other priorities may be sacrificed
- Linkages to vital records provide useful information but require a significant start-up investment
- Few states have EHRs in wide use and available to the health plans and/or Medicaid agency; registries infeasible
- Outcome measures are more likely to require risk adjustment than process measures

Enabling Outcome Measurement: Task Force and State Panelist Discussion

- Is it a priority of the states to move toward more measures of outcomes?
- Can states realistically request plans and providers to provide more data?
- Would addition of more outcome measures to the Core Sets at this point in time hinder states' participation?
- Others in the measurement community have gradually adopted more outcome measures; what experiences are transferable?

Opportunity for Public Comment

Break

Supporting States' Ability to Report Measures and Other Cross-Cutting Recommendations to Strengthen the Core Sets

Supporting State Participation

Factors Influencing State Participation in Reporting

- Clarity of measure specifications
- Feasibility of data collection
- Budgetary environment
- Perceived importance / political will
- Others?

- *Which barriers can be reduced by HHS (or MAP) action?*

Guidance for Future Medicaid Core Sets

- What changes to the reporting programs would assist CMS in meeting its goals?
  1. Increase number of states reporting Core Set measures
  2. Increase number of measures reported by each state
  3. Increase number of states using Core Set measures to drive quality improvement

Summary of the Day

Important Dates

- **Tomorrow:** Task Force discussion of Adult Core Set
- **July 6-August 5:** Public Comment on draft report
- **August, date TBD:** MAP Coordinating Committee review of draft report via web meeting
- **August 31:** Final report due to CMS and made available to the public

Measure Applications Partnership

Medicaid Child and Adult Task Forces
In-Person Meeting

Day 3 – June 11, 2015

NATIONAL QUALITY FORUM

Meeting Objectives

- Consider states' experiences implementing the Medicaid Adult Core Set
- Develop concrete recommendations for strengthening the Medicaid Adult Core Set through identification of:
  - Most important measure gaps and potential measures to address them
  - Measures found to be ineffective, for potential removal
- Formulate strategic guidance to CMS about strengthening the measure set over time to meet program goals

Today's Action Items

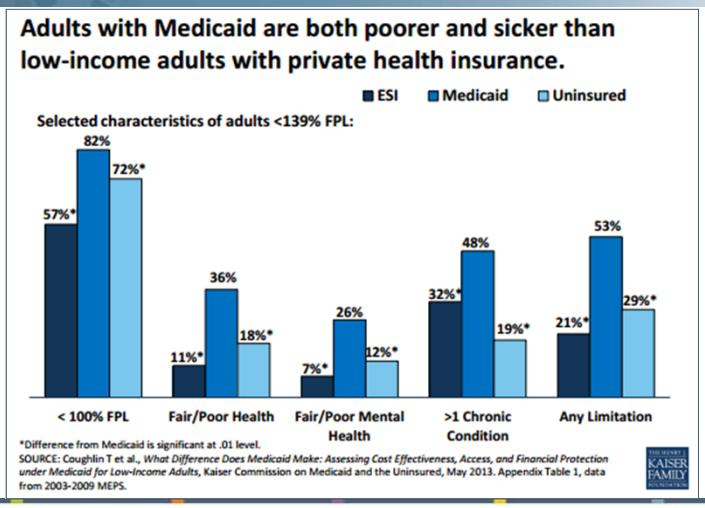
- Review highlights from the previous day
- Share staff analysis of the 2014 Adult Core Set reporting
- Consider measures with low uptake
- Select available measures to fill gap areas
- Rank selected measures for potential addition to the set
- Prioritize remaining measure gap areas

At Web Meeting, CMS Requested of MAP…

- Focus on incremental changes
  - CMS and states continue to learning about current Adult Core Set measures
  - Take into account the state staff time and resources it takes to learn/incorporate a new measure
- MAP can assist CMS by identifying ways to strengthen the Adult Core Set:
  - Which measures can be added to fill critical gap areas
  - Which measures to potentially retire
  - Ways to better reflect CMS's Measurement Quality Domains
  - Ways to better align with other CMS/HHS programs

Medicaid-Eligible Adult Population Overview

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



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

Health Status of Current "Working-Age" Adult Medicaid Enrollees

Health conditions and risks of adult enrollees under 65

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

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

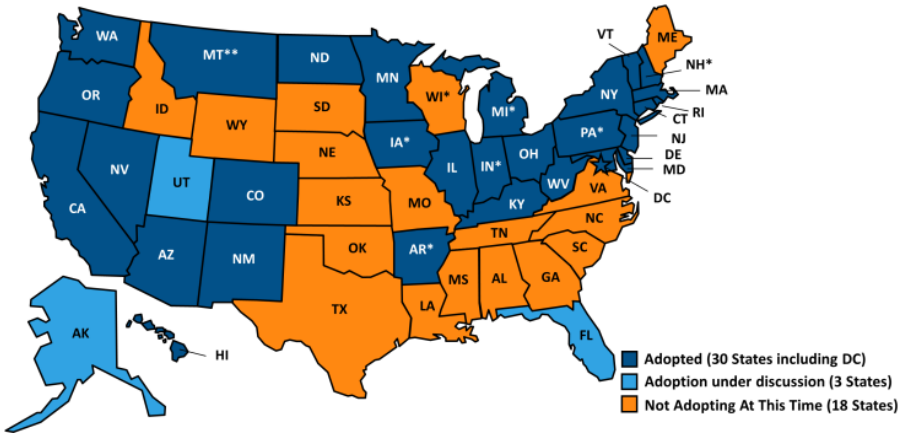
Diversity of Adult Medicaid Population

- Racial and ethnic minority populations are disproportionately represented among Medicaid enrollees
- Across geographic regions, approximately 22% of the population is enrolled in Medicaid
- An additional **11.7 million adults have enrolled in Medicaid as of February 2015**
  - Medicaid expansion decisions and eligibility levels as a percent of the Federal Poverty Level (FPL) vary by State (138%-300%)
  - Disparities in growth of the Medicaid population observed between states that have and have not expanded Medicaid coverage (8% vs. 27%)
- Half of states with majority rural populations are expanding Medicaid coverage

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

Bailey, J. *Medicaid Expansion as a Rural Issue: Rural and Urban States and the Expansion Decision* . Lyons, NE: Center for Rural Affairs; 2013. Available at http://files.cfra.org/pdf/medicaid-expansion-a-rural-issue.pdf. Last accessed May 2014.

Current Status of State Medicaid Expansion Decisions, 2015



SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated May 26, 2015. http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act

MAP Measure Specific Recommendations – Fall 2014

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

CMS - Adult Core Set Update for 2015 Reporting

Issued December 30, 2014

- Informed by MAP's recommendations, CMS updated the Adult Core Set:
  - Retired one measure:
    - » Comprehensive Diabetes Care: LDL-C Screening measure
  - Added one measure:
    - » Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) measure
- The measures recommended by MAP but not added are still "on the table" for continued emphasis, if warranted

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

Medicaid Adult Core Set Measures for FFY 2015 Use

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

Medicaid Adult Core Set Measures for FFY 2015 Use - Continued

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

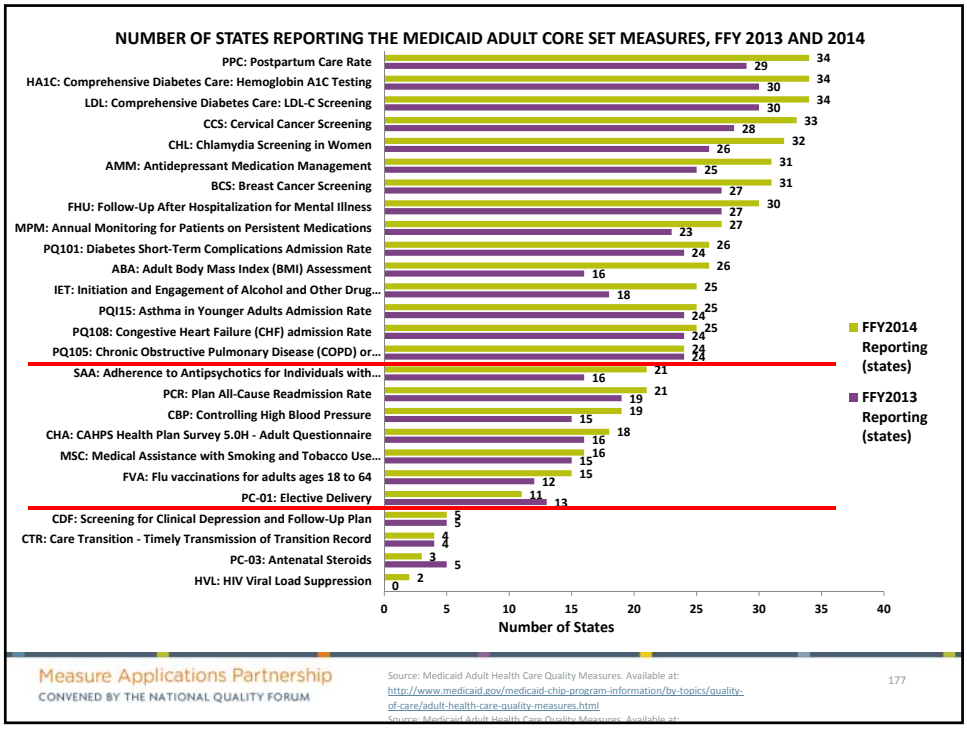
Staff Review of FFY 2014 State Reporting

Overview of Medicaid Adult Core Set FFY 2014 Reporting

Adult Core Set participation is strong, with room for improvement

- Most frequently reported measures focused on:
  - Diabetes care management
  - Postpartum care visits
  - Women's preventive health care
- Fewer Technical Assistance (TA) requests than in 2013
  - Often 0-5 requests per measure
  - 7+ requests received for four measures

Source for slides 44-46: The Department of Health and Human Services 2014 Annual report on the Quality of Health Care for Adults Enrolled in Medicaid
The term "states" includes the 50 states and the District of Columbia Source for slides 44-46: The Department of Health and Human Services 2014 Annual report on



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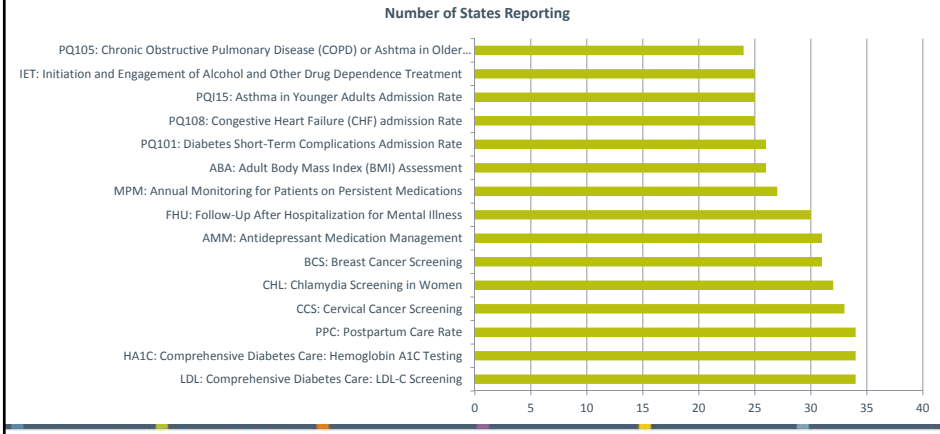
Source: Medicaid Adult Health Care Quality Measures. Available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html

177

Measures with High Levels of Reporting (15)

Measures with at least 24 states reporting



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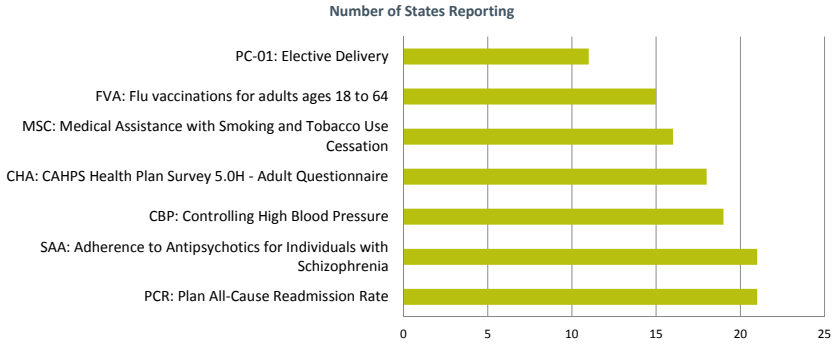
178

Measures with Medium Levels of Reporting (7)

Measures with 6-23 states reporting

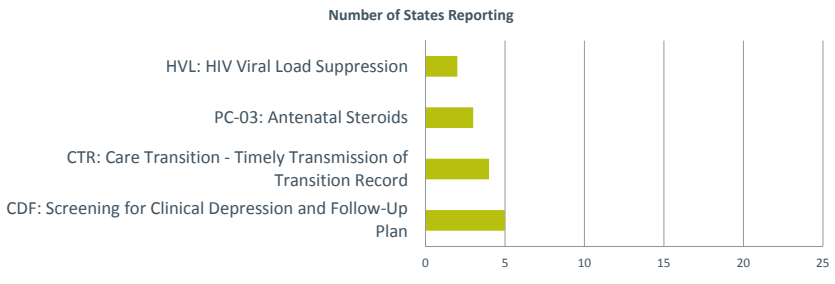
- Levels of reporting these measures are generally gaining ground or holding steady. Only PC-01 was reported by fewer states in 2014.



Measures with Low Levels of Reporting (4)

Measures with only 0-5 states reporting

- HIV Viral Load Suppression was collected for the first time in FFY 2014
- Antenatal Steroids decreased from 5 states collecting this measure in FFY 2013 to 3 for FFY 2014



Staff Review: Reasons Given for Not Reporting and Measures for Potential Removal

- Most commonly cited reason for not reporting most measures was "data not available"
- Based on staff review, none of the measures currently being reported were identified for potential removal.
  - More experience and data points needed
- Do any members of the Task Force wish to propose a measure for removal?

