MEASURE APPLICATIONS PARTNERSHIP

Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2014

EXPEDITED REVIEW

NOVEMBER 14, 2014

NATIONAL QUALITY FORUM

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EXECUTIVE SUMMARY

Together, Medicaid and the Children's Health Insurance Program (CHIP) cover more than 43 million children, which is more than 1 in every 3,[1] and about 40 percent of all births.[2] With such a large share of children relying on Medicaid and CHIP for comprehensive health services, the quality of these services is paramount.

A Core Set of Health Care Quality Measures for Children Enrolled in Medicaid and CHIP (Child Core Set) has been identified to provide the health system with information it needs to monitor quality and undertake improvement activities when deficits are identified. The 2014 Child Core Set contains 23 measures that span an array of clinical topic areas to meet the diverse health needs of children enrolled in Medicaid and CHIP. Although it is a voluntary reporting program, all states provided data for the most recent annual report, with a median of 14 measures in use per state. The Child Core Set is updated annually to continually strengthen and improve this program.

Convened by the National Quality Forum (NQF), the Measure Applications Partnership (MAP) is a public-private partnership that provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for quality reporting programs. MAP's input on the Child Core Set began with an expedited review, which focused on recommending measures to fill critical gap areas. MAP considered feedback from states on the implementation and impact of the Child Core Set to inform its decisionmaking.

MAP supports all but one of the measures in the current Child Core Set for continued use in the program and six measures for phased addition to the Child Core Set.

- MAP recommends removal of the measure Percentage of Eligibles That Received Dental Treatment Services, because it is unclear if an increase or decrease in the rate is desirable. There are other NQF-endorsed oral health measures that are better suited to the needs of the Medicaid and CHIP quality reporting program.

MAP is aware that additional resources are required for each new measure, and has ranked the recommended measures for phased addition to provide a clear sense of priority:

1. #2508 Prevention: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk to the Child Core Set to replace the current dental treatment measure in the Child Core Set, Percentage of Eligibles That Received Dental Treatment Services. This measure more accurately captures the quality of care delivered and is linked to improved outcomes. It also addresses a legislative mandate to HHS.
2. #2548 The Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS) is a pediatric-specific tool that is part of the CAHPS suite of surveys that address patient and family experience of care.
3. #2509 Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk provides a continuation in age range to #2508. This second, similar measure is necessary to evaluate the application of sealants to the second set of molars, which develop at a later age.

Particular emphasis was given to the top three recommendations. Despite lower prioritization, the Task Force also supported the following three measures:

4. (tie) #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment targets a high prevalence mental health condition that can result in severe outcomes without appropriate treatment. It helps to address a potential gap in measures related to behavioral health.

   (tie) #0477 Under 1500g Infant Not Delivered at

Appropriate Level of Care measures an important missed opportunity to provide treatment and guidance for high-risk pregnancies in a regional manner that promotes care coordination across facilities.

6. #0480 PC-05 Exclusive Breast Milk Feeding is part of a set of five 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) and complements other perinatal measures in the Child and Adult Core Sets.

During MAP's review of measures in the Child Core Set, members discussed numerous cross-cutting and strategic issues. These issues include limitations in the data infrastructure to support measurement and particularly eMeasurement, feasibility concerns for measures not specified for state-level analysis, and increasing alignment of measures with the Medicaid Adult Core Set and other quality reporting programs. A major strategic consideration for the future direction of the Child Core Set is the large volume of pediatric measures in development under the auspices of the AHRQ-CMS Pediatric Quality Measures Program (PQMP); these measures will become available for MAP's consideration over the course of the next year. Knowing that other measures were on the horizon influenced MAP's decisionmaking, in particular related to behavioral health and care coordination measures.

These strategic issues, as well as any newly-endorsed measures in critical gap areas, will be considered further during the MAP's next review of the Child Core Set, scheduled to be completed by August 2015.

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 children who are enrolled in Medicaid and the Children's Health Insurance Program (CHIP).

The MAP Medicaid Child 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 Children Enrolled in Medicaid and CHIP (Child Core Set), with a focus on addressing high-priority measure gaps. The task force consists of MAP members from the MAP Coordinating Committee and MAP workgroups (Appendix B).

MAP's input on the Child Core Set began with an expedited review, described in this report, which took place over the course of ten weeks. MAP will also conduct a second, more in-depth review scheduled to be completed in August 2015. Because a comprehensive retirement review was recently completed by the Agency for Healthcare Research and Quality (AHRQ) on behalf of the Centers for Medicare & Medicaid Services (CMS), MAP's expedited review focused on recommending measures to fill critical gap areas. In tandem with the MAP Measure Selection Criteria (MSC) (Appendix C), MAP considered states' experiences implementing the Child Core Set in making its recommendations. HHS will use MAP's findings to inform an annual update of the Child Core Set required by statute to occur by January 2015. NQF will continue to convene the Medicaid Child Task Force and MAP Coordinating Committee to provide additional review and recommendations in 2015 for the January 2016 update.

BACKGROUND ON MEDICAID AND THE CHILD CORE SET

Covering more than 62 million Americans, Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals.[3] CHIP provides coverage to children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. Both Medicaid and CHIP are financed through federal-state partnerships; each state designs and operates its own programs within federal guidelines.[4]

Medicaid and CHIP Benefits for Children

Together, Medicaid and CHIP cover more than 43 million children, which is more than 1 in every 3,[5] and about 40 percent of all births.[6] The federal government sets minimum guidelines for Medicaid eligibility, but states can choose to expand coverage beyond the minimum threshold. Most states have elected to provide Medicaid to children with family incomes above the minimum of 100 percent of the Federal Poverty Level (FPL).[7] The FPL is determined by family size: it is $19,790 for a family of three in 2014.[8] As of April 2014, 29 states (including DC) covered children in families with incomes up to 250 percent FPL under Medicaid and/or CHIP. Nineteen of these states covered children with family incomes up to 300 percent FPL.[9]

States establish and administer their own Medicaid programs but are required to offer certain mandatory benefits and can choose to provide other optional benefits. All children enrolled in Medicaid are entitled to the comprehensive set of healthcare services known as Early Periodic Screening, Diagnosis, and Treatment (EPSDT). This benefit provides comprehensive and preventive healthcare services for children under age 21 who are enrolled in Medicaid. The preventive focus of EPSDT helps to ensure that health problems, including behavioral health issues, are identified and treated early, before problems become more complex and their treatment more costly.[10] Although pharmacy coverage is an optional benefit under federal Medicaid law, all States currently provide coverage for outpatient prescription drugs to all categorically eligible individuals and to most other enrollees within their Medicaid programs.[11]

CHIP also ensures a comprehensive set of benefits for children, but states have flexibility to design the benefit package depending on how the CHIP program is operated. Each state can design its CHIP program in one of three ways: as an expansion of the Medicaid program, as a separate Child Health Insurance Program, or as a combination of the two approaches. If it is a Medicaid Expansion CHIP program, it will provide the standard Medicaid benefit package, including EPSDT. Separate CHIP programs can provide either Benchmark coverage or Benchmark-equivalent coverage.[12]

Health Issues for Children in Medicaid and CHIP

Understanding the health-related needs of children in Medicaid and CHIP contributes to the selection of appropriate measures across the continuum of child health. Data from the National Health Interview Survey (NHIS) in 2012 found that 83 percent of U.S. children under age 18 had excellent or very good health.[13] While most children are healthy, it is important to consider the group of children with complex health needs. Approximately two-thirds of all children with complex health needs are covered by Medicaid,

accounting for about 6 percent of the total number of children with Medicaid. However, this 6 percent of enrollees incur nearly 40 percent of costs.[14]

In 2010, children constituted one-fifth of the approximately 130 million visits to hospital-affiliated emergency departments (EDs) in the United States. The vast majority—96 percent—of ED visits resulted in the child being treated and released from the ED rather than being admitted to a hospital for further care. An analysis of Healthcare Cost and Utilization Project (HCUP) data found that two-thirds of ED visits for infants younger than one year were billed to Medicaid. Medicaid was also the largest primary expected payer for ED visits among children ages 1-4 and 5-9 years. Injuries and poisoning and respiratory disorders were the most common reasons for all ED visits, followed by nervous system disorders and infectious and parasitic diseases. Among ED visits that result in children being admitted to a hospital for further treatment, dehydration and respiratory conditions, especially asthma, were common reasons. Additionally, mood disorders and conduct or disruptive behavioral disorders were frequent reasons for ED visits resulting in admission of older children.[15]

Health expenditures provide another lens on children's health issues. According to the Medical Expenditure Panel Survey (MEPS) data, $117.6 billion was spent for the medical care and treatment of children in 2011. The five most costly medical conditions in terms of total direct medical spending were mental disorders, asthma, trauma-related disorders, acute bronchitis and upper respiratory infections, and otitis media, as defined by the Clinical Classification System (CCS). Of the five most costly conditions for children, mental disorders affected the fewest children but had the highest average expense per child; nearly half of the $13.8 billion spent on mental disorders for children in 2011 was covered by Medicaid. About 41 percent of mental health expenditures on children were for prescription medications.[16]

Poor birth outcomes also have a disproportionately high impact in the Medicaid population. More than half of hospital stays related to short gestation, low birth weight, or inadequate fetal growth were covered by Medicaid.[17]Although poor birth outcomes lead to high average expenditures per infant, they do not occur as frequently as other high-impact conditions, and so do not appear in the list of top five most costly medical conditions. If examining average expenditures per case, the three most costly conditions are infant respiratory distress syndrome, premature birth/low birth weight, and cardiac and circulatory birth defects, all of which are regarded as poor birth outcomes.