Break

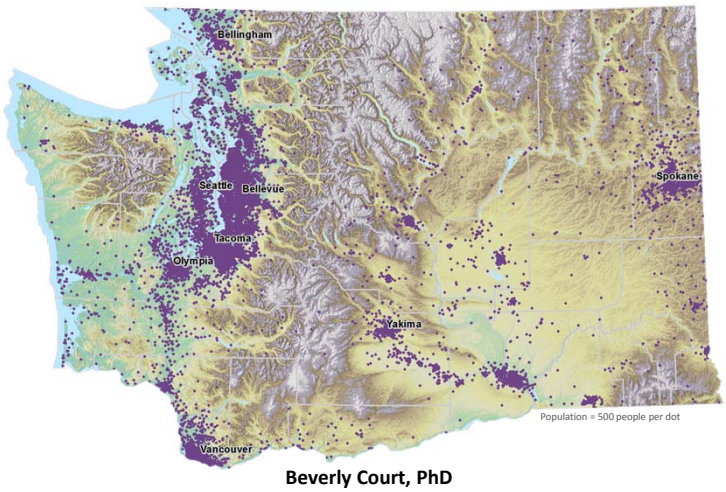
State Perspectives Panel

Beverly Court, MHA, PhD
State of Washington,
Department of Social and Health Services

David Kelley, MD
State of Pennsylvania,
Department of Public Welfare

Medicaid Adult Core Set: Washington State Perspective

National Quality Forum | Measure Applications Partnership Presentation



Beverly Court, PhD
Washington State Department of Social and Health Services | Research and Data Analysis Division
June 11, 2015

Overview

Selecting Measures for Reporting

Data Collection Challenges

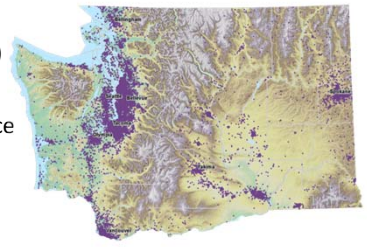
Quality Improvement

Measure Gaps

How HHS can Encourage Voluntary Reporting

Washington State Background

- **Silo'ed delivery systems**
  - Medical and mental health services through separate managed care plans
  - Long term care and home/community services outside managed care
  - Duals mainly fee-for-service
- **Plethora of CMS and state performance measure initiatives**
  - Health Homes
  - Managed Fee-for-Service Dual Integration
  - Medical/behavioral health integration (2016)
  - ACA expansion
  - State leg-mandated cross system performance
  - State Innovation Model grant
- **Urban/rural and West/East divide**
  - Tough budget times



Selecting Measures for Reporting

- **Administrative based only**
  - Survey, hybrid and medical record-only measures too costly
  - Measure specs received too late to incorporate into managed care contracting
  - Multiple CMS reporting requirements: Adult Core Set, Health Homes, Managed Fee-for-Service Duals, Child Core Set, State Innovation Models
- **Reconciling competing CMS definitions of same measure**
- **Timing of data specification updates**

Data Collection Barriers

- **CAHPS Survey**
  - Low response rate when done by managed care plans; not representative
  - Not actionable as currently specified
    - *New York method preferred*
  - Beneficiary survey fatigue
- **MMIS database limitations**
  - Use of suspended, pending and denied claims conflicts with all other analyses using final paid claims; duplication; cost of separate dataset
  - Challenges with bundled services; mom/baby identification
- **Medical Records/Hybrid**
  - If NCQA accreditation required, managed care plans will likely invest in hybrid methods strategically
  - HIE and EHR statewide solutions far in the future

Quality Improvement Activities Funded by Adult Medicaid Quality Grant

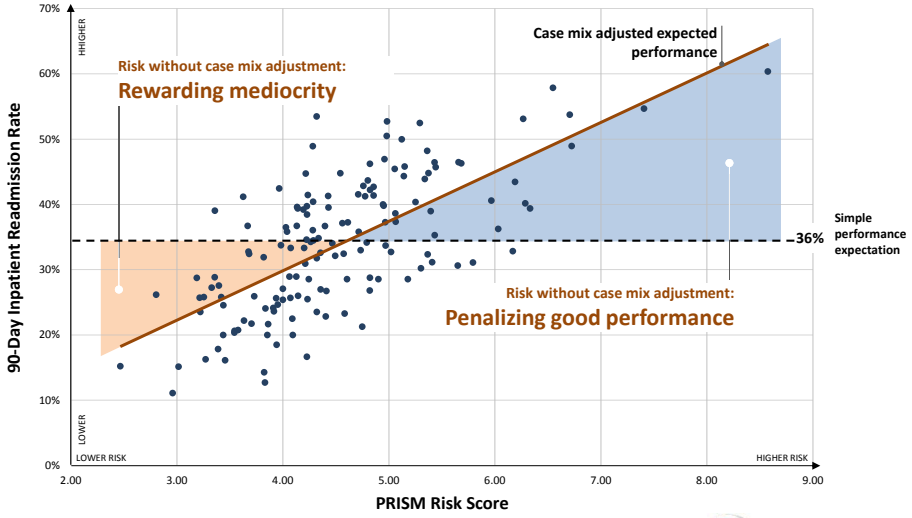
Focus on building cross system integration, especially for dual eligibles:

- **Reducing Psychiatric Rehospitalizations**
  - Resulted in statewide shift to Psych Rehospitalization measure rather than Followup after Mental Health Hospitalization measure
  - White paper in process, due late 2015
- **Reducing Rehospitalizations from Nursing Homes**
  - Interest driven by study of duals
  - In 18 month project, 170 fewer rehospitalizations than expected; savings of approximately $2M
  - http://www.qualishealth.org/sites/default/files/Pierce-Co-Medicaid-NH-Collab-0415.pdf

Quality Measurement and the Need for Risk Adjustment

Duals nursing facility inpatient readmission rates by average PRISM risk score

NOTE: Unit of observation is a nursing facility receiving at least 25 dual eligible hospital inpatient discharges in SFY 2010



SOURCE: David Mancuso, Beverly Court, Barbara Felver, "Patterns of Hospital Readmissions and Nursing Facility Utilization among Washington State Dual Eligibles: Opportunities for Improved Outcomes and Cost Savings," Washington State DSHS, RDA (2012): p5. https://www.dshs.wa.gov/sesa/rda/

Measure Gaps

- **Home and Community Based Long Term Services**
  - Proportion of long term services delivered in the home or community
    - # member months with home or community based long term services/ (# member months with home or community based long term services + # member months with institutional long term care)
- **Psychiatric Outcome Measure**
  - Prefer "Psychiatric Rehospitalization" to "Follow-up After Hospitalization for Mental Illness"
    - Rehospitalization is a clear "bad outcome";
    - Follow-up is process measure; easy to look good, not especially effective as contract performance measure
    - Need to develop measure: level of communication between inpatient and outpatient prescribers

Voluntary Reporting

- **Barriers**
  - Measure definition including partial Medicaid coverage in denominator
  - Selective reporting by other states
  - Inappropriate state-to-state comparisons
    - *Apples to oranges*
    - *Generalizing selective reporting to entire state*
  - Cost of collection of hybrid and survey measures
  - Disincentive to report administrative measures from standard MMIS systems
  - Competing CMS definitions of the same measure
- **Advantages**
  - To illustrate our competency in reporting performance measures

Recommendations

- **Change Measure Specifications**
  - Exclude from the denominator those groups of Medicaid-eligibles who will never be in the numerator
    - *Example: Those with third party liability or partial Medicaid benefits (Family Planning only)*
- **Quantify the portion of the state's Medicaid population being reported**
- **Apples to Apples comparisons**
  - Do not calculate a mean/median across administrative and hybrid versions of a measure
  - Continue to provide copious documentation of what a state actually reported

Questions?

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Key Themes from State Experiences

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

Opportunity for Public Comment

Lunch

Measure by Measure Review

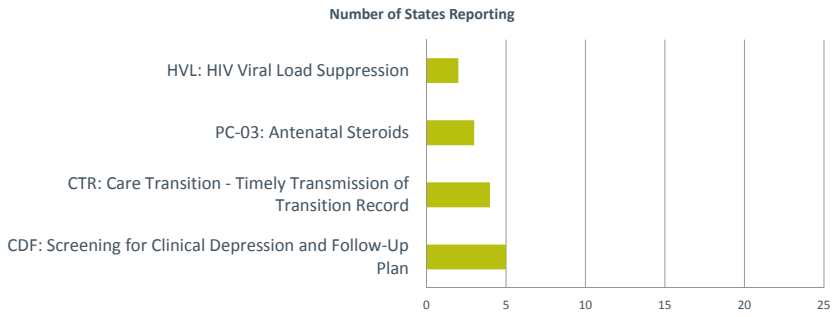
Measure by Measure Review

- The majority of the measures appear to be functioning well and do not warrant detailed discussion.
- Focus on measures with low levels of reporting
- What can we learn about the measures that are (or are not) a good fit for this program based on the handful that relatively few states report?

Measure by Measure Review: Measures with Low Levels of Reporting (4)

Measures with only 0-5 states reporting

- Is there reason to remove any of these measures at this time?
- How might participation be increased?



2082 – HIV Viral Load Suppression

NQF Endorsed
Steward: HRSA

Description:	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.
Numerator:	Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.
Denominator:	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year.
Exclusions:	None
Data Source:	Electronic Clinical Data: Electronic Health Record, Electronic Clinical Data: Laboratory, Paper Medical Records
Type:	Outcome
# of states reported:	2
Reasons for not reporting:	N=32 states reported reason for not reporting; most common reason was that data not available

0476 – PC-03 Antenatal Steroids

NQF Endorsed
Steward: The Joint Commission

Description:	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns.
Numerator:	Patients with antenatal steroid therapy initiated prior to delivering preterm newborns.
Denominator:	Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed with ICD-9-CM Principal or Other Diagnosis Codes for pregnancy.
Exclusions:	• Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Enrolled in clinical trials • Documented Reason for Not Initiating Antenatal Steroid Therapy • ICD-9-CM Principal Diagnosis Code or Other Diagnosis Codes for fetal demise • Gestational Age < 24 or >= 32 weeks
Data Source:	Administrative claims, Electronic Clinical Data: Registry, Paper Medical Records
Type:	Process
# of states reported:	3
Reasons for not reporting:	N=32 states reported reason for not reporting; most common reason was that data not available

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

NQF Endorsed – Steward: AMA-PCPI

Description:	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.
Numerator:	Patients 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.
Denominator:	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.
Exclusions:	Patients who died Patients who left against medical advice (AMA) or discontinued care
Data Source:	Administrative claims, Electronic Clinical Data: Electronic Health Record, Paper Medical Records
Type:	Process
# of states reported:	4
Reasons for not reporting:	N=31 states reported reason for not reporting; most common reason was that data not available

0418 – Screening for Clinical Depression and Follow-Up Plan

NQF Endorsed – Steward: Centers for Medicare & Medicaid Services

Description:	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.
Numerator:	Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented. The standardized screening tools help predict a likelihood of someone developing or having a particular disease. The screening tools suggested in this measure screen for possible depression. Questions within the suggested standardized screening tools may vary but the result of using a standardized screening tool is to determine if the patient screens positive or negative for depression. If the patient has a positive screen for depression using a standardized screening tool, the provider must have a follow-up plan as defined within the measure. If the patient has a negative screen for depression, no follow-up plan is required.
Denominator:	All patients aged 12 years and older.
Exclusions:	Several exclusions, including referral with diagnosis with depression, participation in on-going treatment with screening of clinical depression, individuals with motivation to improve may impact the results such as in certain court appointed cases, severe mental or physical incapacity
Data Source:	Administrative claims, Electronic Health Record, Paper Medical Records
Type:	Process
# of states reported:	5
Reasons for not reporting:	N=30 states reported reason for not reporting; most common reason was that data not available

Discussion

- How might participation in reporting these measures be increased?
- What can we learn about the measures that are (or are not) a good fit for this program based on the handful that relatively few states report?

Measure by Measure Review: Potential Gap-Filling Measures for Addition

MAP's 2014 Recommendations to Address High Priority Gaps

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

MAP's 2014 Recommendations to Address High Priority Gaps

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

Gap Areas with Measures Currently Available

- Perinatal / Maternity Care (discussed yesterday)
- Behavioral health (8)
- Access to primary care (1)
  - *Some measure gap areas may not have strong enough measures for addition at this time. New measures will become available for later reviews.*

Decision Categories

- Support (for immediate use)
- Conditional Support
  - Pending endorsement by NQF
  - Pending a change by the measure steward
  - Pending CMS confirmation of feasibility
- Do Not Support

Medicaid Adult Core Set: Behavioral Health Gap Area

Available Measures

NQF #	Measure Name	Measure Steward
1927	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	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
2605	**Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence**	**NCQA**

2605 – Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence NQF Endorsed – Steward: NCQA

Description:	The percentage of discharges for patients 18 or older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.
Numerator:	The numerator for each denominator population consists of two rates: Mental Health - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge Alcohol or Other Drug Dependence - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after emergency department discharge
Denominator:	Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.
Exclusions:	Please see spreadsheet.
Data Source:	Administrative claims
Type:	Process

Medicaid Adult Core Set: Primary/Specialty Care Access Gap Area

Available Measures

NQF #	Measure Name	Measure Steward
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

Adults' Access to Preventive/Ambulatory Health Services Not NQF Endorsed – Steward: NCQA

Description:	This measure is used to assess the percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line: • Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year • Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year
Numerator Statement	*Medicaid and Medicare*: One or more ambulatory or preventive care visits during the measurement year *Commercial*: One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year
Denominator Statement	Members age 20 years and older as of December 31 of the measurement year (see the related "Denominator Inclusions/Exclusions" field)
Exclusions:	Unspecified
Data Source:	Administrative clinical data
Type:	Process

Recommendations for Strengthening the Adult Core Set

Task Force Votes to Recommend Each Measure for Inclusion

- Vote to support (or conditionally support) inclusion of:
  - #2605: Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
  - *(not endorsed) Adults' access to preventive/ambulatory health services*
- Are there other measures Task Force members would propose for addition?