Dental caries are one of the most common chronic diseases in children in United States,[18] and if left untreated, can lead to problems in eating, speaking, learning, and to lower quality of life.[19] An estimated six percent of children have an unmet need for dental care, in part because their families cannot afford the services.[20] The percentage of children ages 2 to 18 who receive dental benefits from Medicaid increased from 20.5 percent in 2000 to 36.8 percent in 2011.[21]

Child Core Set

With such a large share of children relying on Medicaid and CHIP for comprehensive health services, the quality of these services is paramount. Performance measurement provides the health system with information it needs to monitor quality and undertake improvement activities when deficits are identified.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for the identification of a core set of healthcare quality measures for children enrolled in Medicaid and CHIP. CMS and AHRQ jointly charged a group of experts with creating this core set of measures in 2009.[22] The initial 24 measures contained within the core set are relevant to children ages 0-18 as well as pregnant women in order to encompass both prenatal and postpartum quality of care issues.

CMS' three-part goal for the Child Core Set is to increase the number of states reporting Core Set measures, increase the number of measures reported by each state, and increase the number of states using Core Set measures to drive quality improvement. CHIPRA also required CMS to update the initial core set annually. The 2013 Child Core Set revision added three measures and retired one measure, resulting in a total of 26 measures.[23] For the 2014 update, CMS focused only on measures for retirement. In December 2013, CMS released the 2014 Child Core Set, which retired three measures and brought the total to 23 measures.[24]

Characteristics of the Child Core Set

The 2014 Child Core Set contains 23 measures (**Appendix D**) that are concentrated in the National Quality Strategy priority area of Healthy Living and Well-Being (Exhibit 1).

EXHIBIT 1. MEASURES IN THE CHILD CORE SET BY NATIONAL QUALITY STRATEGY PRIORITY

National Quality Strategy Priority	Number of Measures in the Child Core Set (n = 23)
Patient Safety	1
Person- and Family-Centered Experience of Care	1
Effective Communication and Care Coordination	3
Prevention and Treatment of Chronic Disease	0
Healthy Living and Well-Being	16
Affordability	2

Viewed as an array of measure types, the set contains no structural measures, 19 process measures, 4 outcome measures, and 1 experience of care measure. Additionally, the Child Core Set is well-aligned with other quality and reporting initiatives: seven of the measures are used in one or more federal programs, including the Medicaid Adult Core Set and the Health Insurance Marketplace Quality Rating System Measure Set.[25,26] Representing the diverse health needs of the child Medicaid and CHIP population, the Child Core Set measures span many clinical topic areas (Exhibit 2).

EXHIBIT 2. MEASURES IN THE CHILD CORE SET BY CLINICAL AREA

Clinical Topics	Number of Measures in the Child Core Set (n = 23)
Access to Care	1
Acute Care and Chronic Conditions (e.g., Asthma, Overweight/Obesity)	3
Behavioral Health	3
Consumer Experience	1
Oral Health	2
Perinatal Care	6
Preventive Care and Screening	7

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 Child Core Set from presentations from states that participated in reporting and from the **2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP**. This report states that in 2012, all states reported at least two measures. **Appendix E** provides more details on the frequency of reporting of each measure. CMS now has four years of experience with this voluntary reporting program and providing technical assistance and analytic support for states. These valuable inputs informed MAP's measure-specific and strategic recommendations for the Child Core Set to achieve CMS' three-part goal.

Presentations from two states highlighted that the Child Core Set measures are being used as an important tool to drive improvements on priority issues. The panelists identified implementation and measure-specific challenges to reporting the Child Core set, including:

- Greater clarity is needed in the technical specifications, especially on definitions. Local coding conventions may complicate standardized reporting.
- Measures that require chart review pose significant data collection burdens. Not only can they be resource-intensive, but there also may be legal and or technical barriers for the state to review medical records from hospitals and health systems.
- The differences in reporting mechanisms across care settings and benefit structures also pose challenges. States that have "carve-outs" for mental health services experience challenges in gathering data on follow-up care and other details. Other challenges include capture of data from retail-based clinics and school-based health centers.
- States and their contracted health plans and providers are involved in multiple quality reporting initiatives, such as the Meaningful Use incentives, health homes, demonstration waivers, and managed care organization accreditation. Greater alignment of measures among these programs would improve the efficiency of participation.

The presenters also provided feedback on strategic issues and measure gap areas:

- Greater state capacity for electronic data abstraction and measurement would reduce some of the effort associated with data collection and quality reporting for multiple programs. It would also allow for quality improvement activities that are incorporated into the EHR clinical workflow.
- More measures are needed on mental health topics, such as the complex care issues of children in the foster care system, medication use and overuse, and adolescent suicide.
- Given that the cycle for measurement and improvement activities based on measure results can take three years or more, changing measures in the set on a yearly basis can create challenges for programs and providers.

The median number of measures reported per state is 14. States may have various reasons for reporting some of the Child Core Set measures but not others, including data access and technical capacity. Additionally, states may be using other measures to address local needs and not sharing those results with CMS.

MAP REVIEW OF THE CHILD CORE SET

MAP's expedited review focused on opportunities to strengthen the Child Core Set by recommending measures to fill critical gap areas. Prior to MAP's opportunity to provide input on the Child Core Set, the Subcommittee of the National Advisory Council on Healthcare Research and Quality (SNAC) convened by AHRQ reviewed the measures to determine which should be retired from the set.[27] CMS acted on the SNAC's 2013 recommendations and removed three measures from the set in its January 2014 update: pharyngitis testing, annual HbA1c testing, and the asthma ED measure. The removal of these measures created capacity for a small number of new measures to be added in the next annual update, scheduled to occur by January 2015.

High Priority Gaps

MAP identified numerous gaps in measures in the current Child Core Set. These include:

- Care coordination
  - Home- and community-based care
  - Social services coordination
- Screening for abuse and neglect
- Injuries and trauma
- Mental health
  - Access to outpatient and ambulatory mental health services
  - ED use for behavioral health
- Overuse/medically unnecessary care
  - Appropriate use of CT scans
- Inpatient measures
- Durable medical equipment (DME)
- Cost measures
  - Targeting people with chronic needs
  - Enrollees' out-of-pocket spending

Although the current version of the Child Core Set includes measures pertaining to some of these topics, MAP did not perceive them as comprehensive. For example, two measures in the Child Core Set relate to mental health, but others are available and in development that could be considered for future addition to the set.

Based on the prioritization of gap areas, MAP reviewed available NQF-endorsed® measures for potential addition to the measure set. MAP's Measure Selection Criteria (**Appendix C**) dictate that NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective. NQF-endorsed measures have undergone a rigorous multistakeholder evaluation to ensure that they address aspects of care that are important and feasible to measure, provide consistent and credible information, and can be used for quality improvement and decisionmaking. For some areas, such as screening for abuse and neglect, trauma, and DME, no NQF-endorsed measures were found. These areas will be revisited during the annual review process in 2015.

MAP also took note of a large number of measures in various stages of development under the auspices of the AHRQ-CMS Pediatric Quality Measures Program (PQMP).[28] Seven Pediatric Healthcare Quality Measures Program Centers of Excellence (COEs) have received cooperative agreement grants to support measure development activities. When development and testing are complete, these measures will be publicly available for use and will help address the relative lack of measures designed for use with the pediatric population. Many measures on care coordination, behavioral health, and inpatient care are scheduled to be completed by February 2015, and it is likely that NQF will receive many of them

for endorsement review. Though the timeline for 2014's expedited review precluded full examination of the PQMP measures, MAP will review them in more detail as part of the 2015 process.

Measure-Specific Recommendations

MAP supported all but one of the measures in the current Child Core Set for continued use in the program. Maintaining stability in the measure set will allow states to continue to gain experience reporting the measures, potentially increasing the number of individual measures they are able to submit to CMS on an annual basis. State participants identified some feasibility concerns related to the current measures, but detailed exploration of those challenges will be better addressed during MAP's planned 2015 review. MAP's measure-specific recommendations are described below, with details on the individual measures provided in Appendix D.

Measures for Removal from the Child Core Set

MAP recommends removal of the measure Percentage of Eligibles That Received Dental Treatment Services. CMS and other stakeholders described that the measure is not an effective tool for quality improvement because it is unclear if an increase or decrease in the rate is desirable. Essentially, any dental visit, regardless of its quality or appropriateness, would count in the measure. A higher number of Medicaid enrollees receiving dental treatment could indicate the positive outcome of improved access to care or the negative outcome of more individuals needing treatment for caries or other poor oral health outcomes. Therefore, the information collected is not actionable by states or CMS. The measure is not NQF-endorsed.

Public comments on this MAP recommendation were generally positive, but some dissented based on the importance of measuring access to dental treatment. One of the measures supported for continued use in the set is Percentage of Eligible Children Who Received Preventive Dental Services, which addresses this topic. In addition, MAP recommended two oral health measures as potential replacements. These combined actions maintain a focus on the critical importance of oral health care and ensure that the measure results send a clear signal for quality improvement.

Measures for Phased Addition to the Child Core Set

MAP recommends that CMS consider up to six measures for phased addition to the Child Core Set. These measures received the approval of 60 percent or more of voting MAP Task Force members for inclusion. Their use would strengthen the measure set by promoting the measurement of a variety of high-priority quality issues, including oral health, beneficiary experience, and maternity care. However, MAP is aware that additional federal and state resources are required for each new measure. Past revisions to the measure set have not altered more than three measures at a time, indicating that the immediate addition of all measures supported by MAP is highly unlikely. MAP rank-ordered the measures it supports for inclusion in the Child Core Set by having each Task Force member prioritize up to three measures. This ranking provides CMS with a clear sense of priority among the potential measures. CMS may need flexibility to add the measures gradually over the course of one or more annual updates and only if they are found to be feasible to implement at the state level.