Recommendations for Strengthening the Adult Core Set

Ranking Measures with Support for Addition

- Task Force will prioritize measures selected for use. Priority will indicate the order in which MAP recommends CMS add the measures to the set.
- New measures (TBD)

  and
- Measures recommended in 2014
  - #1799 – Medication Management for People with Asthma
  - #0647 – Transition Record with Specified Elements Received by Discharged Patients

Opportunity for Public Comment

Prioritizing Remaining Gap Areas

Gaps in the Medicaid Adult Core Set

Have any of the gap areas been satisfied?
Do others need to be added?

- Access to primary and specialty care
- Beneficiary-reported outcomes
- Care coordination
- Cultural competency of providers
- Efficiency
- Long-term supports and services
- Maternal health
- Promotion of wellness
- Treatment outcomes for behavioral health conditions and substance use disorders
- Workforce

Strategy for Filling High Priority Measure Gaps

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

Next Steps

Important Dates

- **July 6-August 5:** Public Comment on draft report
- **August, date TBD:** MAP Coordinating Committee review of draft report via web meeting
- **August 31:** Final report due to CMS and made available to the public

Adjourn

Thank You for Participating!

MEASURE APPLICATIONS PARTNERSHIP

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

FINAL REPORT

AUGUST 29, 2014

NATIONAL QUALITY FORUM

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

CONTENTS

EXECUTIVE SUMMARY	2
INTRODUCTION AND PURPOSE	4
BACKGROUND ON MEDICAID AND THE ADULT CORE SET	5
STATE EXPERIENCE COLLECTING AND REPORTING THE CORE SET	8
MAP REVIEW OF THE MEDICAID ADULT CORE SET	13
STRATEGIC ISSUES	18
CONCLUSION	21
APPENDIX A: MAP Background	24
APPENDIX B: Rosters for the MAP Medicaid Task Force and MAP Coordinating Committee	27
APPENDIX C: MAP Measure Selection Criteria	30
APPENDIX D: Medicaid Adult Core Set and MAP Recommendations	33
APPENDIX E: Measures Associated with the Top 10 Conditions for Readmissions Among Adults in Medicaid	43
APPENDIX F: NQF Member and Public Comments	45

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

INTRODUCTION AND PURPOSE

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

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

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

BACKGROUND ON MEDICAID AND THE ADULT CORE SET

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

Medicaid Adult Population

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

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

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

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

Role of Medicaid in Covering Services for Low-Income Adults

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

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

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

Medicaid Adult Core Set

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

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

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

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

Characteristics of the Medicaid Adult Core Set

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

EXHIBIT 1. NQS AND CMS QUALITY STRATEGY PRIORITIES

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

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

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

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

STATE EXPERIENCE COLLECTING AND REPORTING THE CORE SET

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

Participation in Reporting Measures

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

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

Implementation Feedback from Reporting States

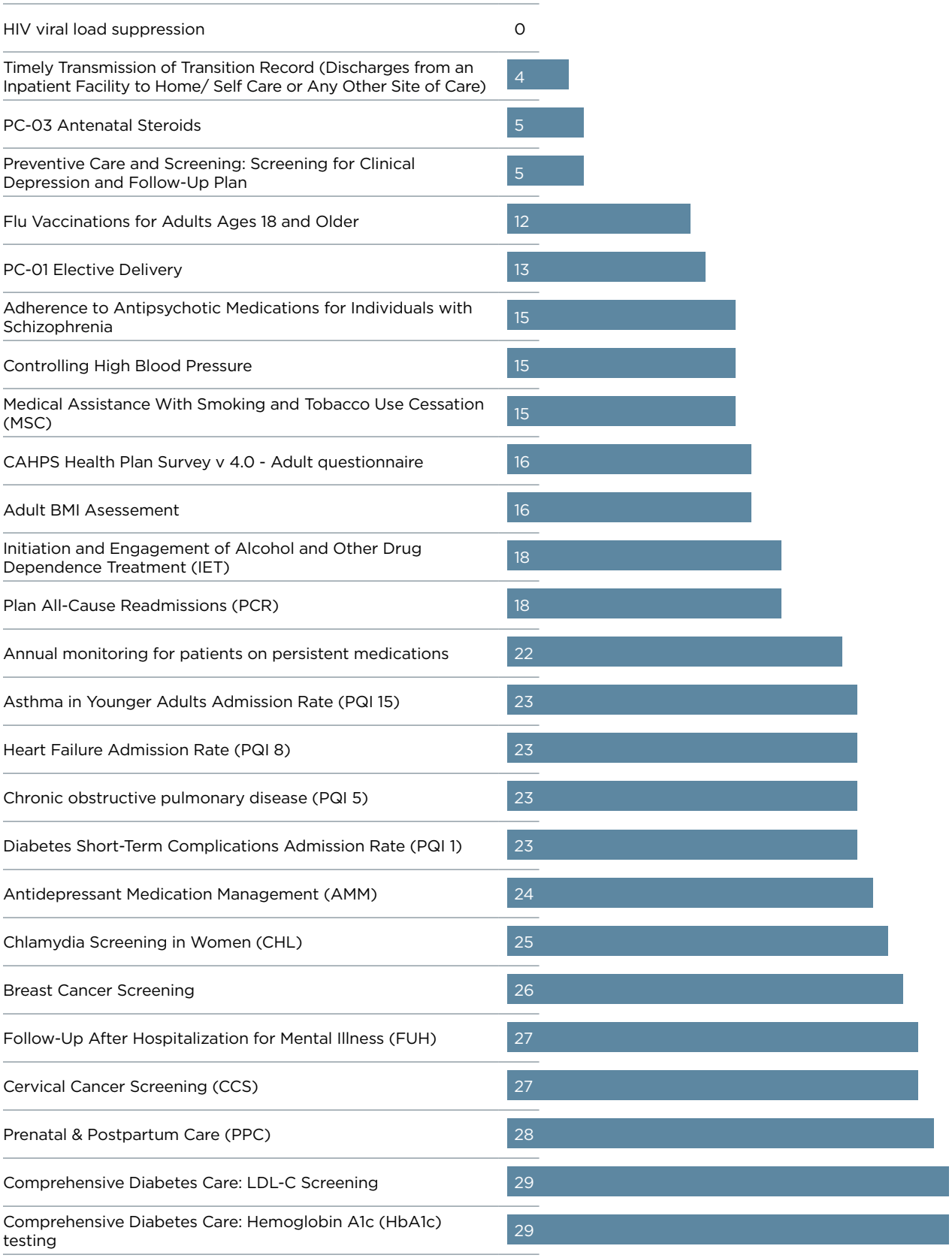
Three states—Louisiana, New Hampshire, and Virginia—shared their implementation experiences collecting and reporting measures to CMS to inform the MAP review of the Adult Core Set. These perspectives are a sample and not representative of all state Medicaid programs. This dialogue was highly informative,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

Louisiana

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

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

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



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

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

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

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

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

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

New Hampshire

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

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

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

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

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

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

Virginia

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

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

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

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

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

Nonreporting States

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

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

MAP REVIEW OF THE MEDICAID ADULT CORE SET

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

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

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

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

Measure-Specific Recommendations

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

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

Measures for Phased Addition to the Adult Core Set

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

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

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

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

MAP conditionally supported the continued use of three measures.

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

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

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

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

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

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

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

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

NQF #2372 Breast Cancer Screening

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

Measures for Removal from the Adult Core Set

NQF #0063 Comprehensive Diabetes Care: LDL-C Screening

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

Recommendations to Address High Priority Gaps

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

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

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

Maternal Health

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

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

Behavioral Health

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

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

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

Access to Primary Care

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

STRATEGIC ISSUES

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

Building State Capacity

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

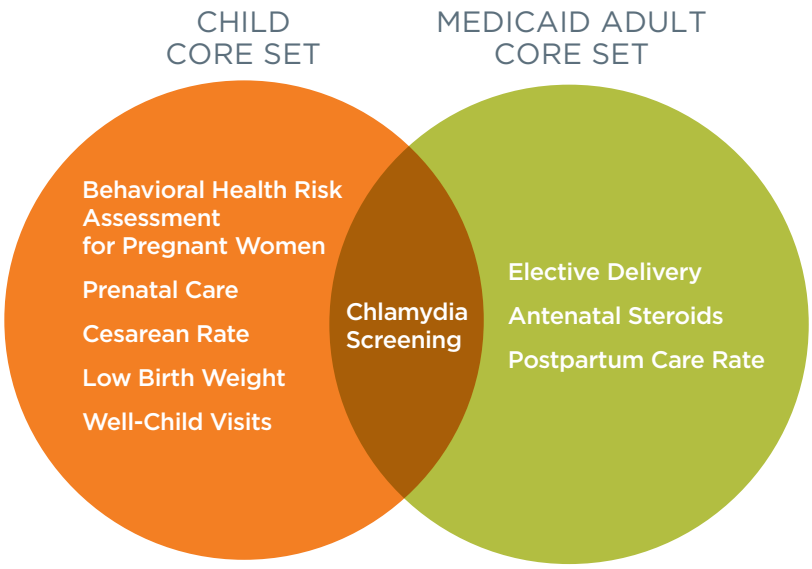
State representatives described the benefit of CMS' grant program in providing funding that allowed the Medicaid agencies to form data-sharing partnerships with the public health system and other key stakeholders. Developing linkages to vital records systems, for example, assisted with the calculation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

Alignment of Measures Across Adult and Child Core Sets

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

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

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



Impact of Payment Models

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

Incorporating Beneficiaries' Perspectives on Quality

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

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

Balancing Rigor and Voluntary Participation

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

Ultimate Uses of Measurement Information

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

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

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

CONCLUSION

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

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

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

ENDNOTES

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APPENDIX A: MAP BACKGROUND

Purpose

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

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

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

MAP's objectives are to:

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

Coordination with Other Quality Efforts

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

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

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

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

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

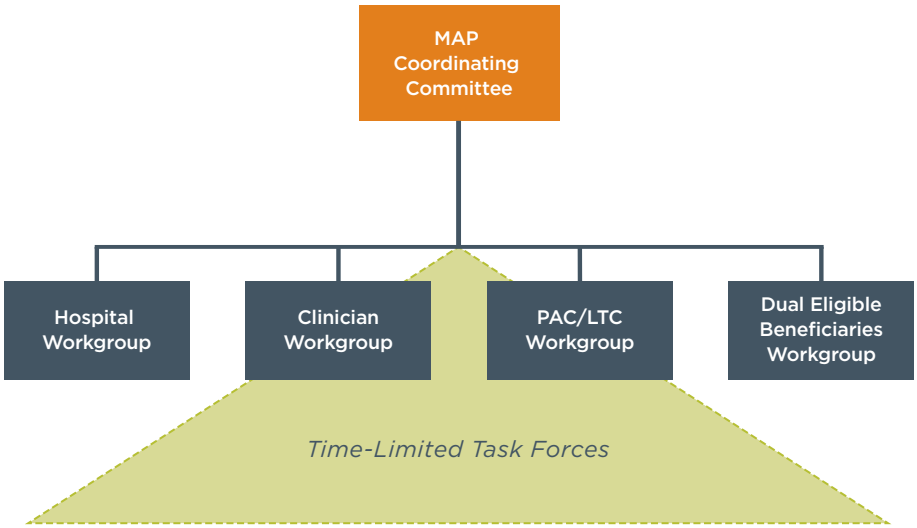
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for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

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

Structure

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

FIGURE A1. MAP STRUCTURE



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

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

Timeline and Deliverables

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

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

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

ENDNOTE

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

Roster for the MAP Medicaid Task Force

CHAIR (VOTING)
Harold Pincus, MD

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

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
Medicaid ACO	Ruth Perry, MD
Mental Health	Ann Marie Sullivan, MD
State Medicaid	Marc Leib, MD, JD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Centers for Medicare & Medicaid Services (CMS)	Marsha Smith, MD, PhD, FAAP

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

Roster for the MAP Coordinating Committee

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

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

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

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

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

NQF Staff

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

APPENDIX C:
MAP Measure Selection Criteria

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

Criteria

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

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

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

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

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

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

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

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

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

Sub-criterion 2.3 Affordable care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

APPENDIX D:
Medicaid Adult Core Set and MAP Recommendations

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

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

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

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

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

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

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

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

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

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	Recommendations and Rationale
1768 Endorsed Plan All-Cause Readmissions Measure Steward: NCQA	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/ Denominator) 5. Total Variance Note: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	18 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Conditional support for continued use in the program MAP recommends the development and application of a risk-adjustment model for the Medicaid population
1879 Endorsed Adherence to Antipsychotic Medications for Individuals with Schizophrenia Measure Steward: CMS	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).	18 states reported FFY 2013 Alignment: HEDIS	Support for continued use in the program Addresses the needs of vulnerable population at greater risk of readmissions and nonadherence to medications Measure requires medical record review and/or data linkage, as a result it is burdensome for states and others to report MAP recommends the steward consider refining this measure to simplify the data collection methodology

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

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

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

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

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

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

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

ENDNOTE

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

APPENDIX F:
NQF Member and Public Comments

State Experience Collecting and Reporting the Core Set

America's Health Insurance Plans

Carmella Bocchino

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

GlaxoSmithKline

Deborah Fritz

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

MAP's Measure Specific Recommendations and Gaps

ActualMeds Corporation

Joseph Gruber

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

American Heart Association

Madeleine Konig

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

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

America's Essential Hospitals

Ashley Ferguson

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

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

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

America's Health Insurance Plans

Carmella Bocchino

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

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

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

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

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

America's Health Insurance Plans

Carmella Bocchino

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

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

AstraZeneca

Kathy Gans-Brangs

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

AstraZeneca

Kathy Gans-Brangs

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

CVS/caremark

Kristin Garnett

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

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

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

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

Eli Lilly and Company

Dawn Blank

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

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

GlaxoSmithKline

Deborah Fritz

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

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

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

Highmark

Christine Pozar

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

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

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

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

MedHere Today

Richard Logan

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

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

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

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

Merck

Patrick Liedtka

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

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

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

NACDS

Alex Adams

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

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

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

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

NACDS

Alex Adams

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

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

National Partnership for Women & Families

Alison Shippy

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

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

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

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

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

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

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

OutcomesMTM

Jessica Frank

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

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

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

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

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

Parata Systems

Gayle Tuttle

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

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

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

PerformRx

Erica Potter

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

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

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

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

Pharmacy Quality Alliance

Woody Eisenberg

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

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

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

PhRMA

Jennifer Van Meter

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

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

RxAnte

Aaron Mckethan

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

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

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

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

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

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

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

VoicePort LLC

Jeffery Maltese

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

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

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

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

Our thanks in advance for your continued efforts and support.

Strategic Issues

America's Health Insurance Plans

Carmella Bocchino

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

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

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

GlaxoSmithKline

Deborah Fritz

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

General Comments on the Report

American Association on Health & Disability

E. Clarke Ross

Recommendations to Address High Priority Gaps

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

National Quality Forum – MAP (Measures Application Partnership)

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

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

2. Shared decision-making

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

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

5. Psychosocial needs

6. Community integration/inclusion and participation

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

These are appropriate for the entire adult Medicaid population.

Beneficiary Experience and Beneficiary-Reported Outcomes

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

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

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

Building state capacity

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

Thank you for considering our views.

American Optometric Association

Kara Webb

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

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

America's Essential Hospitals

Ashley Ferguson

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

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

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

preventable hospital-acquired conditions and 30-day readmissions.

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

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

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

America's Health Insurance Plans

Carmella Bocchino

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

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

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

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

National Partnership for Women & Families

Alison Shippy

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

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

Parata Systems

Gayle Tuttle

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

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

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

ISBN: 978-1-933875-72-9

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

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

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

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: December 30, 2014

FROM: Cindy Mann
Director
Center for Medicaid and CHIP Services

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

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

Background

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

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

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

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

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

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

2015 Child Core Set

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

For the 2015 Child Core Set update, CMCS will:

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

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

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

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

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

[6] Measure steward: CMS, Not NQF Endorsed

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

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

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

2015 Adult Core Set

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

For the 2015 Adult Core Set update, CMCS will:

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

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

Next Steps

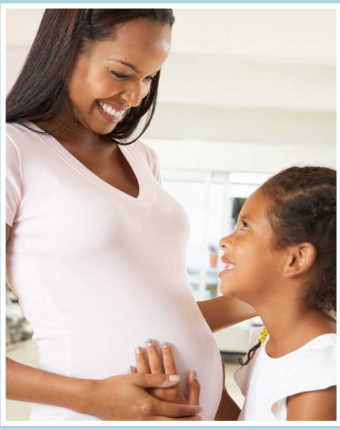
The updates to the Core Sets will take effect in the FFY 2015 reporting cycle, which will begin no later than December 2015. To support states in making these changes, CMCS will release updated technical specifications for both Core Sets in spring 2015 and make them available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care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

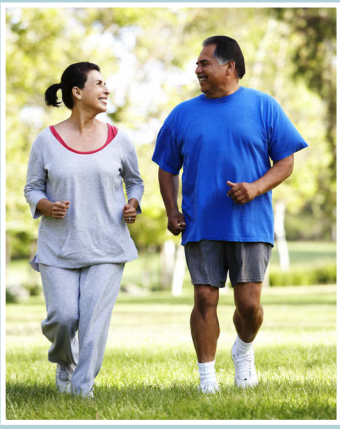
If you have questions about this bulletin, please contact Marsha Lillie-Blanton, Children and Adults Health Programs Group, at marsha.lillie-blanton@cms.hhs.gov

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

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

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





The Department of Health and Human Services

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

Health and Human Services Secretary

Sylvia Mathews Burwell

November 2014

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CONTENTS

EXECUTIVE SUMMARY vii

I INTRODUCTION 1

A. Profile of Adults Enrolled in Medicaid 1

II FEDERAL AND STATE EFFORTS RELATED TO QUALITY MEASUREMENT AND REPORTING STATEWIDE 3

A. Background on the Medicaid Adult Core Set 3

B. CMS Federal-State Data Systems for Quality Reporting 4

C. CMS Activities to Support Quality Measurement 5

1. Technical Assistance and Analytic Support Program 5

2. Adult Medicaid Quality Grant Program 5

3. Testing Experience and Functional Assessment Tools (TEFT) 6

III NATIONAL FINDINGS ON QUALITY AND ACCESS FOR ADULTS ENROLLED IN MEDICAID 7

A. Medicaid Health Plan Quality: NCQA Benchmarking Report 8

1. Methodology 8

2. Findings 9

B. Access to Care in Medicaid: Evidence from the Research Literature 10

IV MONITORING AND IMPROVING CARE IN MANAGED CARE SETTINGS 11

A. Overview 11

B. External Quality Review Technical Reports Submitted to CMS for the 2013–2014 Reporting Cycle 13

C. Reporting of Performance Measures in 2013–2014 External Quality Review Technical Reports 13

D. Description of Performance Improvement Projects in 2013–2014 14

E. Focused Review of Performance Improvement Projects 15

1. Diabetes Care 15

2. Hospital Readmissions 16

3. Emergency Department Visits 16

4. Substance Use Disorders 16

V CONCLUSION 19

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

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

APPENDIX C: GLOSSARY

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EXHIBITS

1 Distribution of Medicaid Enrollees, by Age and Disability Status, CY 2010 22

2 Number of Medicaid Adult Core Set Measures Reported, by State, FFY 2013 23

3 Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2013..... 24

4 Medicaid Health Plan Performance on Selected HEDIS 2013 Measures in the Medicaid Adult Core Set..... 25

5 Change in Medicaid Health Plan Performance on Selected HEDIS Measures in the Medicaid Adult Core Set, 2011–2013 27

6 Number and Percentage of Full-Benefit Adults, Ages 21–64, Enrolled in Medicaid by State and Service Delivery Type, CY 2010* 29

7 Performance Improvement Projects (PIPs) Targeting Adults Included in External Quality Review (EQR) Technical Reports, by Topic Area, 2013–2014 Reporting Cycle..... 31

8 Diabetes Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle 34

9 Hospital Readmissions Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 36

10 Emergency Department (ED) Visits Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 38

11 Substance Use Disorders Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 40

A.1 2013 Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid.....A.3

B.1 Number of Medicaid Health Plans Reporting HEDIS or CAHPS Measures for Adults to NCQA, by Region and State, HEDIS 2011–2013.....B.3

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EXECUTIVE SUMMARY

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

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

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

Status of Medicaid Adult Core Set Quality Measurement and Reporting

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

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

Managed Care External Quality Review Findings

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

Conclusion

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

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

I. INTRODUCTION

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

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

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

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

A. Profile of Adults Enrolled in Medicaid

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Background on the Medicaid Adult Core Set

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

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

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

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

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

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

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

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

B. CMS Federal-State Data Systems for Quality Reporting

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

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

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

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

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

C. CMS Activities to Support Quality Measurement

1. Technical Assistance and Analytic Support Program

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

2. Adult Medicaid Quality Grant Program

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

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

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

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

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

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

3. Testing Experience and Functional Assessment Tools (TEFT)

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

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

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

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

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

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

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

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

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

A. Medicaid Health Plan Quality: NCQA Benchmarking Report

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

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

1. Methodology

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

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

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

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

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

2. Findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. MONITORING AND IMPROVING CARE IN MANAGED CARE SETTINGS

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

A. Overview

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

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

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

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

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

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

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

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

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

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

[31] 42 CFR §438.358(b)(3).

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

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

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

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

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

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

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

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

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

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

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

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

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

In the 2013–2014 reporting cycle:

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

D. Description of Performance Improvement Projects in 2013–2014

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

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

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

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

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

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

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

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

E. Focused Review of Performance Improvement Projects

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

1. Diabetes Care

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

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

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

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

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

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

2. Hospital Readmissions

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

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

3. Emergency Department Visits

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

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

4. Substance Use Disorders

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

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

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

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

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

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V. CONCLUSION

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

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

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

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

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EXHIBITS

1 Distribution of Medicaid Enrollees, by Age and Disability Status, CY 2010 22

2 Number of Medicaid Adult Core Set Measures Reported, by State, FFY 2013 23

3 Number of States Reporting the Medicaid Adult Core Set Measures, FFY 2013..... 24

4 Medicaid Health Plan Performance on Selected HEDIS 2013 Measures in the Medicaid Adult Core Set..... 25

5 Change in Medicaid Health Plan Performance on Selected HEDIS Measures in the Medicaid Adult Core Set, 2011–2013 27

6 Number and Percentage of Full-Benefit Adults, Ages 21–64, Enrolled in Medicaid by State and Service Delivery Type, CY 2010* 29

7 Performance Improvement Projects (PIPs) Targeting Adults Included in External Quality Review (EQR) Technical Reports, by Topic Area, 2013–2014 Reporting Cycle..... 31

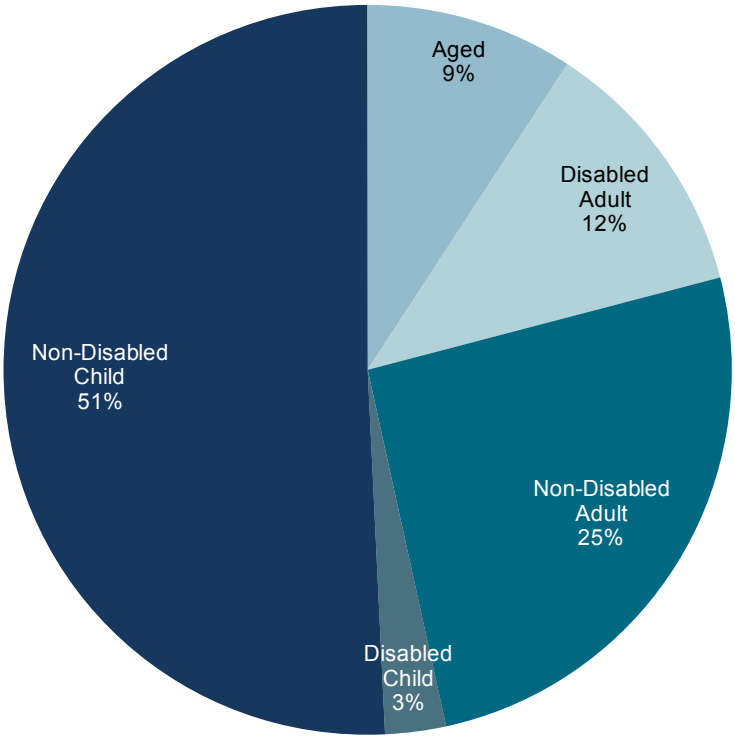
8 Diabetes Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle 34

9 Hospital Readmissions Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 36

10 Emergency Department (ED) Visits Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 38

11 Substance Use Disorders Performance Improvement Projects (PIPs) Included in External Quality Review (EQR) Technical Reports, 2013–2014 Reporting Cycle..... 40

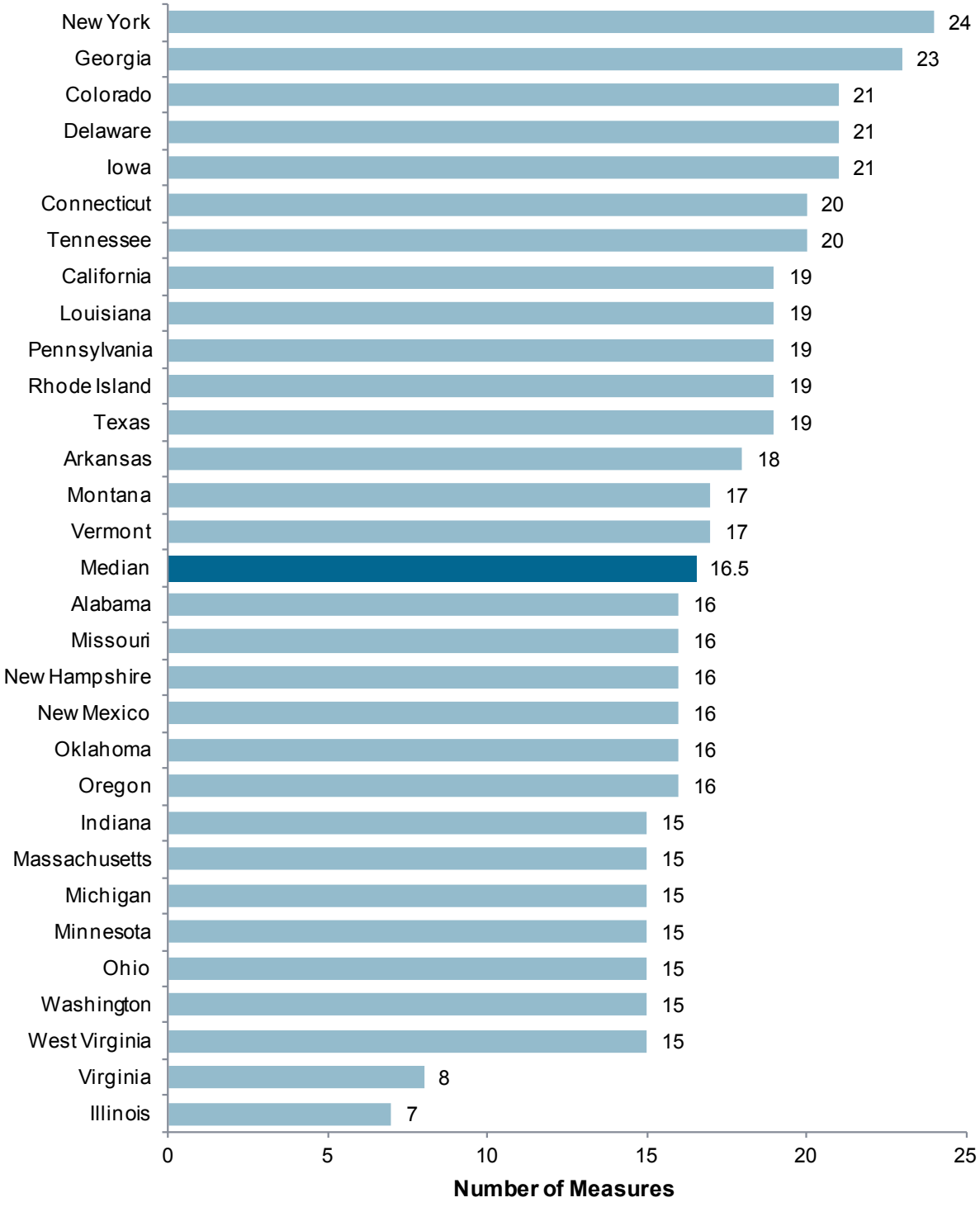
Exhibit 1. Distribution of Medicaid Enrollees, by Age and Disability Status, CY 2010



Source: Mathematica analysis of the 2010 Medicaid Analytic eXtract.