EXHIBIT 5. RANKING OF MEASURES SUPPORTED FOR ADDITION TO THE CHILD CORE SET

Ranking	Measure Number and Title	Votes for Prioritization
1	NQF #2508 Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk	10
2	NQF #2548 Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS)	7
3	NQF #2509 Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk	5
4 (tie)	NQF #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment NQF #0477 Under 1500g infant Not Delivered at Appropriate Level of Care	4
6	NQF #0480 PC-05 Exclusive Breast Milk Feeding	3

MAP awards particular emphasis to the first three measures. Several public comments seconded the notion that the first three measures are the most important. NQF #2508 Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk is intended as a replacement for the dental treatment measure recommended for removal. It is clearly linked to improved outcomes and will more accurately capture the quality of care delivered than the original utilization-oriented measure. The use of this measure will also allow CMS to respond to a legislative mandate to measure the use of dental sealants in this age group. Measure #2509 is similar but evaluates the application of sealants to the second set of molars, which develop at a later age. MAP members discussed whether the use of both measures is necessary, noting that children of all ages need to benefit from these services but also that use of one measure is likely to drive broader changes in practice.

MAP also prioritized the new CAHPS® tool focused on evaluating the family's experience of care when a child is hospitalized. Developed through the PQMP, this measure would help to address gaps that were noted in the measure set: inpatient measures, patient experience, and care coordination. At present, hospitals may be using a variety of local, proprietary tools to gauge pediatric patient/family experience. Broad adoption of a survey that is in the CAHPS family will enhance comparability across sites and across populations. The survey contains a field to capture the payer of care, so MAP concluded that it would be feasible for survey administrators to subset those that apply to Medicaid for purposes of reporting.

Despite lower prioritization, MAP also supported the remaining measures because they addressed important gaps in the current measure set. Specifically, MAP determined that suicide risk screening among children and adolescents with depression was an important intervention for one of the most common behavioral health diagnoses in this population. Participants also flagged the issue of rising rates of antipsychotic medication use as a prime opportunity for quality improvement, especially among children in the foster care system insured by Medicaid. One measure of antipsychotic medication use in young children was considered by the group but did not reach the consensus threshold necessary to gain MAP's support. Comments reflected the many facets to consider in selecting measures to address this gap area, and MAP members had a robust discussion of both available behavioral health measures and those under development. Because several measures, including those from the PQMP, are nearly complete but have not yet been reviewed by NQF for endorsement, MAP plans to re-evaluate the measures on this topic during its next review.

Use of NQF measure #0477 and NQF measure

#0480 would strengthen the presence of perinatal care issues in the Child Core Set. Although delivery of a low birth weight infant at a facility not well-equipped to handle complex cases is not always avoidable, MAP members agreed that there is much room for improvement on this indicator. It represents an opportunity for women experiencing high-risk pregnancy to receive counseling about the appropriate site of delivery and for regional medical systems to coordinate and communicate about their NICU capabilities. Similarly, breast milk feeding is associated with a variety of positive downstream health outcomes for both mothers and babies, including lowering risk of asthma, allergies, obesity, and certain infections.[29] Comments reflect strong opinions both for and against the addition of the Exclusive Breast Milk Feeding. In response to a comment that cited reasons for not breastfeeding, it should be noted that the measure specifications allow for a second "subset" rate that excludes mothers whose documented initial feeding plans were not to exclusively feed breast milk.[30]

In addition to full support for measures ready and available for immediate use, MAP can conditionally support measures that are pending NQF endorsement, are not ready for implementation until a change is made by the measure steward, need further confirmation of feasibility, or need further experience or testing before being used in the program. Two of the above measures received MAP's conditional support for inclusion because they are currently undergoing review for NQF endorsement. NQF #2548 Child HCAHPS and NQF #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment have both been recommended for endorsement by standing committees and are pending final approval and ratification.

STRATEGIC ISSUES

During MAP's review of measures in the Child Core Set, members discussed numerous cross-cutting and strategic issues. Although 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.

Feasibility of Reporting and Electronic Data Infrastructure

Several important factors underpin the feasibility of reporting state-level data on quality measures. MAP discussed the impact of gaps in Medicaid data infrastructure and limited resources available to invest in analytics. States have varied, but generally limited, capacity to collect clinical quality information electronically as eMeasures at this time. Although MAP discussed the possibility of adding more eMeasures to the Child Core Set, most participants felt that uptake of those measures would be quite low in the near term. However, the group called for continued development of eMeasures that are appropriate for use in the Medicaid population, understanding that is the future direction of the quality measurement enterprise. Finally, feasibility of measure implementation can be diminished when measures designed to be used in facilities and/or health plans are retrofitted for state-level reporting. CMS needs to provide clear technical guidance for states to ensure uniformity in data collection and reporting.

Pipeline of Measures in Development

A major strategic consideration for the future direction of the Child Core Set is the large volume of measures undergoing development and

testing in Pediatric Centers of Excellence under the PQMP. As previously described, dozens of measures pertaining to important issue areas will become available for MAP's consideration over the course of the next year. Knowing that other measures were on the horizon influenced MAP's decisionmaking related to behavioral health and care coordination measures, in particular. The majority of participants wanted to defer action on supporting measures in these topic areas until more information on the new measures could be made available for MAP's review. Some, but not all, of the new measures are expected to be submitted to NQF for endorsement review. Submission to NQF was encouraged but not a grant requirement.

One measure (behavioral health risk screening for pregnant women) created by a PQMP grantee is already included in the Child Core Set. Conscious that the current grant support is scheduled to end in 2015, MAP recognized the need for additional long-term planning for measure development and stewardship to ensure that work on high-priority pediatric care measures continues to be pursued. This sentiment was echoed by commenters who supported MAP's deferment to measures in development that may better address gap areas; however, it was also noted that new measures are not as likely to be used in other reporting programs and so may not advance alignment efforts.

Alignment of Measures

When making recommendations about measures for the Child Core Set, MAP considered the relationship between the selected measures and those contained in the Adult 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. Additionally, MAP's 2014 review of the Adult Core Set noted this inter-relationship. Comments noted that alignment efforts for the Medicaid quality reporting programs also advances alignment and harmonization of measures being used across states.

Alignment of measures across the programs is especially apparent when considering the quality of the continuum of the prenatal, maternity, and postnatal care of mothers and infants. Perinatal measures have a large presence in the Child Core Set and three others are contained in the Adult Core Set (i.e., elective delivery, antenatal steroids, and postpartum care rate). This accurately reflects the longstanding importance of Medicaid in providing health coverage to low-income women and babies. MAP discussed the need to further explore health outcomes of the mother/child dyad, specifically how a mother's health and healthcare affects that of her child or children.

Alignment is important on other planes as well. MAP discussed the synergies that arise when measures are shared across the physician-level EHR Incentive Program, better known as Meaningful Use, and the National Committee for Quality Assurance's (NCQA) HEDIS® measure set for health plans. Overlap with HEDIS is especially helpful for states with a significant presence of managed care in their Medicaid delivery systems because the collection of common measures can satisfy multiple program reporting requirements.

CONCLUSION

Medicaid is the largest health insurance program in the United States and, together with CHIP, provides coverage for more than a third of the nation's children.[31] States' participation in reporting measures in the Child Core Set greatly contributes to understanding how successful Medicaid programs are in delivering high-quality care to their enrollees. MAP's recommendations are intended to strengthen the measure set and support CMS's goals for the Child Core Set reporting program.

MAP requests that CMS remove a measure of the utilization of dental treatment services because it is not actionable for quality improvement purposes. MAP supports the addition of up to six measures to the measure set, including two measures that better address oral health. In general, the measures recommended for addition address healthcare services and clinical conditions that have significant impact on low-income families and long-term health outcomes.

This expedited review was completed over a period of 10 weeks to assist CMS in meeting a statutory deadline, limiting the scope of the review and its ability to thoroughly explore states' experiences reporting the current measures and the status of numerous measures still undergoing development and testing. MAP will conduct a more in-depth review of the Child Core Set in 2015 to inform the next annual update of the measure set.

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 to 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.

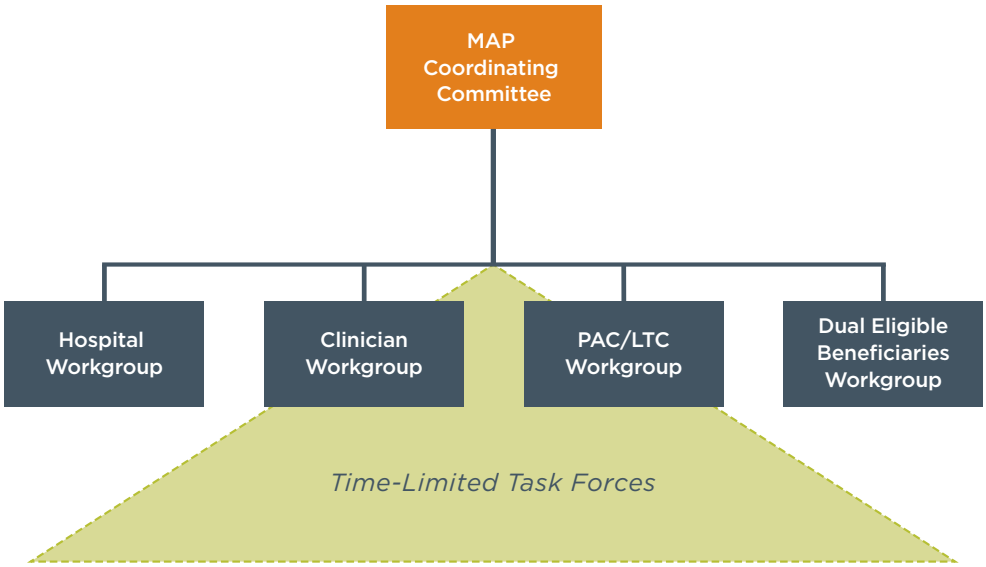
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for 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 Exhibit A1). The MAP Coordinating Committee 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 specific initiatives provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

EXHIBIT A1. MAP STRUCTURE



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

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see MAP 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 Medicaid Adult Core Set and the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces.
- Developed **coordination strategies** intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives.

ENDNOTE

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

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

Roster for the MAP Medicaid Child Task Force

CHAIR (VOTING)
Foster Gesten, MD, FACP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
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	Beth Feldpush, DrPH
Children's Hospital Association	Andrea Benin, MD
Kaiser Permanente	Susan Fleischman, MD
March of Dimes	Cynthia Pellegrini
National Partnership for Women and Families	Carol Sakala, PhD, MSPH

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Anne Cohen, MPH
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	Shaun O'Brien
American Board of Medical Specialties	Lois Margaret Nora, MD, JD, MBA
American College of Physicians	Amir Qaseem, MD, PhD, MHA
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
America's Health Insurance Plans	Aparna Higgins, MA
Blue Cross and Blue Shield Association	Trent T. Haywood, MD, JD
Catalyst for Payment Reform	Shaudi Bazzaz, MPP, MPH
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip N. Kahn, III
Healthcare Financial Management Association	Richard Gundling, FHFMA, CMA
Healthcare Information and Management Systems Society	Representative TBD
The Joint Commission	Mark R. Chassin, MD, FACP, MPP, MPH
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Steve Wojcik
National Committee for Quality Assurance	Margaret E. O'Kane, MHS
National Partnership for Women and Families	Alison Shippy
Pacific Business Group on Health	William Kramer, MBA
Pharmaceutical Researchers and Manufacturers of America (PhRMA)	Christopher Dezii, RN, MBA,CPHQ

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Marshall Chin, MD, MPH, FACP
Harold Pincus, MD
Carol Raphael, MPA

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

NQF Staff

Sarah Lash	Senior Director
Elizabeth Carey	Senior Project Manager
Nadine Allen	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 strengths and weaknesses of a program measure set, and how the addition of measures 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

APPENDIX D:
Child Core Set and MAP Recommendations

In February 2011, HHS published the initial core set of quality measures for children enrolled in Medicaid and CHIP. The authorizing legislation also requires HHS to publish annual changes to the Child Core Set beginning in January 2013. Exhibit D1 below lists the measures included in the current version of the Child Core Set along with their current NQF endorsement number and status. States voluntarily collect the Child 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. Exhibit D2 lists the measures supported by MAP for potential addition to the Child Core Set.

EXHIBIT D1. CURRENT CHILD CORE SET

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0024 Endorsed Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) Measure Steward: National Committee for Quality Assurance	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: • Body mass index (BMI) percentile documentation • Counseling for nutrition • Counseling for physical activity	27 states reported FY 2012 Alignment: Meaningful Use (EHR Incentive Program) - Eligible Professionals (MU-EP), Physician Feedback, Physician Quality Reporting System (PQRS), Health Insurance Exchange–Quality Rating System (HIX-QRS)	Support continued use of this measure in the program. No significant implementation issues identified at this time.
0033 Endorsed Chlamydia Screening in Women (CHL) Measure Steward: National Committee for Quality Assurance	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.	35 states reported FY 2012 Alignment: Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (Medicaid Adult Core Set), MU-EP, PQRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0038 Endorsed Childhood Immunization Status (CIS) Measure Steward: National Committee for Quality Assurance	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B(HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	34 states reported FY 2012 Alignment: MU-EP, PQRS, HRSA program(s), HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
0108 Endorsed Follow-Up Care for Children Prescribed ADHD Medication (ADD) Measure Steward: National Committee for Quality Assurance	The percentage of children newly prescribed attention-deficit/ hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. • Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. • Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	29 states reported FY 2012 Alignment: MU-EP, PQRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0139 Endorsed National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure Measure Steward: Centers for Disease Control and Prevention	Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • other inpatient locations. (Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.	40 states reported FY 2012 Alignment: Hospital Acquired Condition Reduction Program, Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, Long-term Care Hospital Quality Reporting, PPS-Exempt Cancer Hospital Quality Reporting	Support continued use of this measure in the program. No significant implementation issues identified at this time.
0471 Endorsed PC-02 Cesarean Section Measure Steward: Joint Commission	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).	12 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0576 Endorsed Follow-Up After Hospitalization for Mental Illness (FUH) Measure Steward: National Committee for Quality Assurance	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of discharges for which the patient received follow-up within 30 days of discharge • The percentage of discharges for which the patient received follow-up within 7 days of discharge.	27 states reported FY 2012 Alignment: Dual Eligibles Core Quality Measures - Capitated Demonstrations and Managed Fee For Service Demonstrations, Medicaid Adult Core Set, Inpatient Psychiatric Hospital Quality Reporting, Medicare Part C Plan Rating, HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1382 Endorsed Percentage of low birthweight births Measure Steward: Centers for Disease Control and Prevention	The percentage of births with birth weight <2,500 grams	15 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1391 Endorsed Frequency of Ongoing Prenatal Care (FPC) Measure Steward: National Committee for Quality Assurance	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: • <21 percent of expected visits • 21 percent–40 percent of expected visits • 41 percent–60 percent of expected visits • 61 percent–80 percent of expected visits • > or =81 percent of expected visits	25 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
1392 Endorsed Well-Child Visits in the First 15 Months of Life (W15) Measure Steward: National Committee for Quality Assurance	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported: • No well-child visits • One well-child visit • Two well-child visits • Three well-child visits • Four well-child visits • Five well-child visits • Six or more well-child visits	43 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1407 Endorsed Immunizations for Adolescents (IMA) Measure Steward: National Committee for Quality Assurance	The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.	32 states reported FY 2012 Alignment: HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1448 Endorsed Developmental Screening in the First Three Years of Life Measure Steward: Oregon Health & Science University	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.	12 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1516 Endorsed Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) Measure Steward: National Committee for Quality Assurance	Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	46 states reported FY 2012 Alignment: HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
1517 Endorsed Prenatal & Postpartum Care (PPC)* Measure Steward: National Committee for Quality Assurance *Child Core Set includes "Timeliness of Prenatal Care" rate only. "Postpartum Care" rate is evaluated in Medicaid Adult Core Set.	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.	31 states reported FY 2012 Alignment: Medicaid Adult Core Set, HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1799 Endorsed Medication Management for People with Asthma (MMA) Measure Steward: National Committee for Quality Assurance	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.	0 states reported FY 2012 (New)	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1959 Endorsed Human Papillomavirus Vaccine for Female Adolescents (HPV) Measure Steward: National Committee for Quality Assurance	Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	0 states reported FY 2012 (New)	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
N/A Not Endorsed Maternity Care: Behavioral Health Risk Assessment Measure Steward: AMA-PCPI/NCQA/ACOG	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	0 states reported FY 2012 (New)	Support continued use of this measure in the program. No significant implementation issues identified at this time.
N/A Not Endorsed Percentage of Eligible Children Who Received Dental Treatment Services Measure Steward: CMS	The percentage of individuals ages one to twenty years old eligible for Medicaid or CHIP Medicaid Expansion programs (that is, individuals eligible to receive EPSDT services) who received dental treatment services.	51 states reported FY 2012	Recommend the removal of this measure from the program. Measure is not actionable for quality improvement because it is unclear whether an increase in the number of children receiving dental treatment is a positive outcome (e.g., access is improved) or a negative outcome (e.g., more children require treatment because of poor oral health).
N/A Not Endorsed Children and Adolescents' Access to Primary Care Practitioners Measure Steward: NCQA	The percentage of children 12 months –19 years of age who had a visit with a primary care practitioner. Four separate percentages are reported: Children 12 through 24 months and children 25 months through 6 years who had a visit with a primary care practitioner during the measurement year; Children 7 through 11 years and adolescents 12 through 19 years who had a visit with a primary care practitioner during the measurement year or the year prior to the measurement year.	43 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
N/A Not Endorsed Adolescent Well-Care Visits Measure Steward: NCQA	The percentage of enrolled adolescents 12–21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.	43 states reported FY 2012 Alignment: HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
N/A Not Endorsed Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0, Child Version Measure Steward: NCQA	This measure provides information on parents' experience with their child's health care for population of children with chronic conditions. Results include same ratings, composites, and individual question summary rates as reported for the CAHPS Health Plan Survey 4.0H, Child Version. Three CCC composites summarize satisfaction with basic components of care essential treatment, management and support of children with chronic conditions. 1. Access to Specialized Services; 2. Family Centered Care: Personal Doctor Who Knows Child; 3. Coordination of Care for CCC. Question summary rates also reported individually for summarizing the following two concepts: 1. Access to Prescription Medicines; 2. Family Centered Care: Getting Needed Information. Five composite scores summarize responses in key areas: 1. Customer Service; 2. Getting Care Quickly: 3. Getting Needed Care: 4. How Well Doctors Communicate; 5. Shared Decision Making.	27 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
N/A Not Endorsed Percentage of Eligible Children Who Received Preventive Dental Services Measure Steward: CMS	The percentage of individuals ages one to twenty years old eligible for Medicaid or CHIP Medicaid Expansion programs (that is, individuals eligible to receive EPSDT services) who received preventive dental services.	51 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
N/A Not Endorsed Ambulatory Care: Emergency Department Visits Measure Steward: NCQA	The rate of emergency department visits per 1,000 member months among children up to age 19.	28 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