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

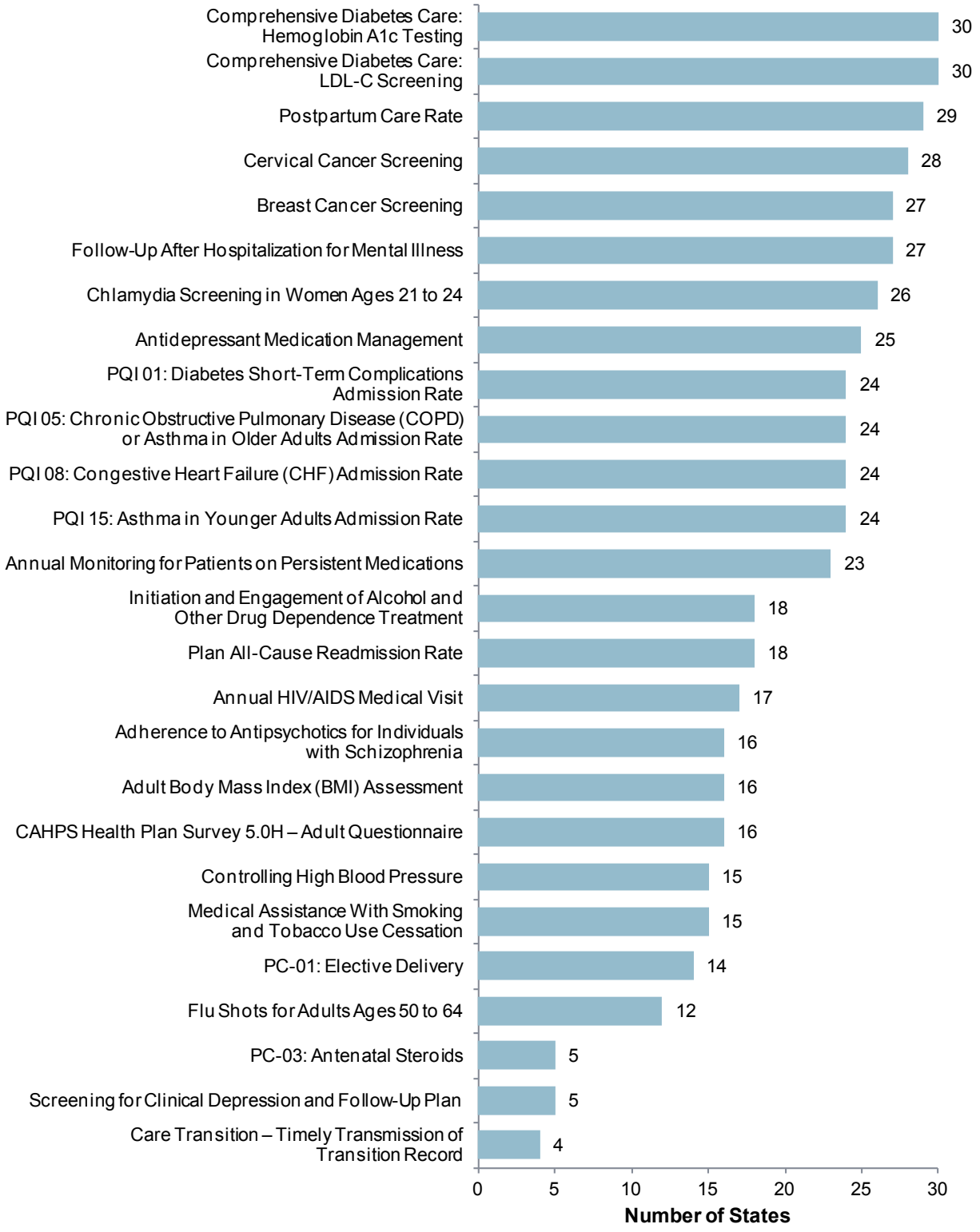
Exhibit 2. Number of Medicaid Adult Core Set Measures Reported, by State, FFY 2013



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

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

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



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

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

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

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

Exhibit 4 (continued)

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

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

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

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

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

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

Exhibit 5 (continued)

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

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

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

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

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

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

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

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

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

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

Exhibit 6 (continued)

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

Source: Mathematica analysis of the 2010 Medicaid Analytic eXtract.

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

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

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

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

Exhibit 7 (continued)

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

Exhibit 7 (continued)

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

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

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

* PIP topic was mandated by the state.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit 8 (continued)

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

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

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

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

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

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

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

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

Exhibit 9 (continued)

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

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

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

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

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

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

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

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

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

Exhibit 10 (continued)

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

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

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

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

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

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

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

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

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

Exhibit 11 (continued)

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

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

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

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

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APPENDIX A

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

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

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

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

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APPENDIX B

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

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

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

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

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APPENDIX C

GLOSSARY

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GLOSSARY

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

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

NATIONAL QUALITY FORUM

Meeting Summary

HHSM-500-2012-00009I – Task Order HHSM-500-T0011

Joint Web Meeting of the MAP Medicaid Adult and Child Task Forces

April 27, 2015 | 12:00pm – 2:00pm ET

The National Quality Forum (NQF) convened a web-based meeting of the Measure Applications Partnership (MAP) Adult and Child Medicaid Task Forces on Monday, April 27, 2015. An online archive of the meeting is available.

Task Force Members in Attendance

Task Force	Name	Organization
Child	Foster Gesten, MD - *Task Force Chair*	
Adult	Harold Pincus, MD - *Task Force Chair*	
Child	Terry Adirim, MD, MPH, FAAP	American Academy of Pediatrics
Adult	George Andrews, MD, MBA, CPE, FACP	Humana, Inc.
Child	Andrea Benin, MD	Children's Hospital Association
Child	Luther Clark, MD	Subject Matter Expert
Child/Adult	Anne Cohen, MPH	Subject Matter Expert
Child	Jeff Convissar, MD	Kaiser Permanente
Child	Denise Cunill, MD, FAAP	American's Essential Hospitals
Adult	Kirstin Dawson	America's Health Insurance Plans
Child	Carole Flamm, MD, MPH	Blue Cross and Blue Shield Association
Child	Amy Gibson	Patient-Centered Primary Care Collaborative
Adult	Sue Kendig	American Academy of Nurse Practitioners
Child	Susan Lacey, RN, PhD, FAAN	American Nurses Association
Child	Kevin Larsen	Office of the National Coordinator for Health IT
Child/Adult	Marc Leib, MD, JD	Subject Matter Expert
Adult	Daniel Lessler, MD, MHA, FACP	National Association of Medicaid Directors
Adult	Lisa Patton	Substance Abuse and Mental Health Services Administration
Child/Adult	Cynthia Pellegrini	March of Dimes
Adult	Ruth Perry, MD	Subject Matter Expert
Child	Carol Sakala, PhD, MSPH	National Partnership for Women and Families
Adult	Marissa Schlaifer	Academy of Managed Care Pharmacy
Child/Adult	Alvia Siddiqi, MD, FAAFP	American Academy of Family Physicians
Adult	Brock Slabach, MPH, FACHE	National Rural Health Association
Adult	Marsha Smith, MD, MPH, FAAP	Centers for Medicare and Medicaid Services
Child	Sandra White, MD, MBA	Aetna

Welcome and Review of Meeting Objectives

Dr. Harold Pincus and Dr. Foster Gesten, chairs of the Adult and Child Task Forces respectively, welcomed the task force members and members of the public to the web meeting. Ann Hammersmith, NQF's General Counsel, led the Committee's introductions and disclosures of interest. The meeting objectives were to:

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

Dr. Gesten reviewed the MAP Medicaid Adult and Child Task Forces' charge to remind members of the purpose and structure of this year's review, which is to provide input on the Adult and Child Core Sets by August 2015.

CMS Overview of the Child and Adult Quality Measurement Programs

Marsha Lillie-Blanton and Karen LLanos, Centers for Medicare & Medicaid Services (CMS), conveyed their appreciation of the Task Forces' work and expressed CMS' support of MAP's effort to combine the work of both the Adult and Child Core Sets during the 2015 review. Ms. LLanos provided background on how the Core Sets operate and fit together. She discussed CMS' three-part goal for both the Child and Adult Core Sets, the statutory requirements for annual updates, changes in both Core Sets as a result of annual measure updates, and the role that MAP plays in strengthening the Core Sets by informing CMS.

CMS provides technical assistance and analytic support to both of these voluntary state-level reporting programs. The Child Core Set is the older of the two reporting programs. CMS and states have five years of experience working with the Child Core Set, compared to two years of experience working with the Adult Core Set. The Core Sets are governed by two separate pieces of legislation. CHIPRA requires annual updates to the Child Core Set and the Affordable Care Act section 2701 requires annual improvements to the Adult Core Set.

CMS stressed the value of multi-stakeholder perspectives and encouraged MAP to strengthen the Child and Adult Core Sets by recommending measures that can fill key gap areas and promote better alignment with other CMS/HHS programs while focusing on incremental changes. CMS reviews MAP's feedback with various internal and external stakeholders and will release annual updates to both Core Sets by January 2016.

Task Force remarks during the discussion included:

- While the majority of the measures in both Core Sets are claims-based measures, eMeasures and hybrid measures have been included. Experience shows that fewer states report on measures that are not claims-based.
- There are some PQMP Centers of Excellence measures that are ready to be or are being considered for NQF endorsement. CMS is open to including those measures in the Core Sets and encourages the Task Forces to consider them, if they fill critical gap areas. Behavioral Risk for

Pregnant Women, a PQMP measure, was added to the Core Set two years ago but has not yet been endorsed.

Child Core Set: Recent Changes and Properties of the Measures

Shaconna Gorham, Senior Project Manager, NQF, reviewed the current measures, properties, and the characteristics of the Child Core Set. Ms. Gorham highlighted that measures are concentrated in the National Quality Strategy (NQS) priority area of Healthy Living and Well-Being and in the clinical areas of Maternal and Perinatal Care and Preventive Care.

Dr. Gesten reviewed MAP's 2014 measure and gap recommendations for the Child Core Set and noted recent changes based on CMS updates for FFY 2015. He remarked that MAP identified numerous gaps in measures in the 2014 Child Core Set during its expedited review. MAP reviewed available NQF-endorsed® measures for potential addition to the measure set, however for some areas, such as screening for abuse and neglect, trauma, and DME, no NQF-endorsed measures were found. MAP also noted measures (i.e., care coordination, behavior health, and inpatient care) in various stages of development under the auspices of the AHRQ-CMS Pediatric Quality Measures Program (PQMP) that could enhance the Child Core Set. These areas and potential measures will be revisited during this year's annual review process. Dr. Gesten noted that MAP recommendations included the removal of one measure and the phased addition of six measures to the Child Core Set. He highlighted CMS's responsiveness to MAP's recommendations exemplified by their updates to the 2015 Child Core Set.

Dr. Gesten provided an overview of the Medicaid Child Core Set FFY 2013 reporting results. In 2013, all states and the District of Columbia reported two or more of the Child Core Set measures. The measures most frequently reported by states include access to primary care, well-child visits, and use of dental services. A full report, published annually by HHS, is available: 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP.

Dr. Gesten also facilitated a discussion related to opportunities to further strengthen the Child Core Set. Members suggested leveraging the Centers of Excellence measures and revisiting MAP's previous recommendations that were not added to the 2015 Child Core Set.

Adult Core Set: Recent Changes and Properties of the Measures

Sarah Lash, Senior Director, NQF, reviewed the current composition of the Medicaid Adult Core Set, measure properties, and recent changes to the Core Set. Most of the Task Force's 2014 recommendations are well-represented on the 2015 Core Set, in particular its strong alignment with other program sets and parsimonious number of measures. Measures in the Adult Core Set are primarily process measures, with 23 of the 26 currently in use in one or more federal programs and three measures also included in the Child Core Set. Changes to the Core Set reflect the need to enable greater state-level reporting.

Dr. Pincus reviewed MAP's 2014 measure and gap recommendations for the Adult Core Set and noted recent changes based on CMS updates for FFY 2015. He led the discussion on gap areas identified by the Task Force during last year's deliberations, with an emphasis on topics particularly relevant to the Medicaid population such as maternal/child health, behavioral health, and access to primary care. Dr. Pincus noted that MAP recommended the continued use of 25 of the 26 measures to provide stability

and the opportunity to gain additional experience. MAP recommendations included the removal of one measure and the phased addition of three measures to the Adult Core Set.