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

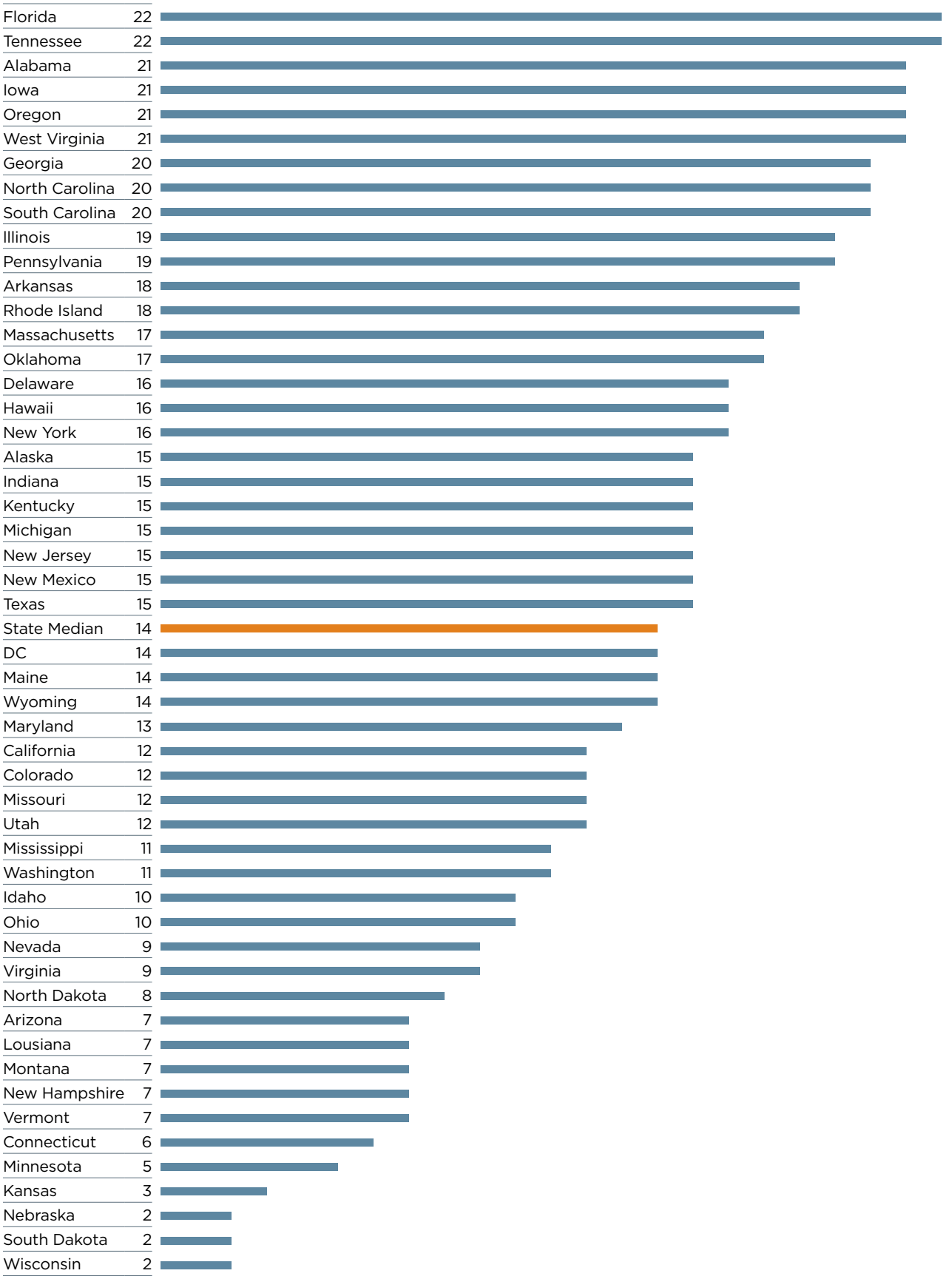
Measure Number and NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
2508 Endorsed Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk Measure Steward: American Dental Association on behalf of the Dental Quality Alliance	Percentage of enrolled children in the age category of 6-9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year.		Support addition of this measure to the program. Potential replacement for measure of dental treatment services recommended for removal.
2548 Undergoing Endorsement Review Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS) Measure Steward: Center for Quality Improvement and Patient Safety-Agency for Healthcare Research and Quality	The Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS) is a standardized survey instrument that asks parents and guardians of children under 18 years old to report on their and their child's experiences with inpatient hospital care.		Support addition of this measure to the program. Addresses gaps in inpatient measures and beneficiary experience of care.
2509 Endorsed Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk Measure Steward: American Dental Association on behalf of the Dental Quality Alliance	Percentage of enrolled children in the age category of 10-14 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent second molar tooth within the reporting year.		Support addition of this measure to the program. Potential replacement for measure of dental treatment services recommended for removal.

Measure Number and NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
1365 Endorsed Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	Meaningful Use (EHR Incentive Program) - Eligible Professionals; Physician Quality Reporting System (PQRS)	Support addition of this measure to the program. Addresses gap in behavioral health.
0477 Endorsed Under 1500g infant Not Delivered at Appropriate Level of Care Measure Steward: California Maternal Quality Care Collaborative	The number per 1,000 livebirths of <1500g infants delivered at hospitals not appropriate for that size infant.		Support addition of this measure to the program. Enhances perinatal measures and would improve regional care coordination for high-risk pregnancies.
0480 Endorsed PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice Measure Steward: The Joint Commission	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 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).	Meaningful Use (EHR Incentive Program) - Hospitals, CAHs	Support addition of this measure to the program. Enhances perinatal measures and is associated with positive health outcomes for mother and child.

APPENDIX E:
State Implementation and Participation in Reporting Measures

CMS now has four years of experience with this voluntary reporting program and providing technical assistance and analytic support for states. In 2012, CMS began calculating the two dental measures, Percentage of Eligible Children Who Received Dental Treatment Services and Percentage of Eligible Children Who Received Preventive Dental Services, using data reported by states on Form CMS-416. Thus, all states report on at least two measures (Exhibit E1). Thirty-five states reported at least 11 of the 22 core measures to CMS, with a median of 14. Notably, Florida and Tennessee reported 22 of the core measures while Nebraska, South Dakota, and Wisconsin reported 2 measures.[1]

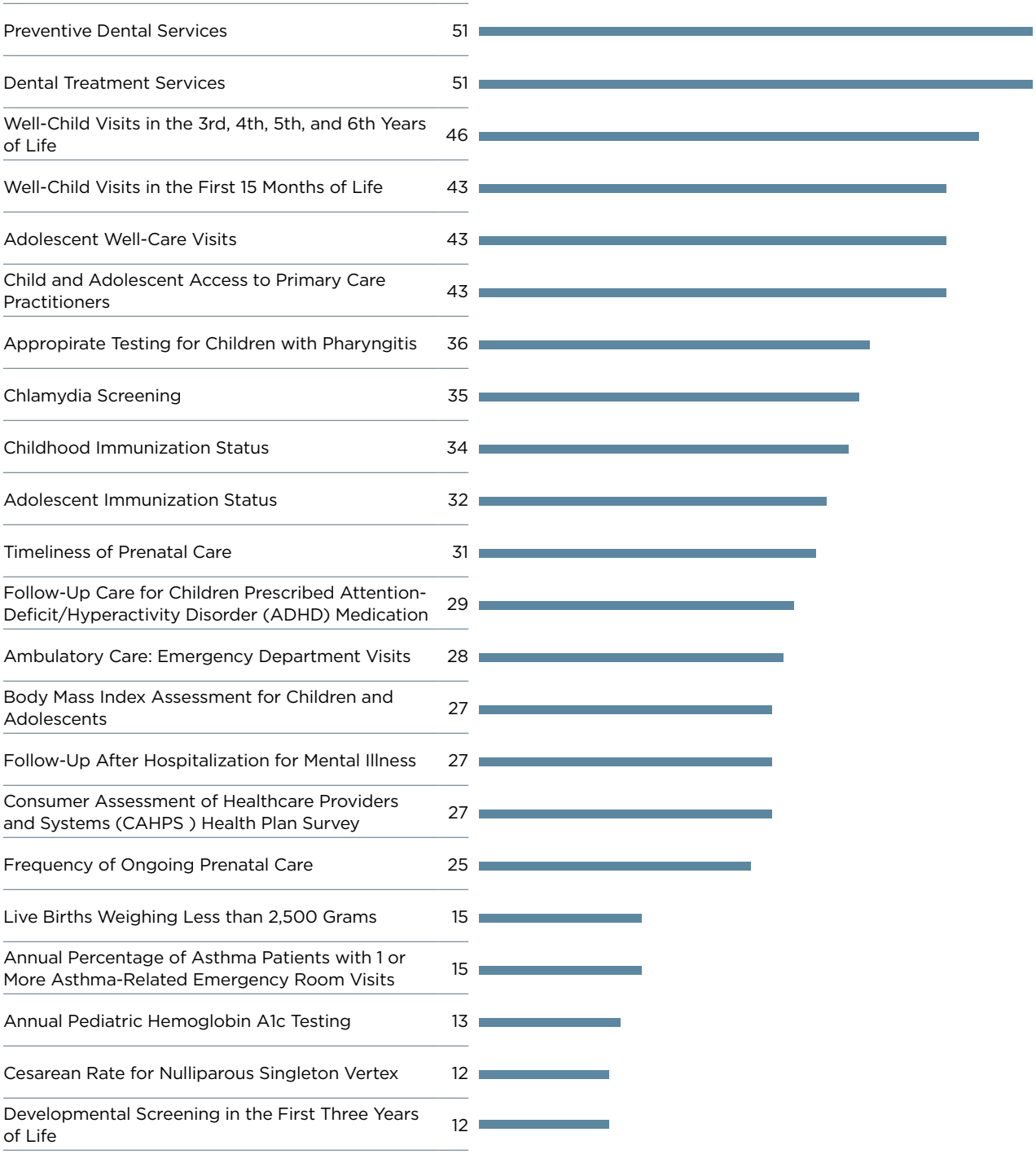
EXHIBIT E1. NUMBER OF MEDICAID/CHIP CHILD CORE SET MEASURES REPORTED BY STATES IN FY 2012



(Source: *2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP*)

As shown in Exhibit E2, The most frequently reported measures in FY2012 assess dental services, well-child visits, and access to care.[1]

EXHIBIT E2. NUMBER OF STATES REPORTING MEASURES IN MEDICAID/CHIP CHILD CORE SET IN FY 2012



(Source: *2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP*)

ENDNOTE

1 Department of Health and Human Services (HHS). *2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP*. Washington, DC:HHS;2013. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf. Last accessed September 2014.

APPENDIX F:
NQF Member and Public Comments

General

Mount Sinai Hospital

Lawrence Kleinman

I found this report to be thoughtful and an important step forward. It should be the beginning, as it is intended to be, and not allowed to evolve into the authoritative word, as sometimes a good preliminary report can do. This is a strong beginning.

The PQMP Centers are in a difficult position regarding NQF. Despite committing to be available to steward our measures beyond the close of the grants, neither AHRQ nor CMS has yet funded us to do so. In the absence of such funding some of the centers, including the CAPQuaM are struggling to see if we can make the stewardship commitment that is required when submitting for NQF review. As yet, none of our measures are submitted to NQF. While we are hopeful, we currently don't have the resources. I think the failure to consider PQMP measures that are not NQF endorsed would be a failing of this body and a serious missed opportunity.

Further, the asymmetry in evidence between adult and pediatric health care suggests that standards for accepting measures should focus not only on the evidence base but on the mode of development. Those developed in PQMP using systematic, transparent, and engaged methods should be highly considered.

I suggest that we need a larger than recommended corpus of measures in the core set, that should be used by Medicaid in a rotating fashion designed to broaden the scope of areas being assessed, reduce the potential for gaming, and reduce the absolute burden of measurement (via sampling of the measures) at the same time.

The CAPQuaM has a number of measures in process or developed that I think ought to be acknowledged as filling critical strategic or tactical gaps:

1. An enhanced asthma ED use measure that assesses the rate of undesirable utilization outcomes (ED visit or hospitalization) using a person-time denominator. A complementary measure considers whether the ED was an appropriate level of care for that child.

2. A suite of safety measures for perinatal inpatient that are an enhanced approach to assessing performance related hypothermia in low birth weight infants.

3. A suite of measures to assess the availability of high risk obstetrical care (HROB). These measures bridge maternal and child health care. Additional measures are in development.

4. CAPQuaM has developed or is developing a series of measures related to coordination and continuity of care.

a. Several HROB measures relate to the use of specialty or multidisciplinary care.

b. Asthma ED measures that look at the connection to primary care before and after the ED visit

c. In development are measures to assess the continuity and coordination following discharge from a mental health hospitalization. We expect this to include a patient experience measure.

d. In development are measures assessing performance of medication reconciliation for children. This too is expected to include a patient experience measure. Thank you for the invitation to comment on this document.

Children's Hospital Association

Ellen Schwalenstocker

On behalf of the nation's children's hospitals, the Children's Hospital Association is pleased to comment on the MAP report "Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2014." The Association commends the MAP Task Force on the excellent report, particularly the section on health issues for children in Medicaid and CHIP. We applaud

the Task Force for recognizing the diverse health care needs among children and, especially, children with complex health care needs. We also appreciate the report's finding that the measures included in the current Child Core Set are concentrated in the National Quality Strategy priority of Healthy Living and Well-being. Over time, it is essential that the core set is sufficiently robust to address all children, including children with special health care needs and medical complexity in order to meet the original intent of CHIPRA, which included a core set that encompassed "the types of measures that, taken together, can be used to estimate the overall national quality of health care for children, including children with special needs." The Association agrees with the high priority gaps identified by the Task Force and is eager to support the addition of measures in these areas, especially meaningful measures related to care coordination, mental health and inpatient care.

America's Health Insurance Plans

Carmella Bocchino

We are supportive of MAP's review of additional quality measures to augment the Child Medicaid Core Set and to fill measure gaps. We are also pleased that MAP will conduct a second in-depth review of this measure set during the spring of 2015.

The National Partnership for Women & Families

Alison Shippy

The National Partnership for Women & Families commends the MAP Medicaid Child Task Force and the National Quality Forum for the extraordinary effort that has gone into thoughtfully examining the opportunities for improvement in the Medicaid Child Core Set. The National Partnership supports continued measure alignment and the use of outcomes measures to address priority areas in health care.

The MAP Medicaid Child Task Force identified a series of gap areas in the existing Medicaid Child Health Core Set, one of which is measures focused on outcomes in the inpatient setting. A majority of Task Force members found the NQF-endorsed Exclusive Breast Milk Feeding measure (#0480) suitable for filling this gap area. This measure identifies the proportion of newborns exclusively fed breast milk throughout the hospital stay. The National Partnership for Women & Families considers this measure to be an essential component of the Medicaid Child Core Set and strongly urges the MAP Coordinating Committee to recommend and the Department of Health and Human Services to include Exclusive Breast Milk Feeding in the Child Health Core Set, beginning in 2015.

The many advantages of this measure include:

- *Applicability to a very large population*: This measure applies to nearly our entire child population, as over 98 percent of babies are born in facilities and the measure has few exclusions. It also applies to nearly all of the 85 percent of women who give birth one or more times.
- *Prevention*: Breastfeeding confers a series of shorter- and longer-term benefits to both children and mothers, as clarified, for example, in AHRQ and Cochrane reviews. It is protective of childhood infectious diseases and numerous chronic conditions in women and offspring. These benefits include child conditions and risks that the National Quality Forum has prioritized.
- *Evolving evidence of potentially great consequence*: Numerous frameworks now identify the perinatal period as a sensitive window for long-term impacts on health. These include developmental origins of health and disease, lifecourse health development, human microbiome, and epigenetics. It is increasingly clear that breastfeeding plays a very favorable role, for example in immune function and the human microbiome.
- *Recommendations of leading professional organizations and agencies:* Organizations with longstanding recommendations for exclusive breastfeeding through the first six months of life include American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and World Health Organization. The U.S. Department of Health and Human Services also supports this goal, including through Healthy People 2020 objectives for increased rates of exclusive breastfeeding through both three and six months.
- *Opportunities for improvement*: There are significant opportunities to improve performance

on hospital practices supportive of establishing breastfeeding, as shown in the Centers for Disease Prevention and Control's regular mPINC (Maternity Practice in Infant Nutrition and Care) hospital surveys. There are considerable opportunities to improve actual breastfeeding practice, as illustrated by baseline figures for the Healthy People 2020 exclusive breastfeeding goals.

- *Possibility to reduce burden of collection*: This measure is specified as both an electronic measure and a paper measure. Our health system is moving toward the ability to collect eMeasures to reduce the burden of collection.
- *Alignment with other federal quality reporting initiatives*: Exclusive Breast Milk Feeding is included as an optional measure in the Inpatient Quality Reporting program and as an optional measure for Eligible Hospitals in the Meaningful Use program. National Partnership for Women & Families hopes to eventually see both programs require Exclusive Breast Milk Feeding as an integral component of these reporting programs. Further, we would also support this measure's inclusion in upcoming Title V performance measurement programs, recognizing that successfully meeting the requirements of the Exclusive Breast Milk Feeding measure would meet the requirements of the ever breastfed measure currently proposed for Title V.
- *Alignment with other federal program priorities*: Various agencies have prioritized breastfeeding. The Centers for Disease Control and Prevention has recently expanded its breastfeeding support programs, and many other agencies and offices also support breastfeeding.
- *Alignment with national facility accreditation policies*: Exclusive Breast Milk Feeding is a measure within The Joint Commission's Perinatal Care core set (PC-05). Beginning in 2014, The Joint Commission mandated that facilities with over 1,100 births annually report on its Perinatal Care core set measures. In the future, TJC will review this experience and consider extending this requirement to remaining facilities. Further, The Joint Commission includes collection and reporting of this measure in its proposed Perinatal Care Certification Requirements.
- *Disparities*: The original developer of this measure reports that it has been effective in improvement across hospitals serving childbearing families of varying demographic composition, including those in which women have traditionally breastfed at lower rates. The measure has the potential to help bring benefits of breastfeeding to all communities and close disparities, including for African American women who have often lacked adequate support for breastfeeding and had relatively low breastfeeding rates.
- *Relationship to core maternity nursing measure set*: The Association of Women's Health, Obstetric and Neonatal Nurses is in the testing phase with its set of Women's Health and Perinatal Nursing Care Quality Measures. Measures in that set that are compatible with Exclusive Breast Milk Feeding include: Eliminating supplementation of Breast Milk Fed Healthy, Term Newborns; Skin-to-Skin is Initiated Immediately Following Birth; and Duration of Uninterrupted Skin-to-Skin Contact.
- *Facility concerns about mothers' preferences*: Exclusive Breast Milk Feeding has a subset measure limited to women who choose to breastfeed (PC-05a) to address concerns of facilities and others about considering women's preferences.