Dr. Pincus provided an overview of the Medicaid Adult Core Set FFY 2013 reporting results. In 2013, 30 states reported a median of 16.5 measures. The most frequently reported measures focused on: diabetes care management, postpartum care visits, mental health treatment, and women's preventive health care. A full report, published annually by HHS, is available: 2014 Annual Report on the Quality of Health Care for Adults Enrolled in Medicaid.

Discussions between the task force members and CMS representatives focused on opportunities to fill gap areas and further strengthening the Adult Core Set by possibly revisiting measures previously recommended but not included in the Core Set, further aligning measures with other programs, and ensuring that measures recommended for addition or removal limit states' burden.

Looking Ahead to the In-Person Meeting

Dr. Pincus and Ms. Lash presented a preview of the meeting objectives for the Task Forces' June convening. They led the discussion on additional information needed to support the Task Forces' deliberations. In addition to the presented planned sources of information, the Task Force members requested information to gain a better understanding of States' use of measures and their challenges, along with other factors influencing measure reporting.

Opportunity for Public Comment

Several public comments were received during the meeting, most of them reinforcing the task forces' earlier discussion on measure alignment in several programs, filling gaps in critical areas in the Child Core Set in particular, and information on availability of measure utilization by state.

Next Steps

NQF staff noted important upcoming events for the Task Forces included:

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

Ms. Gorham thanked the Task Forces, presenters, and public for their participation, and the web meeting was adjourned.

Measure (Developmental)
Use of Contraceptive Methods by Women Aged 21-44 Years

A. DESCRIPTION

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 (e.g., by calculating the median and focusing on those providers/entities that are performing well below the mean).

NOTE: *This is a developmental measure, and feedback obtained from state Medicaid programs over the first year of its use will lead to refinements and the development of additional guidance for reporting.*

B. DEFINITIONS

At risk of unintended pregnancy	Women are considered at risk of unintended pregnancy if they have ever had sex, are fecund, and are not pregnant or seeking pregnancy.
Use of a most effective method of contraception	Use of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS)
Use of a moderately effective method of contraception	Use of injectables, oral pills, patch, ring, or diaphragm
Use of a long-acting reversible method of contraception (LARC)	Use of contraceptive implants, intrauterine devices or systems (IUD/IUS)
Measurement year	The most recent calendar year for which data is available, and after the grace period within which providers must submit claims. This is typically within 12 months of the data of service.

C. ELIGIBLE POPULATION

Age	Women ages 21 through 44 years who are enrolled in Medicaid as of December 31 of the measurement year
Continuous enrollment	The measurement year

Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year
Benefit	Medical
Event/diagnosis	At risk of unintended pregnancy.

D. ADMINISTRATIVE SPECIFICATIONS

Denominator for both measures

The eligible population that is at risk of unintended pregnancy.

Exclusions

Women who are not capable of getting pregnant;

1. Omit from the data set any woman with a code for hysterectomy, bilateral oophorectomy, natural menopause (or premature menopause due to surgery, radiation or other factors) as those women are not capable of getting pregnant.

   Table 1. ICD-9-CM Codes for Infertility due to non-contraceptive reasons

Code	Description
V88.01	Hysterectomy
65.5x, 58720, 58150, 58940, 58700	Oophorectomy (bilateral; salpingo-partial or total, unilateral or bilateral) Total Abdominal Hysterectomy, w/w-o removal of tubes and/or ovaries
256.2, 256.31	Premature menopause due to surgery, radiation or other factors
V49.81, 627.0-627.9	Natural menopause

2. Omit from the dataset any women who were pregnant and/or received prenatal care or delivery care at any point in the 12-month reporting period as listed.

   Table 2. ICD-9-CM Codes for pregnancy

Code	Description
V72.42	Pregnancy test/exam positive
V61.7	Unwanted pregnancy
V22.x	Pregnancy

Table 3. CPT Codes to identify prenatal care visits

59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622, 59425, 59426

The denominator includes all women 21-44 years of age, but preliminary NSFG estimates show that 19% of this population is not at risk of unintended pregnancy because they have never had sex, are infecund, or are trying to get pregnant. Hence, the highest level of performance expected for the first measure may be 81% in many primary care settings. However, in reproductive health programs (such as a state Medicaid family planning expansion or Title X-funded service sites) a higher proportion of the client population is likely to be at risk for unintended pregnancy.

Numerator for measure 1

The eligible population that is using a most or moderately effective method of contraception.

1. Use the codes in Table 4 to identify women who adopted or continued use of one of the following methods of contraception in the measurement year among the population of clients identified for the denominator: sterilization IUD, implant, contraceptive injection, contraceptive pills, patch, ring or diaphragm; among the population of clients identified for the denominator.

2. Take the following two steps to adjust for some unique characteristics of the most effective methods of contraception:

    a. The most effective contraceptive methods (sterilization, IUD, implant) are either permanent or last many years, so adjustments must be made to estimate the number of women who received the most effective method in the year(s) preceding the measurement year. To do this, reassign to the most effective method 29.7% of the women who are using a least effective or no method of contraception.

    b. LARC methods (IUD, implant) can be removed at the client's request so adjustments must be made to reflect this. To do so, use the codes in Table 5 to identify women who had their IUD or implant removed at any point during the measurement year. Check to see if they had an IUD or implant reinserted on the same or a subsequent date. If there is no code indicating reinsertion, reassign them as using the next most effective method reported. If a subsequent method is not identified, reassign them as a non-user of contraception.

3. Sum the number of women identified in steps 1-2 above to determine the numerator.

Numerator for measure 2

The eligible population that is using a LARC method.

1. Use the codes in Table 6 to identify women who adopted or continued use of the contraceptive implant or IUD/IUS; among the population of clients identified for the denominator.

2. Take the following two steps to adjust for some unique characteristics of the most effective methods of contraception:

    a. LARC methods (IUD, implant) last many years, so adjustments must be made to estimate the number of women who received the method in the years preceding the measurement year. To do this, reassign as using a LARC method 3.5% of the women who are using a least effective or no method of contraception.

    a. LARC methods (IUD, implant) can be removed at the client's request so adjustments must be made to reflect this. To do so, use the codes in Table 5 to identify women who had their IUD or implant removed at any point during the measurement year. Check to see if they had an IUD or implant reinserted on the same or a subsequent date. If there is no code indicating reinsertion, reassign them as using the next most effective method reported. If a subsequent method is not identified, reassign them as a non-user of contraception.

3. Sum the number of women identified in steps 1-2 above to determine the numerator.

E. ADDITIONAL NOTES

The ideal denominator for a clinical performance measure of contraceptive services is all women at risk of unintended pregnancy. However, it is not possible to identify this population with existing claims data because there are no codes for a woman's pregnancy intention, history of sexual activity, and receipt of sterilization or LARC in the year(s) preceding the measurement year. This document proposes a way to create a denominator that more accurately represents all women at risk of unintended pregnancy by using estimates from the National Survey of Family Growth (NSFG) to adjust the claims data. The NSFG is a national survey that gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. It is conducted by CDC's National Center for Health Statistics and generates a nationally representative sample of women and men 15-44 years of age. Approximately 5000 individuals are interviewed each year, and data files are released every two years (http://www.cdc.gov/nchs/nsfg.htm). The preliminary estimates in this document come from the NSFG conducted in 2006-2010, among women who were enrolled in Medicaid for at least 11 months of the previous year (n=2062). The percentage of women who were pregnant/seeking pregnancy came from the following publication: Frost J et al (2013). Contraceptive Needs and Services, 2010: Methodological Appendix, Guttmacher Institute, NY,NY. The NSFG estimates used in this measure specifications document will be revised over the coming year as more experience is gained with applying the NSFG data in the context of these

The measure is focused on outpatient delivery of contraceptive services, for the most part in primary care settings. As such, it does not consider use of postpartum contraception. This is due to the complexity of measuring postpartum contraception using claims data, and that the most appropriate denominator would be all women with a recent live birth. Additionally, a measure focused exclusively on postpartum contraception has been proposed and may be approved by NQF/NCQA in the near future; omitting data about postpartum contraception from this measure will facilitate any future harmonization of the two measures.

Table 4. Codes used to identify use of most or moderately effective contraceptive methods

Description	ICD-9	CPT	HCPCS	NDC codes
Female Sterilization	**V25.2**, Sterilization **V26.51**, Tubal ligation status **66.2**	**58565, 58600, 58605, 58615, 58611, 58670, 58671, 58340, 74740**	**A4264, 58340, 74740**	
Intrauterine device (IUD/IUS)	***V25.1,*** *Encounter for insertion or removal of intrauterine* contraceptive device **V25.11,** Encounter for insertion of intrauterine contraceptive device **V25.13**, Encounter for removal and reinsertion of intrauterine contraceptive device **V25.42,** Surveillance of previously prescribed contraceptive method, intrauterine device **V45.51,** Post-surgical presence of intrauterine contraceptive device **996.32, 996.65,** Mechanical complication due to intrauterine contraceptive device or infection **V45.59,** contraceptive device **69.7**, Insertion	**58300,** Insertion of IUD	**J7300,** Intrauterine copper contraceptive **J7302,** Levonorgestrel-releasing intrauterine contraceptive system, 52 mg **S4989,** Contraceptive intrauterine device (e.g. progestacertiud), including implants and supplies **Q0090,** Skyla (2013) **S4981**, Insertion of levonorgestrel-releasing intrauterine system	
Hormonal implant	**V25.5,** Encounter for contraceptive management, insertion of implantable subdermal contraceptive, **V25.43**, Surveillance of previously prescribed contraceptive method; implantable subdermal	**11981**,Insertion, non-biodegradable drug delivery implant, Implanon or Nexplanon **11983**,Removal with reinsertion, non-biodegradable drug delivery implant, Implanon or Nexplanon	**J7306**, Levonorgestrel (contraceptive) implant system, including implants and supplies **J7307**,Etonogestrel [contraceptive] implant system, including implant and supplies (A4260, Levonrgesterol implant system, code expired 2006 S0180, Etonogesterol	

	contraceptive. This code is reported for checking, reinsertion, or removal of the implant. **V45.52**, Post-surgical presence of subdermal contraceptive implant **996.30**, Mechanical complication of unspecified genitourinary device, implant, and graft **V45.59,** contraceptive device		implant system, code expired 2008)	
Injectable (1-month/ 3-month)	***V25.9****, Start other hormonal method: Unspecified contraceptive management ***V25.40****, Follow up other hormonal method: Contraceptive surveillance; unspecified	**96372** **90772,** before 2009	**J1050, 1051, 1055, 1056,** Injection, medroxyprogesterone acetate, 1 mg (J1051, Injection, medroxyprogesterone acetate, 50 mg, code expired 2013 J1055,Injection, medroxyprogesterone acetate for contraceptive use, 150 mg, code expired 2013 J1056, Injection, medroxyprogesterone acetate / estradiol cypionate, 5mg / 25mg, code expired 2013)	**54569370100** **54569490400** **54569552700** **54569561600** **54569621900** **54868361300** **54868410000** **54868410001** **54868525700** **55045350501** **59762453701** **59762453702** **59762453801** **59762453802** **59762453809**
Oral contraceptive	**V25.01**, Counseling and prescription of oral contraceptives **V25.41**, Surveillance of contraceptive pill ***V25.9****,* Start other hormonal method: Unspecified contraceptive management ***V25.40****,* Follow up other hormonal method: Contraceptive surveillance; unspecified		**S4993,** Contraceptive pills for birth control	**52544063128** **52544084728** **52544084828** **52544089228** **52544093628** **52544094028** **52544094928** **52544095021** **52544095121** **52544095328** **52544095428** **52544095931** **52544096691** **52544096728** **52544098131** **52544098231** **54569067900**

				54569068500 **54569068501** **54569068900** **54569068901** **54569143900** **54569384400** **54569422200** **54569422201** **54569426900** **54569427301** **54569481700** **54569487800** **54569487801** **54569489000** **54569498400** **54569499700** **54569499800** **54569516100** **54569534300** **54569534900** **54569549300** **54569549302** **54569579600** **54569579700** **54569579800** **54569581600** **54569582600** **54569603200** **54569612800** **54569614400** **54569627200** **54569628000** **54569628100** **54868042800** **54868044300** **54868050200** **54868050700** **54868050801** **54868050901** **54868051600** **54868151200** **54868156400** **54868231600** **54868260600** **54868270100** **54868377200** **54868386300** **54868394800** **54868409300** **54868423900** **54868436900** **54868453800** **54868459000** **54868460700** **54868473000** **54868473100**

				54868474200 **54868474500** **54868475400** **54868477600** **54868481400** **54868482800** **54868485100** **54868486000** **54868491100** **54868502800** **54868528600** **54868532600** **54868535600** **54868582600** **54868582800** **54868594200** **55045348506** **55045349701** **55045349801** **55045378106** **55045378206** **55289024708** **55289088704** **55887005228** **55887028628** **58016474701** **58016482701** **66993061128** **66993061528** **68180084313** **68180084413** **68180084613** **68180084813** **68180085413** **68180087611** **68180087613** **68180089713** **68180089813** **68180090213** **68462030329** **68462030529** **68462030929** **68462031629** **68462031829** **68462038829** **68462039429** **68462055629** **68462056529**
Patch	***V25.9*,*** Start other hormonal method: Unspecified contraceptive management ***V25.40*,*** Follow up other hormonal method:		**J7304,** Contraceptive supply, hormone containing patch, each	**54569541300** **54868467000**

	Contraceptive surveillance; unspecified			
Vaginal ring	***V25.9*,*** Start other hormonal method: Unspecified contraceptive management ***V25.40*,*** Follow up other hormonal method: Contraceptive surveillance; unspecified		**J7303,** Contraceptive supply, hormone containing vaginal ring, each	**54569586500** **54868483201** **55887075401**
Diaphragm		**57170**	**A4266,** Diaphragm for contraceptive use	