We would like to clarify that the two presentations of state experiences with the Medicaid Child Core Set at the recent MAP Medicaid Child Task Force meeting expressly identified various issues noted above. For example, presenters identified the need for measures that apply to large segments of the child population, the importance of access to eMeasures, and the burden to families and states of numerous chronic child health conditions. One of those states is currently voluntarily using the Exclusive Breast Milk Feeding measure, as it is considered to be foundational.

The above points clarify that this measure is compatible with MAP Measure Selection Criteria and with where our health system is headed in the coming years. The coming year would be an opportune time to bring this measure into the Medicaid Child Core Set.

National Association of State Mental Health Program Directors

Stuart Gordon

The National Association of State Mental Health Program Directors (NASMHPD) —representing the state executives responsible for the $37 billion public mental health service delivery systems serving 7.2 million people annually in 50 states, 4 territories, and the District of Columbia— strongly recommends the Measures Application Partnership (MAP) strengthen its recommendations for inclusion of behavioral measures in the revised 2015 Medicaid Core Set of Children's Health Quality Measures.

In its draft report, MAP builds a strong case for the need for additional behavioral health measures, highlighting the high frequency of emergency department visits by Medicaid children with mood and conduct disorders and noting that the most costly medical conditions among Medicaid children are mental disorders. Unfortunately, its final recommendations included only one measure—Suicide Risk Assessment—and then ranked it only fourth of the six quality measures recommended for addition in 2015.

During its October 17 discussions leading to the report recommendations, MAP members indicated they are waiting for more perfect behavioral health quality measures to emerge from the CMS-designated Pediatric Centers of Excellence. While we, like MAP, are pleased there are several promising measures in the developmental pipeline, the time is now for strengthening quality measurement of Medicaid pediatric behavioral health services. Children suffer with behavioral health conditions today, and nowhere more pervasively than in the Medicaid population.

We'd also note that many studies have shown a high prevalence of co-occurring medical conditions among individuals with behavioral health conditions. The more severe the medical condition, the more likely that the patient will experience clinical depression. At the same time, depression and other behavioral health conditions may be a precursor to severe medical conditions. However, people treated for co-occurring depression often experience an improvement in their overall medical condition, better compliance with general medical care, and a better quality of life. Thank you for your attention to our comments.

AmeriHealth Caritas Family of Companies

Thomas James

I appreciate the opportunity to review and comment of the work of the MAP Medicaid Child Task Force. The goals of the health care quality measures is on target in trying to improve the physical and behavioral health of children. This was an initial set to augment the core set of measures. We are pleased that a more in depth look will be planned for Spring 2015. That will allow for creating measures that are broader in scope than those currently available or proposed.

National Initiative for Children's Healthcare Quality (NICHQ)

Charles Homer

We would like to commend the MAP Medicaid Child Task Force for a thoughtful approach based on data and stakeholder perspectives. The linkage of measures to population need is especially valuable and to be commended.

Highmark, Inc

Nancy Mulvaney

In general - In agreement with MAPs effort to use NQF and NCQA measures to be aligned with more global populations. There should also be a continued measure focus on access and education for mental and behavioral health issues.

AmeriHealth Caritas

Chelsea Newhall

AmeriHealth Caritas Family of Companies supports the work of MAP to strengthen the core set of quality measures for children enrolled in Medicaid and CHIP. AmeriHealth Caritas has over 30 years of experience managing care for individuals and families in publicly-funded programs serving nearly 6 million individuals in 16 states and the District of Columbia. We support the core measure set as these measures represent the diverse health needs of the child Medicaid and

CHIP population, as well as furthers the integration of physical and behavioral health care services.

Family Voices NJ/SPAN

Lauren Agoratus

In general we support the measures as they include 5 out of 6 of the Maternal/Child Health Bureau's six core outcomes (patient satisfaction, care coordination/medical home, insurance access, early screening, and community-based services). However, transition from pediatric to adult health care is an important component that is missing. Effective transition to adult care results in better health outcomes. In addition, there are no measures specifically for children with special health care needs. As 1 in 5 children has special needs, high quality care for this population that is cost effective needs to be addressed. There should be a measure for children with special needs on access to care, particularly in the area of network adequacy. In addition, measures on care coordination/medical home, insurance access, community-based services, and early and continuous screening should be reviewed to identify additional or particularly critical components of care for children and youth with special healthcare needs.

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 Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2014. Established in 2006, PQA is a multi-stakeholder, consensus-based membership organization that collaboratively promotes appropriate medication use and develops strategies for measuring and reporting performance information related to medications. Assessment of the quality of medication use and management throughout the healthcare delivery continuum leads to improved health.

During a September 2014 web meeting, MAP identified numerous gaps in measures in the current Child Core Set, including measures of mental health and overuse/medically unnecessary care. PQA suggests that the MAP consider the following additional medication measure:

NQF #2337: Antipsychotic Use in Children Under 5 years old.

This measure calculates the percentage of children under age 5 who were dispensed antipsychotic medications during the measurement year.

We recognize that these medications are being used increasingly among children, particularly in the Medicaid population, and that for very young children under age 5 there are no FDA approved indications. There are, however significant metabolic adverse effects, which are currently being characterized, but which include at least significant weight gain.

Measure-Specific Recommendations

Children's Hospital Association

Ellen Schwalenstocker

In general, the Children's Hospital Association agrees with the Task Force's measure-specific recommendations. We are especially supportive of the inclusion of the Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version. This survey addresses an important gap in currently available pediatric measures and is an example of the significant contributions being made by the Pediatric Quality Measurement Program (PQMP). The Children's Hospital Association agrees with the comment made by Family Voices with regard to the importance of measures related to network adequacy, including access to specialty care and treatment. Although we understand the rationale for recommending the removal of the current measure on dental treatment, we believe development of and inclusion of meaningful measures of access to and effectiveness of treatment are critically important. We understand that access to/ availability of specialty services is a topic for which additional measures are being developed through the PQMP. The Children's Hospital Association looks forward to the more in-depth review of measures emerging from this program in

2015. Finally, if available, it would be helpful to see a discussion of other measures that may have been considered by the Task Force but not included in the list of measures supported for addition to the Child Core Set.

America's Health Insurance Plans

Carmella Bocchino

MAP has recommended that CMS consider up to six measures for phased addition to the Child Core Set. We recommend that the MAP modify this recommendation given that new quality measures developed by the CHIPRA Pediatric Healthcare Quality Measures Program Centers of Excellence (COEs) and the anticipated NQF-endorsement of care coordination, behavioral health, and inpatient care measures are forthcoming in 2015. Additionally, the proliferation and use of quality measures by various programs have increased the cost and administrative burden to health plans, providers, and states to collect and report measures, thus we support the inclusion of a limited number of measures that address important gaps in the current measure set until additional measure development and endorsement work is complete. At this time, we only recommend inclusion of the following three measures that MAP ranked highest priority: #2508 – Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk; #2548 – Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS); and #2509 – Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk in the Core Child Set.

We also support MAP's recommendation to remove the measure Percent of Eligibles that Received Dental Treatment Services. This measure is not effective for quality improvement purposes as it does not capture the necessity or quality of services rendered.

National Association of State Mental Health Program Directors

Stuart Gordon

The National Association of State Mental Health Program Directors (NASMHPD) —representing the state executives responsible for the $37 billion public mental health service delivery systems serving 7.2 million people annually in 50 states, 4 territories, and the District of Columbia— strongly recommends the Measures Application Partnership (MAP) strengthen its recommendations for inclusion of behavioral measures in the revised 2015 Medicaid Core Set of Children's Health Quality Measures.

In its Expedited Review draft report, MAP builds a strong case for the need for additional behavioral health measures, highlighting the high frequency of emergency department visits by Medicaid children with mood and conduct disorders and noting that the most costly medical conditions among Medicaid children are mental disorders. Unfortunately its final recommendation for measures included only one measure—Suicide Risk Assessment—and then ranked it only fourth of the six quality measures recommended.

The Substance Abuse and Mental Health Services Administration (SAMSHA) had sent a letter of support for Measure 0418 (Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan), one of the five behavioral health measures considered by the MAP Task Force on October 17. That measure was rejected when it received only five of the necessary seven Task Force votes because only five states are currently doing analogous adult screenings and because the screenings could be operationally challenging; MAP members contended that not all states or managed care providers have the capacity to conduct the required follow-up planning.

The rejection of measures on these bases disregards the underlying aspirational objective behind the Medicaid child quality measures: that providers and states should be focused on improving services to achieve higher quality outcomes. A measure like 0418 should be used to drive the use of follow-up planning, not rejected because the intended outcome is not currently being widely achieved or is not easily achieved. Thank you for your attention to our comments.

AmeriHealth Caritas Family of Companies

Thomas James

I was privileged to be present at the MAP meeting on these measures and agree with the concerns over percent of eligible receiving dental treatment services as the measure does not define the necessity or quality of those services, but only assumes that appropriateness.

I agree with the Core measure set and with measures for phased addition to the child core set. There does seem to be a balance of pre-natal care, growth and development, preventive services, medical (chlamydia and Asthma), hospital safety, dental, consumer-focused (CAHPS), and behavioral health measures.

California Dept. of Health Care Services

Robert Isman

We agree with the addition of the two sealant measures (NQF #2508 and 2509).

We agree with removal of the CMS dental treatment measure for the reasons stated. However, there were three other NQF-endorsed measures that were not included in the MAP recommendations. These were Utilization of Services, Oral Evaluation, and Topical Fluoride Intensity. We believe that together, the five NQF-endorsed dental measures provide a much better overall picture of the quality of care being provided to Medicaid children than just the two sealant measures.