Table 5. Codes used to identify removal/discontinued use of LARC

Table DU-A: Codes to Identify Removal/Discontinued Use of LARC

Description	ICD-9	CPT
Discontinue Intrauterine device (IUD)	**V25.12**, Encounter for removal of intrauterine contraceptive device (97.71, Removal)	**58301**, Encounter for removal of intrauterine contraceptive device
Discontinue Implant		**11976,** Removal, non-biodegradable drug delivery implant, Norplant **11982,** Removal, non-biodegradable drug delivery implant, Implanon or Nexplanon

Table 6. Codes used to identify use of a long-acting reversible contraceptive method (LARC)

Description	ICD-9	CPT	HCPCS
Intrauterine device (IUD/IUS)	***V25.1,*** *Encounter for insertion or removal of intrauterine* contraceptive device **V25.11,** Encounter for insertion of intrauterine contraceptive device **V25.13**, Encounter for removal and reinsertion of intrauterine contraceptive device **V25.42,** Surveillance of previously prescribed contraceptive method, intrauterine device **V45.51,** Post-surgical presence of intrauterine contraceptive device **996.32, 996.65,** Mechanical complication due to intrauterine contraceptive device or infection **V45.59,** contraceptive device 69.7, Insertion	**58300,** Insertion of IUD	**J7300,** Intrauterine copper contraceptive **J7302,** Levonorgestrel-releasing intrauterine contraceptive system, 52 mg **S4989,** Contraceptive intrauterine device (e.g. progestacertiud), including implants and supplies **Q0090,** Skyla (2013) **S4981**, Insertion of levonorgestrel-releasing intrauterine system
Hormonal implant	**V25.5,** Encounter for contraceptive management, insertion of implantable subdermal contraceptive, **V25.43**, Surveillance of previously prescribed contraceptive method; implantable subdermal contraceptive. This code is reported for checking, reinsertion, or removal of the implant. **V45.52**, Post-surgical presence of subdermal contraceptive implant **V45.59,** contraceptive device **996.30**, Mechanical complication of unspecified genitourinary device, implant, and graft	**11981**,Insertion, non-biodegradable drug delivery implant, Implanon or Nexplanon **11983**,Removal with reinsertion, non-biodegradable drug delivery implant, Implanon or Nexplanon	**J7306**, Levonorgestrel (contraceptive) implant system, including implants and supplies **J7307**,Etonogestrel [contraceptive] implant system, including implant and supplies (A4260, Levonrgesterol implant system, code expired 2006 S0180, Etonogesterol implant system, code expired 2008)

Effective Postpartum Contraception Access
Measure Work-Up

Measure Description

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.

- *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.
- *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.

Eligible Population

Product lines	Report the following tables for each applicable product line. Commercial, Medicaid (report each product line separately).
Member months	For each product line and table, report all member months for the measurement period.
Ages	None specified. Report two age stratifications and a total rate for each numerator. • Less than 18 years. • Greater than or equal to 18 years. • Total.
Continuous enrollment	43 days prior to delivery through 99 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of live birth.
Benefit	Medical.
Event/diagnosis	*Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.* Include women who delivered in a birthing center. Refer to Tables PPC-A and PPC-B for codes to identify live births.

Administrative Specification

Denominator	Follow the first two steps below to identify the eligible population.
Step 1	Identify live births. Use Method A and and Method B below to identify all women with alive birth between November 6 of the year prior to the measurement year and November 5 of the measurement year. Organizations must use both methods to identify the eligible population, but a member only needs to be identified by one to be included in the measure.
Method A	Codes listed in Table PPC-A identify a delivery *and* indicate the outcome of the delivery was a live birth. Women who are identified through the codes listed in Method A are automatically included in the eligible population and require no

further verification of the outcome.

Table PPC-A: Codes to Identify Live Births

Description	Codes	Codes	Codes

Method B Identify deliveries and verify live births. Codes in Table PPC-B, step A, identify deliveries but do not indicate the outcome. Organizations must use step B to eliminate deliveries that did not result in a live birth.

Table PPC-B: Codes to Identify Deliveries and Verify Live Births

Description	Codes	Codes	Codes

Step 2 Identify continuous enrollment. For women identified in step 1, determine if enrollment was continuous between 43 days prior to delivery and 99 days after delivery, with no gaps.

Numerator

Highly Effective Postpartum Contraception Effectiveness The percentage of women who received contraceptives such as implants, intrauterine devices or systems (IUD/IUS), or female sterilization within 99 days after birthing.

Step 1 Identify the codes for highly effective postpartum contraception.

Table XXX: Codes to Identify Highly Effective Postpartum Contraceptive Methods

Description	
CPT	**11981** Insertion, non-biodegradable drug delivery implant **11983** Removal with reinsertion, non-biodegradable drug delivery implant **58300** Insertion of IUD 58600 Ligation or transection of fallopian tubes, abdominal or vaginal approach (sterilization) 58605 Ligation or transection of fallopian tubes, postpartum, unilateral or bilateral, during same hospitalization 58611 Ligation or transection of fallopian tubes when done at the time of cesarean delivery or intra-abdominal surgery. 58615 Occlusion of fallopian tubes by device (eg, band, clip, Falope ring) 58670 Laparoscopy with fulguration of oviducts 58671 Laparoscopy with occlusion of oviducts by device
ICD-9	**V25.5** Encounter for contraceptive management, insertion of implantable subdermal contraceptive **V25.43** Surveillance of previously prescribed contraceptive method; implantable subdermal contraceptive. This code is reported for checking, reinsertion, or removal of the implant. **V25.11** Insertion of intrauterine contraceptive device **V25.13** Removal and reinsertion of intrauterine contraceptive device **V25.42** Surveillance of previously prescribed contraceptive method, intrauterine device
ICD-10	Z30.0 Encounter for contraceptive management Z30.01 Encounter for initial prescription of contraceptives

	Z30.013 injectable Z30.014 IUD Z97.5 device intrauterine (in situ) Z30.019 initial prescription Z30.019 subdermal implantable Z30.431 IUD Z30.49 specified type NEC Z30.49 subdermal implantable Z30.9 Management Z30.8 specified type NEC Z30.019 prescription Z30.40 repeat Z30.2 Encounter for sterilization Z30.4 Encounter for surveillance of contraceptives Z30.40 Encounter for surveillance of contraceptives, unspecified Z30.42 Encounter for surveillance of injectable contraceptive Z30.43 Encounter for surveillance of IUD Z30.430 Encounter for insertion of UID Z30.431 Encounter for routine checking of IUD Z30.433 Encounter for removal and reinsertion of IUD Z30.49 Encounter for surveillance of other contraceptives Z30.8 Encounter for other contraceptive management Z30.9 Encounter for contraceptive management, unspecified
HCPCS	**J7307** Etonogestrel [contraceptive] implant system, including implant and supplies **J7300** Intrauterine copper contraceptive **J7302** Levonorgestrel-releasing intrauterine contraceptive system, 52 mg S4981 Insertion of levonorgestrel-releasing intrauterine system S4989 Contraceptive intrauterine device (eg, progestacert IUD), including implants and supplies
ICD-10-PCS	0U2DXHZ, 0UHC, 0JH8, 0JH6, 0JHH, 0JHG, 0JHP, 0JHN, 0JHF, 0JHD, 0JHM, 0JHL, 0UH9, 0JWW, 0JWT, 0JWV, 0UWD

Step 2 Report each woman's postpartum contraceptive utilization in the appropriate category in Table XXX: Highly Effective Postpartum Contraception

- Less than 18 years.
- Greater than or equal to 18 years.
- Total.

Table XXX: Highly Effective Postpartum Contraception

Age	0-7 days postpartum	8-33 days postpartum	34-66 days postpartum	67-99 days postpartum	0-99 days postpartum
Less than 18 years	_____	_____	_____	_____	_____
18-29 years	_____	_____	_____	_____	_____
30-39 years	_____	_____	_____	_____	_____

Greater than 40 years	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____

Moderately Effective Postpartum Contraception Effectiveness

The percentage of women who received contraceptives such as injectables, oral pills, patch, or ring within 99 days after birthing.

Step 1 Identify the codes for moderately effective postpartum contraception.

Table XXX: Codes to Identify Moderately Effective Postpartum Contraceptive Methods

Description	Codes
HCPCS	H1010 Nonmedical Family Planning Education, per session S4993 Contraceptive Pills for birth control
CPT	57170 Diaphragm or cervical cap fitting with instructions
ICD-10	Z30.011 pills Z30.018 encounter for initial prescription of other contraceptives, specified type NEC Z30.019 Encounter for initial prescription of contraceptives, unspecified Z30.02 Counseling and instruction in natural family planning to avoid pregnancy Z30.41 Encounter for surveillance of contraceptive pills

Step 2 Report each woman's postpartum contraceptive effectiveness in the appropriate category

- Less than 18 years.
- Greater than or equal to 18 years.
- Total.

Table XXX: Moderately Effective Postpartum Contraception

Age	0-7 days postpartum	8-33 days postpartum	34-66 days postpartum	67-99 days postpartum	0-99 days postpartum
Less than 18 years	_____	_____	_____	_____	_____
18-29 years	_____	_____	_____	_____	_____
30-39 years	_____	_____	_____	_____	_____
Greater than 40 years	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____

Topic Overview

Importance and Prevalence

Health importance

Effective Postpartum Contraception Access Measure Work-Up

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). 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).

Unwanted and mistimed pregnancies lead to delayed prenatal care, poorer intra-partum health and adverse pregnancy behaviors with negative consequences for both the mother and the fetus including later entry into prenatal care, decreased likelihood of smoking cessation, increased incidence of low birth weight babies and decreased breastfeeding (Gipson et al, 2008). Children from unintended pregnancies have a higher risk of experiencing poor mental and physical health during childhood and have higher risk of behavioral problems than their planned peers. Even after controlling for socioeconomic and demographic factors, there is a strong association between both mistimed and unplanned pregnancies and behavioral problems at age 5 and 7 (Carson et al, 2013). Unintended pregnancy is a significant source of social and economic hardship for women and families in the United States and the U.S. has been unable to reduce the rate of unintended pregnancies or unintended births. Postpartum contraception is important to prevent both unintended pregnancies and short birth intervals, defined by the World Health Organization as a birth-to-pregnancy interval of less than 24 months (WHO, 2006). Short birth intervals are associated with adverse health outcomes for both the mother and the infant, including increased risks for low birth weight and preterm births (Zhu et al, 1999; Conde-Agudelo and Belizán, 2000). Compared to women with inter-pregnancy intervals of 18-23 months, those with inter-pregnancy intervals of 5 months or less have been shown to have a 70% increased risk of third trimester bleeding and premature rupture of membranes and a 30% increased risk of anemia and puerperal endometritis. These women also had a significantly greater risk of maternal death (adjust OR 2.54 95% CI 1.22 – 5.38) (Conde-Agudelo and Belizán, 2000). A large meta-analysis was conducted in 2006 including 20 studies conducted in the United States as well as a large number of women from populations around the world. The analysis showed that birth to conception intervals shorter than 18 months and longer than 59 months is associated with increased risk of poor perinatal outcomes including preterm birth, low birth weight, and small for gestational age babies. Meta-regression curves also suggested that inter-pregnancy intervals shorter than 6 months are associated with increased risk of fetal and early neonatal death. (Conde-Agudelo et al, 2006)

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.

Financial importance & cost-effectiveness

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).

Effective Postpartum Contraception Access Measure Work-Up

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).

Not included in these cost estimates are the ongoing costs of children's medical care beyond their first year of life and other government or social programs utilized to support the families through pregnancy and birth as well as housing, food and other support. Ongoing social and psychological impacts to women and families of unintended pregnancies, losses, terminations and births should not be underestimated.

Evidence Supporting Postpartum contraception

While it is widely known and accepted that effective birth control is important in preventing unintended pregnancies, many women and their partners do not use effective contraception or use contraception ineffectively. Public health advocates believe that the post-partum period is an important time to educate patients about the effective use of contraceptives and discuss a contraceptive plan. During this period, women may have increased motivation to avoid another pregnancy. Those women who were receiving pre-natal care were having multiple contacts with health care providers and, ideally, several opportunities to discuss post-partum contraception and optimal birth spacing. For those women who did not have pre-natal care, it is an opportunity to plug them into care. At least one post-partum visit is generally scheduled for 4-8 weeks postpartum, earlier for any women with problems requiring closer follow-up, and presents another opportunity to emphasize the importance of post-partum contraception and begin contraception as previously planned or further any discussions that were postponed per patient preference. Some methods, such as the IUD, subdermal implant, and injectables can be initiated before discharge after birth if the patient desires.

Though it is known that long-acting reversible contraception (LARC) such as IUD and hormonal implants are the most effective form of contraception and that intra-uterine contraceptives are significantly easier to place in the post-partum period, most women are not utilizing LARCs. Instead, the majority of women use user-dependent forms of birth control such as oral contraceptive pills and condoms which depend on consistent, proper use.

In one large study of postpartum women enrolled in MediCal, 55% of women used user-dependent hormonal contraception as their most common contraceptive method and one third of women had no contraceptive claim. Women who used LARC had 3.89 times the odds of achieving an optimal birth interval compared with women who used barrier methods only. Women who used user-dependent hormonal methods had 1.89 times the odds and those with no method had 0.66 times the odds of achieving an optimal birth interval (Thiel de Bocanegra et al, 2014). Therefore women without a method of contraception have 0.34 times the odds of becoming pregnant without adequate birth interval spacing.

Contraceptive methods

Of the 50% of pregnancies that are unintended in the United States, about 60% of them occur in women who are using some form of contraceptive during the month of conception (Hurt et al, 2011). Of the many reversible contraceptive methods available to women and their partners, only the pill, patch, ring, injectable, implant and intrauterine devices and sterilization are moderate and highly effective.