National Initiative for Children's Healthcare Quality (NICHQ)

Charles Homer

1. We recommend retaining the measure of dental access. Having one visit is consistent with preventive service recommendations. Visits for acute illness would not drive performance differentially on this measure.

2. We endorse the measures for sealant use.

3. We strongly support the measure of suicidality assessment given the importance of mental health.

4. We strongly endorse inclusion of the new HCAHPS measure. It is well tested and fills a great need.

5. We strongly endorse the two perinatal measures--level of care and breastfeeding. Both have a strong evidence base, are aligned with numerous national initiatives, and address key public health concerns.

Highmark, Inc

Nancy Mulvaney

Percentage of Eligibles that Received Dental Treatment Services

Highmark comment: In agreement with removing this measure.

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

Highmark comment: Because of timing issues receiving claims through state Medicaid and CHIP programs there should be a 2 to 3 month allowance in the measurement period for claims processing. We are also in agreement with this measure as a priority.

NQF #2509 Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk

Highmark comment: See above for same comments #2508

NQF #0480 PC-05 Exclusive Breast Milk Feeding

Highmark comment - Not in agreement with this measure. There is strong evidence of the benefits of breast feeding but individual and community support for successful breast feeding varies or may not exist. A mother's comfort and cultural preferences should be taken into account.

AmeriHealth Caritas

Chelsea Newhall

AmeriHealth Caritas broadly supports the quality measures given the availability of NQF-endorsed measures. We encourage MAP to modify their recommendations to CMS for inclusion of up to six new measures to the Child Core Set. Given that new quality measures developed by CHIPRA Pediatric Healthcare Quality Measures Program Centers of Excellence (COEs) and the anticipated NQF-endorsement of care coordination, behavioral health, and inpatient care measures are forthcoming in 2014, we only recommend inclusion of three measures in

the Core Child Set:

- NQF #2508 -- Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk
- NQF #2548 -- Consumer Assessment of Healthcare Providers and Systems Hospital Survey -- Child Version (Child HCAHPS)
- NQF #2509 -- Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk

These measures are the three that received highest priority ranking from MAP. Recognizing the cost and administrative burden to States to collect and report measures, we support the inclusion of limited measures that address important gaps in the current set until additional measure development and endorsement work is complete in 2015.

Family Voices NJ/SPAN

Lauren Agoratus

We disagree with the deletion of the measure "Percentage of Eligibles That Received Dental Treatment." Although the new measures on dental sealants are good, it is not enough. Access to dental care is one of the measures with the lowest performance in Medicaid and failure to ensure ongoing dental care can have devastating consequences. Just because a vital measure is hard to achieve does not mean that it should be removed; our quality reach may well exceed our grasp, and while the reaching does not result in achieving the measure, it keeps us trying to achieve it; removing the measure may turn our attention away from it because "we treasure what we measure."

Measures for Phased Addition to the Child Core Set

We understand that there are 6 proposed measures. Two measures are regarding dental sealants with which we agree, but we disagree with elimination of the general dental measure as stated previously. We strongly support the use of the CAHPS (Consumer Assessment of Healthcare Providers) child version. We agree that this will help "address two gaps… inpatient measures and patient experience." We also agree that it is important to align with the adult version of CAHPS. However if possible, we would recommend a core set of optional questions for states in the child version for consistency.

We strongly agree with the measure on suicide risk. Although there has been over-prescribing of psychotropic medications especially for young children and those in foster care, we would exercise caution regarding the statement on rising rates as recent research is showing that the pendulum is swinging in the opposite direction. Providers are now hesitant to prescribe due to "black box warnings" and this has also resulted in increased suicides, so there needs to be a balance. We also agree with the proposed measures regarding low birthweight infants as well as breastfeeding for best outcomes. Longitudinally there are still underserved populations. For example in NJ the mortality rate for African American infants has been 3 times higher than for white infants for years.

Strategic Recommendations

Children's Hospital Association

Ellen Schwalenstocker

The Children's Hospital Association agrees with the strategic issues described in the report. We strongly agree with the MAP's recognition of the need for additional long-term planning for measure development to ensure that work on high-priority pediatric quality measures continues once the current funding for the PQMP ends. The PQMP is the first significant national investment in pediatric measure development. It is critical that mechanisms for additional funding be identified for measure development as well as maintenance, stewardship and implementation. Additionally, given limitations in states' capacity to collect clinical quality information, mechanisms for implementing pediatric quality measurement beyond state reporting of the core set are needed to address the intent of CHIPRA to "allow purchasers, families and health care providers to understand the quality of care in relation to the preventive needs of children, treatments aimed at managing and resolving acute conditions and diagnostic and treatment services whose purpose is to correct or ameliorate physical, mental or developmental conditions." The Children's Hospital Association believes that alignment of measures across programs is important; however, we believe that alignment should be secondary to ensuring

that a sufficiently robust set of measures is available to address the quality domains appropriate to all sub-populations of children. Finally, we believe that is essential to recognize the need for a national platform for collecting and aggregating data as a strategic issue.

America's Health Insurance Plans

Carmella Bocchino

We support MAP's efforts to align measures across programs, particularly given the administrative burden and limited available resources to collect and report measures to CMS. We encourage continued measure harmonization and development of a more parsimonious measure set where appropriate. Such a parsimonious measure set should be inclusive enough to address the quality of care delivered to poor and vulnerable populations.

We agree with MAP's concern over the loss of integrity when facility- and/or health plan-level measures are retrofitted for state-level reporting without consideration of feasibility and reliability. The issue of feasibility of existing measures for state-level reporting must remain a high-priority area for future discussion and consideration.

Finally, the Child Medicaid population has needs that exceed the capacity of the health care system. To improve the health of children there need to be community measures of school effectiveness, urban planning and physical safety. NQF should lead the quality community in working toward the development of non-medical system measures impacting health or at least measures of the medical system integrating with community resources for a global approach to child health at the individual and population level.

AmeriHealth Caritas Family of Companies

Thomas James

Despite the very real need for parsimony in aggregate numbers of measures we see areas that we feel are important child health issues that are missing. These include:

1. Sickle Cell Disease measures (since this and asthma are the two largest causes for hospitalization among children on Medicaid.

2. Autism—one in 68 school children have this disorder but the variation in management is extremely wide leading to disparities in care.

3. Need for Socioeconomic Risk Adjustment for outcomes measures.

Finally, this population faces needs that exceed the capacity of the health care system. To improve the health of children there need to be community measures of school effectiveness, urban planning and physical safety. NQF should lead the quality community in working toward the development of non-medical system measures impacting health or at least measures of the medical system integrating with community resources for a global approach to child health at the individual and population level.

National Initiative for Children's Healthcare Quality (NICHQ)

Charles Homer

We firmly support a clear, consistent and transparent process for endorsement and use of measures for Medicaid and CHIP including the measures under development by the COE. A strong statement from NQF supporting the continued federal investment in robust measurement development and testing may be helpful.

Highmark, Inc

Nancy Mulvaney

New measures undergoing development and testing

Highmark comment - Agree that new measures by Pediatric Quality Measures Program PQMP may be better to address stated gaps; however alignment with other reporting programs (HEDIS, PQRS, QRS etc) leads to better efficiency of resources and more focused efforts on specific quality issues. Addition of new measures outside of existing programs should have strong rationale for inclusion.

Feasibility of reporting and electronic data

Highmark comment - Agree with issues on feasibility of electronic data reporting with the lack of Medicaid data infrastructure and resources, so recommend pursuit of 'Emeasures', but only if an alternative administrative method exists.

AmeriHealth Caritas

Chelsea Newhall

We strongly support MAP's efforts to align measures across programs, particularly given the administrative burden and limited available resources at the state-level to collect and report measures to CMS. As a Medicaid managed care organization with health plans in multiple states, we understand the variation across states to measure the impact of the Medicaid and CHIP programs. We believe that harmonization of measures across states is critical.

AmeriHealth Caritas agrees with MAP's concerns over the loss of integrity when facility- and/or health plan-level measures are retrofitted for state-level reporting without consideration of feasibility and reliability. We believe measures use for state-level reporting should be reviewed through the NQF consensus development process to ensure that measures are tested and validated. The issue of feasibility of existing measures for state-level reporting must remain a high-priority area for future discussion and consideration. This is an area of on-going concern for AmeriHealth Caritas.

Family Voices NJ/SPAN

Lauren Agoratus

Feasibility of Reporting and Electronic Data Infrastructure

Unfortunately we agree that "uptake of …measures would be quite low" and agree that there should be "continued development of eMeasures." We also concur that the Centers for Medicaid and Medicare (CMS) need to provide technical assistance to states. Currently the priority right now needs to be addressing the Medicaid backlog in states for those enrolling, including from the Marketplace.

Pipeline of Measures in Development

We can appreciate that there are future measures in development. We agree with the consensus to "defer action on supporting measures in these topic areas until more information on the new measures could made available" as clarification is needed.

Alignment of Measures

As stated previously, we agree with aligning child and adult measures and appreciate the consideration given to "the relationship between the selected measures and those contained in the Adult Core Set." However, we caution against rigid over-alignment or alignment for alignment's sake when adult measures are not appropriate for children, and when there are child measures that must be added despite the fact that they are not adult measures. We also agree that it is important to align with Meaningful Use, which involves electronic health records use for physicians. Lastly we strongly agree that there should be "overlap with HEDIS (Healthcare Effectiveness Data and Information Set) for quality measurement of Medicaid.

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

www.qualityforum.org