Table 1

		% with Unintended Pregnancy	% Actual Effectiveness Rate
Method	**Perfect Use**	**Typical Use**	**(100-Typical Use)**
No method	85	85	15
Spermicides	18	29	71
Withdrawal	4	27	73

Periodic Abstinence			
Calendar	9	25	75
Standard days method	5	12	88
Ovulation method	3	25	75
Symptothermal	2	25	75
Postovulation	1	25	75
Diaphragm with spermicide	6	16	84
Condom			
Female	5	21	79
Male	2	15	85
Pill (combined)	0.3	8	92
Mini-pill (progestin only)	1.1	13	87
Patch	0.3	8	92
Vaginal Ring	0.3	8	92
Depo Provera	0.3	3	97
Subdermal hormonal Implant	0.05	0.05	99.95
IUD			
Copper T	0.6	0.8	99.2
Levonorgestrel IUS	0.2	0.2	99.8
Female sterilization	0.5	0.5	99.5
Male sterilization	0.10	0.15	99.85

Values are the percentage of women who experience an unintended pregnancy within the first year of typical use and the first year of perfect use for each listed method. From Hanson SJ and Burke AE. Fertility Control: Contraception, Sterilization, and Abortion. In Hurt KJ, Guile MW, Bienstock JL, Fox HE, Wallach EE., eds. *The Johns Hopkins Manual of Gynecology and Obstetrics: Fourth Edition.* Philadelphia, PA: Lippincott Williams & Wilkins, 2011.

Contraceptive methods that are dependent on consistent and correct use by the individual users are more likely to result in unintended pregnancies due to user error. LARCs such as the IUD and subdermal hormonal implant are

not user-dependent and are the most effective forms of reversible contraception. LARCs require provider training and an office visit for placement. However, they are extremely cost-effective and long-lasting. The copper-T can be left in place for 10 years, the Levonorgestrel IUS 5 years and the subdermal implant 3 years allowing for fewer clinical visits. All forms can be removed early if desired and do not have lasting effects on fertility after removal. In fact, these forms of contraception have the quickest return to fertility. These hormonal birth control methods do not increase risk for venous thromboembolism and can be used immediately after delivery, including post-cesarean delivery, unlike combined oral contraceptive pills (CDC, 2010).

Combined hormonal contraceptives can increase the risk for VTE in all women and post-partum women are at increased risk due to their already hypercoagulable state. The CDC recommends that post-partum women should not use combined hormonal contraceptives during the first 21 days postpartum for this reason. During postpartum days 21-42, women with risk factors for VTE or post-cesarean delivery should not use combined hormonal contraceptives. After 42 days, there are no restrictions based on post-partum status (CDC, 2010).

Progestin-only forms of contraception including progestin-only pills, the subdermal implant and depot medroxyprogesterone acetate injections are all considered safe for postpartum women, do not interfere with breastfeeding and can be started immediately postpartum. Progestin-only contraceptive pills require that the user take the pill at the same time every day with more than a 3-hour delay considered a missed pill. This method therefore has greater risk for user error, making it far less effective with typical use (Hanson SJ and Burke AE, 2011).

Gaps in care

Many 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).

Health care disparities

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).

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Effective Postpartum Contraception Access Measure Work-Up

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Effective Postpartum Contraception Access Measure Work-Up

Recommendations for Contraception

Organization (Guideline Date)	Population	Recommendation	Type/ Grade
World Health Organization	Women after live birth	After a live birth, the recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes	
	Women after abortion	After a miscarriage or induced abortion, the recommended minimum interval to next pregnancy is at least six months in order to reduce risks of adverse maternal and perinatal outcomes.	
American College of Obstetricians and Gynecologists (2011)		Routine antibiotic prophylaxis to prevent pelvic infection is not recommended before intrauterine device (IUD) insertion	Level A
		Insertion of a copper IUD is the most effective method of postcoital contraception when inserted up to 5 days after unprotected intercourse	Level A
		IUDs may be offered to women with a history of ectopic pregnancy	Level B
		Insertion of the implant is safe at any time in nonbreastfeeding women after childbirth	Level B
		Implants may be offered to women who are breastfeeding and more than 4 weeks after childbirth	Level B
		Insertion of an IUD or implant immediately after either an abortion or miscarriage is safe and effective	Level B
		Immediate postpartum IUD insertion, which is an insertion within 10 minutes of placental separation, appears safe and effective.	Level B
		The *U.S. Medical Eligibility Criteria for Contraceptive Use* classifies placement of an implant in breastfeeding women less than 4 weeks after childbirth as Category 2 because of theoretic concerns regarding milk production and infant growth and development.	Level C
		Nulliparous women and adolescents can be offered long-acting reversible contraceptive (LARC) methods, including IUDs.	Level C
		Long-acting reversible contraceptive methods have few contraindications, and almost all women are eligible for implants and IUDs.	Level C
		Insertion of an IUD or an implant may occur at any time during the menstrual cycle as long as pregnancy may be reasonably excluded.	Level C
		For women at high risk of sexually transmitted infections (STIs) (e.g., aged 25 years or younger or having multiple sex partners), it is reasonable to screen for STIs and place the IUD on the same day (and administer treatment if the test results are positive) or when the test results are available.	Level C
		Long-acting reversible contraceptive methods have an effect on menstrual bleeding, and patients should be given anticipatory guidance about these effects.	Level C
		An endometrial biopsy may be performed without removing the IUD. Cervical colposcopy, cervical ablation or excision, or endometrial sampling, may be performed with an IUD left in place.	Level C
		The U.S. Food and Drug Administration (FDA) and the World Health Organization (WHO) recommend that IUDs be removed from pregnant women when possible without an invasive procedure.	Level C
Update to CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: Revised Recommendations for the Use of Contraceptive	All Women		
	<21 days Postpartum	In women who are <21 days postpartum, use of combined hormonal contraceptives represents an unacceptable health risk and should not be used	Category 4
	<4 weeks after delivery of the placenta (Including	Levonorgestrel-releasing IUD - the advantages generally outweigh the risks, and they can usually be used. Although IUD expulsion rates are somewhat higher when insertion occurs within 28 days of delivery, continuation rates at 6 months are similar among women who receive an IUD postpartum and those who plan for delayed insertion.	Category 2

Effective Postpartum Contraception Access Measure Work-Up

Organization (Guideline Date)	Population	Recommendation	Type/ Grade
Methods During the Postpartum Period	post-cesarean delivery)		
	>4 weeks after delivery of the placenta (including post-cesarean delivery)	Levonorgestrel-releasing IUD – No restrictions	Category 1
	<10 min after delivery of the placenta (including post-cesarean delivery)	Copper-bearing IUD – No restrictions	Category 1
	10 min to <4 weeks after delivery of the placenta (including post-cesarean delivery)	Copper-bearing IUD - the advantages generally outweigh the risks, and they can usually be used.	Category 2
	>4 weeks after delivery of the placenta (including post-cesarean delivery)	Copper-bearing IUD – No restrictions	Category 1
	Puerperal sepsis	IUDs – Copper-bearing and Levonorgestrel-releasing IUD's are an unacceptable health risk and should not be used	Category 4
	Non-breastfeeding Women		
	21--42 days postpartum with other risk factors for VTE	CHC - In women who are 21--42 days postpartum and have other risk factors for VTE in addition to being postpartum, the risks for combined hormonal contraceptives usually outweigh the advantages and therefore combined hormonal contraceptives generally should not be used	Category 3
	21--42 days postpartum without other risk factors for VTE	CHC - In women who are 21--42 days postpartum, in the absence of other risk factors for VTE, the advantages of combined hormonal contraceptives generally outweigh the risks, and they can usually be used	Category 2
	>42 days postpartum	CHC - In women who are >42 days postpartum, no restriction applies for the use of combined hormonal contraceptives because of postpartum status. Nonetheless, any other medical conditions still should be taken into consideration when determining the safety of the contraceptive method.	Category 1
	Any time	Progestin-only hormonal methods, including progestin-only pills, depot medroxyprogesterone acetate injections, and implants, are safe for postpartum women and can be initiated immediately postpartum	Category 1
	Breastfeeding Women		
	<21 days postpartum	Progestin-only hormonal methods, including progestin-only pills, depot medroxyprogesterone acetate injections, and implants – The advantages generally outweigh the risks, and they can usually be used.	Category 2

Effective Postpartum Contraception Access Measure Work-Up

Organization (Guideline Date)	Population	Recommendation	Type/ Grade
	21 to < 30 days postpartum with other risk factors for VTE	CHC - For women with other risk factors for VTE, these risk factors might increase the classification to a "4"; for example, smoking, deep venous thrombosis/pulmonary embolism, known thrombogenic mutations, and peripartum cardiomyopathy.	Category 3/4
	21 to < 30 days postpartum without other risk factors for VTE	CHC – For women without other risk factors for VTE, the risks for combined hormonal contraceptives usually outweigh the advantages and therefore combined hormonal contraceptives generally should not be used	Category 3
	All women 21 to < 30 days postpartum	Progestin-only hormonal methods, including progestin-only pills, depot medroxyprogesterone acetate injections, and implants – The advantages generally outweigh the risks, and they can usually be used.	Category 2
	30-42 days postpartum with other risk factors for VTE	CHC - For women with other risk factors for VTE, these risk factors might increase the classification to a "4"; for example, smoking, deep venous thrombosis/pulmonary embolism, known thrombogenic mutations, and peripartum cardiomyopathy.	Category 3/4
	30-42 days postpartum without other risk factors for VTE	CHC – For women without other risk factors for VTE, the advantages of combined hormonal contraceptives generally outweigh the risks, and they can usually be used.	Category 2
	>42 days postpartum	CHC – For women without other risk factors for VTE, the advantages of combined hormonal contraceptives generally outweigh the risks, and they can usually be used.	Category 2
	All women ≥30 days postpartum	Progestin-only hormonal methods, including progestin-only pills, depot medroxyprogesterone acetate injections, and implants, are safe and can be initiated immediately postpartum	Category 1
Faculty of Sexual and Reproductive Healthcare (2009)		Health professionals should find opportunities during both the antenatal and postnatal period to discuss all methods of contraception	Good practice point
		Health professionals should assess a woman's postpartum contraceptive needs by taking account of her personal beliefs/preferences, cultural practices, sexual activity, breastfeeding pattern, menstruation, medical and social factors	Good practice point
		The benefits of long-acting reversible contraception (LARC) methods in terms of efficacy should be highlighted to all postpartum women	Good practice point
	Breastfeeding women	Women can be informed that available evidence suggests that use of progestogen-only contraception while breastfeeding does not affect breast milk volume	Grade B
	Breastfeeding women	Women can be informed that there is currently insufficient evidence to prove whether or not combined hormonal contraception (CHC) affects breast milk volume	Grade C
	Breastfeeding women	Women can be informed that progestogen-only contraception has been shown to have no effect on infant growth	Grade A
		CHC should not be commenced before Day 21 due to the increased risk of thrombosis. Non-breastfeeding women may start CHC from Day 21 postpartum	Grade C
	Breastfeeding women	Breastfeeding women should avoid CHC in the first 6 weeks postpartum as there is insufficient evidence to prove the safety of CHC use while establishing breastfeeding	Grade C

Effective Postpartum Contraception Access Measure Work-Up

Organization (Guideline Date)	Population	Recommendation	Type/ Grade
	Breastfeeding women	Use of CHC between 6 weeks and 6 months should not be recommended in fully breastfeeding women unless other methods are not acceptable or available. In partially or token breastfeeding women the benefits of CHC use may outweigh the risks	Good practice point
		Postpartum women (breastfeeding and non-breastfeeding) can start the POP at any time postpartum	
	Non-breastfeeding women	Non-breastfeeding women can start a progestogen-only injectable method at any time postpartum	Grade C
	Breastfeeding women	Breastfeeding women should not start a progestogen-only injectable method before Day 21 unless the risk of subsequent pregnancy is high	Grade C
		Women should be advised that troublesome bleeding can occur with use of depot medroxyprogesterone acetate (DMPA) in the early puerperium	Grade C
		If more convenient, breastfeeding and non-breastfeeding women can choose to have a progestogen-only implant inserted before Day 21, although this is outside the product licence for Implanon	Good practice point
		Unless a copper-bearing intrauterine device (Cu-IUD) can be inserted within the first 48 hours postpartum (breastfeeding and non-breastfeeding women), insertion should be delayed until Day 28 onwards. No additional contraception is required	Grade C
		An LNG-IUS can be inserted from Day 28 postpartum (breastfeeding and non-breastfeeding women). Women should avoid sex or use additional contraception for 7 days after insertion unless fully meeting LAM criteria	Grade C
		Women who choose a diaphragm or cervical cap should be advised to wait at least 6 weeks postpartum before attending for assessment of size requirement	Grade C

Grading System Key

American College of Obstetricians and Gynecologists

Level A Recommendations are based on good and consistent scientific evidence; *Level B* Recommendations are based on limited or inconsistent scientific evidence.; *Level C* Recommendations are based primarily on consensus and expert opinion.

CDC

Categories: 1 = a condition for which there is no restriction for the use of the contraceptive method, 2 = a condition for which the advantages of using the method generally outweigh the theoretical or proven risks, 3 = a condition for which the theoretical or proven risks usually outweigh the advantages of using the method, 4 = a condition that represents an unacceptable health risk if the contraceptive method is used.

Faculty of Sexual and Reproductive Healthcare

A: Evidence based on randomised controlled trials (RCTs)
B: Evidence based on other robust experimental or observational studies
C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities
Good Practice Point where no evidence exists but where best practice is based on the clinical experience of the multidisciplinary group

References for Recommendations

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Effective Postpartum Contraception Access Measure Work-Up

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